Lifestyle (Abbey Care) Limited

Lifestyle (Abbey Care) Limited Archery - Bower

Inspection report

Abbey Care Village
Scorton
Richmond
DL10 6EB
Tel: 01748 811971
Website: www.abbeycarevillage.co.uk

Date of inspection visit: 4 and 10 February 2015
Date of publication: 19/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 July 2014 which was undertaken during the testing phase of our new approach to regulating adult social care services. During this inspection we found a breach of legal requirements. We undertook a comprehensive inspection on 4 and 10 February 2015 to follow up on whether action had been taken to deal with the breaches.

Lifestyle (Abbey Care) Limited Archery – Bower provides nursing care and accommodation for up to 60 older people which included a dementia care service. The home has four areas three were operational at the time of the visit and one unit was closed. Each unit has a lounge and dining room. All accommodation has en-suite facilities. During our inspection there were 25 people living at the home.

Summary of findings

After our inspection of 22 July 2014 we asked the provider, that is, the legal entity that provides a regulated adult social care or healthcare service to members of the public, to write to us to tell us what they were going to do to meet legal requirements in relation to breaches of regulations identified at that inspection. The breaches were of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services, Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers; Regulation 13 HSCA 2008 (Regulated Activates) Regulations 2010. Management of medicines; Regulation 14 HSCA 2008 (Regulated Activates) Regulations 2010. Meeting nutritional needs; Regulation 18 HSCA 2008 (Regulated Activates) Regulations 2010. Consent to care and treatment; Regulation 20 HSCA 2008 (Regulated Activates) Regulations 2010.Records; Regulation 23 HSCA 2008 (Regulated Activates) Regulations 2010. Supporting workers. The provider did not provide an action plan detailing what they were going to do to meet these legal requirements.

This inspection was carried out to look at the five questions, is the service safe, effective, caring, responsive and well-led and to follow up on whether action had been taken to deal with the breaches. At this inspection we found further breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe. The acting manager and staff had undergone refresher training with regard to safeguarding adults from abuse. Staff were able to tell us what they would do if they suspected abuse had taken place.

Action had been taken to improve the safety and maintenance of the building and equipment used to support people. There was an action plan in place to ensure this continued.

Accidents and incidents were not analysed effectively. Risk assessments did not contain sufficiently detail and were not reviewed. This had a direct impact on some people's health and wellbeing.

Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

Appropriate checks were completed to help reduce the risk of employing unsuitable staff. There were enough staff on duty and while there were plans to make sure staff had the right skills and knowledge to meet people's needs this was not yet the case for all staff.

Some staff had received training with regard to the Mental Capacity Act (2005) and Deprivation of Liberty safeguards. However we found some practice still did not take into account people's mental capacity and best interests.

We found improvements to the food and drink provided and people we spoke with told us they were happy with the improvements. The new chef provided nutritious and appetising looking meals.

We found people's needs were still not being assessed sufficiently and inaccurate, conflicting information recorded in care plans resulted in some people not having their needs met.

The provider responded to complaints in a timely manner and people felt confident any concerns would be listened to and acted upon.

Although a new general manager had recently started in post, quality and monitoring of the service had not been previously been taking place. This meant improvements to the service had not been made in a timely manner.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found the service was not safe.

People who were able, told us they felt safe.

Staff had received updated safeguarding training and were able to demonstrate an understanding of what constitutes abuse and how to raise a safeguarding alert. The manager was now making safeguarding alerts to the local authority which meant people could be better protected from harm.

There were some improvements in the maintenance of the building and equipment; servicing and monitoring systems were in place.

We found a lack of robust risk assessing and analysis of accidents and incidents which had impacted on people's health and wellbeing. This was a previous breach of regulations. We are taking further enforcement action.

We found some poor practice with regard to infection control and recommended the provider consults with guidance on reducing the risk of infection.

There sufficient numbers of staff on duty. There were plans to redeploy staff according to their skills and experience to make sure people's needs were met but these were not fully implemented.

Medicines were not administered or recorded properly. This had been a previous breach in regulations. We are taking further enforcement action.

Is the service effective?

Requires improvement

We found the service was not effective.

During the period between the previous inspection and this inspection staff had not received supervision and updated training. Since the general manager came into post a programme of training and supervision had started. The provider keeps the commission informed of progress with this. Staff did not have the knowledge and skills to provide a specialist service for people living with dementia and we recommended the provider consider how to improve on this.

Due to a lack of understanding of the complexity of consent and capacity with regard to day to day care practice people were not always consulted about their preferences. However some staff had received training about the Mental Capacity Act 2005 and Deprivation of liberty safeguards (DoLs) and the provider had begun to make appropriate referrals and carry out mental capacity assessments.

Summary of findings

People were very pleased with the improvements in the food provided. There was a new chef in post, with new food suppliers and menus. People were supported sensitively if they needed assistance.

Is the service caring?
The service was caring

People were positive about the staff and told us they were kind and caring. We observed staff respond to people in a kind and caring manner; they were patient and we heard some light hearted banter.

People had their privacy and dignity respected. We saw staff knocking on people's bedrooms doors before entering.

Good

Is the service responsive?
The service was not responsive.

People we spoke with expressed satisfaction with the care and support they or their relative received.

A lack of robust care planning impacted on people's health and wellbeing. Care plans lacked or contained contradictory information which meant staff were not always able to provide care and support in manner which responded to the person's needs.

We found staff lacked the skills and understanding in providing up to date , good quality dementia care.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

The provider had made some efforts to seek the views of people but had not collated them in the form of an action plan to improve the service.

Inadequate

Is the service well-led?
We found the service was not well led.

The provider had taken action and recruited a general manager whose role was to improve the service and meet regulations. At the time of the inspection this person had not been in post for sufficient time to make those improvements.

Auditing and monitoring the quality of the service since the previous inspection had not been taking place and this had impacted on people's health and wellbeing.

Requires improvement

Lifestyle (Abbey Care) Limited Archery - Bower

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the

Overall quality of the service, and provided a rating for the service under the Care Act 2014.

You can find full information about our findings in the detailed findings sections of this report.

We carried out an unannounced comprehensive inspection of Lifestyle (Abbey Care) Limited Archery Bower on 3 and 10 February 2015. This inspection was completed to check that improvements had been made to meet the legal requirements identified at the inspection of 22 July 2014.

The inspection team inspected the five questions we ask about the service : is the service safe, effective, caring, responsive and well led?

The inspection was undertaken by three adult social care inspectors, a pharmacy inspector and an expert by experience.

We spoke with ten people who used the service and six relatives. During our inspection we carried out observations of staff interacting with people and included structured observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us. We looked at all areas of the home including a sample of people's bedrooms.

During the inspection visit we reviewed five people's care records in detail and specific aspects within the records for a further three people. We looked at three staff recruitment files, records required for the management of the home such as maintenance records relating to equipment and the health and safety of the home. We looked at quality assurance audits, minutes from meetings and satisfaction surveys, medication storage and administration. We also spoke to the general manager, the manager; and eight members of staff including two nursing staff, four care staff, one ancillary staff and the chef.

Before the inspection we had attended or received minutes of meetings arranged by the local authority and attended by representatives of the local authority safeguarding team, the local authority contract and commissioning team and the local Commissioning Group (CCG) as well as the directors of this service in order to monitor the situation at Lifestyles (Abbey Care) Archery Bower.

We looked at notifications we had received for this service and reviewed all the intelligence CQC had received. We reviewed all of this information to help us make a judgement about this care home.

We received information from Healthwatch. They are an independent body who hold key information about the local views and experiences of people receiving care. CQC has a statutory duty to work with Healthwatch to take account of their views and to consider any concerns that may have been raised with them about this service.

Inadequate

Is the service safe?

Our findings

The service was not safe

The previous inspection of 22 July 2015 had found breaches in legal requirements.

During this inspection we found some areas of improvement but these were not sufficient to address the breaches in legal requirements identified at the previous inspection.

The previous inspection had identified a failure to properly risk assess and monitor the safety of the environment and equipment in the service this was a breach in regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we spoke with managers and staff about managing risks for the service as a whole and for people individually. The general manager informed us that they were in the process of recruiting new maintenance staff to fill a recent vacancy. Temporary maintenance staff were available and had been given an action plan of issues to rectify. The general manager told us they had produced new auditing systems in order to check and follow up any issues in a timely manner. The general manager had arranged contracts with utility services and had followed up on outstanding health and safety servicing, for example, gas, hoisting equipment, passenger lifts, electrical systems and legionella testing.

We tested the hot water in bathrooms and found it to feel cool. An ancillary worker told us this happened occasionally; she told us she wasn't sure what to do about this or who to report it to. This meant staff were unaware of how to report faults which then caused a time delay in action to rectify them. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed how risk was assessed and responded to for people. During our visit on 10 February 2015 we carried out observations over the lunchtime period. We noted that one person was reluctant to eat and had to be coaxed to open their mouth. We checked the records for this person and noted that records stated they had a good appetite we saw this person had lost weight. We saw recorded on 30 October 2014 that this person's mouth was painful with bleeding gums and staff had recorded a query about the possibility of toothache. Records in November 2014 identified that this person was getting progressively slower in eating and they were taking longer to chew and then swallow their food. This was repeated in records throughout November 2014 and stating they had begun to hold food in their mouth. We saw staff had recorded they had requested a soft diet until they had been assessed by the SALT (speech and language therapist team.) According to this person's nutritional care plan a MUST (malnutrition risk assessment tool.) was to be completed each month. However, we saw the last entry was dated December 2014 despite evidence of further weight loss between January and February 2015. The acting manager confirmed to us that they were not aware of a problem with this person's mouth and that no referral had been made to the SALT team. We raised this with the general manager who gave assurances that an urgent relevant health referral would be made. We saw another person's record stated they were at risk from weight loss and required monthly weights however the last weight recorded was December 2014. We asked staff about this person and they told us they no longer needed weighing.

We looked at accident and incident reports and saw a specific form to complete to analyse and respond to falls. The format of the document was detailed with headings which led the person completing the form to examine areas to consider which would then lead to the action to reduce the risk of falling. For example, the time of day the person was falling, the medicines they were taking, any changes to physical or emotional heath and any changes to the environment. We noted for one person for the period between October 2014 and February 2015 they had experienced nine (9) falls. All had been recorded but there was no action recorded or review of this person's care plan or risk assessment to reduce the risk of falls. Although there was an effective process this had not been followed and therefore put people at further risk.

We saw in the same person's file they experienced distressed reactions manifesting in confronting staff and other people living at the service; they repeatedly requested to go home. We could see no comprehensive risk assessment which had mapped this person's' behaviour to understand it or guide staff about responding and alleviating this person's distress. The service had referred to the local community mental health team who had advised

completing 'ABC' charts following an incident; ABC charts are a recording tool to assist in understanding and identifying triggers to distressing behaviours and in identifying best to alleviate and improve the person's wellbeing. We did see a care plan which directed staff to 'distract.' The 'aggressive behaviour' risk assessment stated this person posed a risk of injury to self and others and directed staff to be aware and refer to home policy on dealing with challenging behaviours. It advised staff to 'utilise uniform management strategies (safe holding and breakaway) document and complete ABC charts. Analyse and evaluate for ongoing management.' We noted seven incidents recorded since December 2014. ABC charts had been completed but there was no analysis or care plan completed to assist staff and support this person to reduce distress. We saw an incident recorded on 04/02/15 where by this person's distress lasted for over two hours. We saw the plan was reviewed monthly with 'no change' recorded where clearly there had been some notable changes.

We did observe this man's distress during the inspection and noted one carer's approach was excellent. However this practice was based on the carer's own approach and was not supported by any robust care planning or risk assessments.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action because the provider was breaching this Regulation.

The previous inspection had identified a failure to ensure people's medicines were managed safely. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took enforcement action because the provider was breaching this Regulation.

At this visit we asked if medicines were handled safely. We looked at the medicine administration records for 14 people, talked to staff and people living in the home.

We looked at how medicines were administered and found that the arrangements were not always safe. The home had introduced a checking system for stocks of boxed medicines. However when we checked a sample of boxed and liquid medicines alongside the records we found that four medicines did not match up so we could not be sure if people were having their medication administered correctly.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that care workers did not have enough information about what medicines were prescribed for and how to safely administer them.

All of the people who used this service had their medicines given to them by the staff. We watched a nurse giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines.

People were not protected against the risks associated with covert administration of medication. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. Three people had medicines administered crushed and mixed with food however clear records were not available to show how the decision to administer this medication in this way had been reached. No guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way.

Records relating to medication were not completed correctly placing people at risk of medication errors. There were gaps on people's medicine records where the records had not been signed to show that the medicine had been taken as prescribed. If the dose had been omitted staff had not recorded the reason for this.

We saw for some medicines no record had been made of any quantities carried forward from the previous month. This is necessary so accurate records of medicines are available so that staff can monitor when further medicines would need to be ordered.

For one person the medication record was handwritten and incorrectly listed the strength of the medicine being administered. Normally this record would be checked by a second person to confirm that an accurate record was made but that had not happened for this person.

Inadequate

Is the service safe?

We found that records were not clear when the dose of a medicine was changed. For example one person was prescribed a medicine with an increasing dose regime. It was not clear from the medicine administration record what dose was currently being administered

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home completed checks on the medication records weekly. Some of these had not been accurately completed and therefore the issues we found had not been identified.

We found that the service's arrangements for the management of medicines did not protect people. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action because the provider was breaching this Regulation and can be seen in the enforcement section of this report.. (Need to say was the breach was in the enforcement action taken section at the end)

We asked people if they felt safe. They told us "I feel very safe here – a lot safer than on my own."

And "I trust the night staff." Someone else told us "We both feel safe – I couldn't wish for anything different."

Since the previous inspection four members of staff had received updated safeguarding training.

We were told this training was in the form of e learning and understanding of the training was not verified by managers of the service. However, with the exception of one member of staff, when we spoke with staff about safeguarding they were able to demonstrate an understanding of the issues and how and in what circumstances they would raise an alert. The local authority team reported an improvement in the numbers of alerts being made directly by the service.

The previous inspection had identified unsafe moving and handling techniques. We noted that in one person's file they needed to use a hoist but the type and size of hoist sling was not identified. We asked the acting manager whether people had individual slings and were told only if there was a risk of infection such as MRSA. The general manager told us slings were routinely laundered at a high temperature. We clarified that it is best practise for people to have their own sling for safety and risk of infection. We reviewed the training records for moving and handling and saw that out of 27 care staff listed on the training matrix 9 required up dated training, one of whom was the acting manager and two nursing staff, all of whom held responsibility for taking charge of shifts and people's care. The provider's policy and procedure stated that for hoisting people this required two staff both of which have up to date training in moving and handling. We checked the rota against those staff with up to date training and saw for example that on 30 December 2014 there were six people on duty. According to the training matrix only three members of staff were qualified as safe in moving and handling. This placed people at risk of receiving unsafe moving and handling.

We toured the premises and noted a number of issues which raised concerns about people's safety. For example people who lacked capacity had access to an office where scissors, staplers and nail varnish remover was left on a desk. We noted a vacuum cleaner left unattended with a trailing flex despite it being drawn to the attention of the manager.

During our visit we identified some issues around the cleanliness of the home. Bins situated around the home were of a 'flip top' variety. During our visit we observed staff using the bins without washing their hands after touching waste material. Foot operated bins are better for hygiene because they reduce the risk of hands picking up germs when they touch the bin lid. We also observed smear marks on one toilet wall. In one toilet cubicle a bin was labelled 'use other bin for sanitary products'. However, no other bin was in the room. Domestic staff completed a daily work sheet but there was no quality assurance for the checks being carried out. The acting manager acknowledged these failings to us.

We saw an infection control audit dated 30 January 2014 and 30 January 2015. When we asked the manager the correct date they agreed the incorrect date had been added to the former record and confirmed both audits were carried out over one day in January 2015. Action was

Is the service safe?

identified as needed in relation to dirty commodes, bed pans and floor seals. The manager told us an action plan was in place but was not able to locate it during our visit. The level of cleanliness in the home indicated to us that the auditing tool was not being use effectively.

We spoke with people about staffing levels. One person said "There's not enough staff." Another person told us they spent a lot of time in bed and commented that "the staff don't have time to talk to me." We spoke with two relatives who said there was "possibly not enough staff" and "They could do with more staff." Another person commented that "There have been quite a lot of staff changes." We noted that people looked clean and well groomed but we heard comments from two people that they would like to have more baths.

We spoke with staff about staffing levels, one person said there were no issues but three other staff reported feeling under pressure to complete care tasks. The general manager said when they commenced in post staff were reporting feeling rushed and overworked leading to low staff morale and potentially poor standards of care. The general manager identified putting some of this down to poor management. They were in the process of implementing an action plan which included a new staff rota; deploying staff more effectively according to skills and experience to ensure people's assessed care needs were better met. We did not see any delays in people being attended to during both days of our visit but we did see care being provided in a task orientated way rather than person centred. We saw staff did not have sufficient time to deliver any activities either individually or as a group. The manager told us that they had not needed to work on shift for the past three months which had allowed them to concentrate on management tasks.

We looked at the staff recruitment files for three members of staff. We saw from the records that application forms had been completed and important information had been received and checked to make sure those using the service were not at risk from staff who were unsuitable to work with vulnerable people. We saw two references had been sought and a Disclosure and Barring Service check (previously called Criminal Records Bureau (CRB check) to make sure people employed were suitable to work with vulnerable adults. We spoke with a new member of staff who was completing their induction. They told us they had completed a number of training courses with regard to safeguarding adults, the Mental Capacity Act (2005) and health and safety training. They were unsure if their induction was complete or when their probationary period would finish but thought the induction had helped them understand their new role.

We recommend the provider reviews the deployment of staff and considers practice guidance in promoting a culture which is person centred.

We recommend the provider reviews effective infection control making reference to guidance provided by the partner agencies.

Requires improvement

Is the service effective?

Our findings

The service was not effective

The previous inspection had identified breaches in Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider had failed to take steps to assist people to make decisions and the decisions people can make should be recorded. The provider had not made an application for DoLS authorisations even though people's liberty may have been restricted.

During this inspection we spoke to the manager who confirmed she and staff had received training in this area of practice since the previous inspection. They were able to demonstrate an understanding of the recent supreme court ruling which had clarified the notion of deprivation of liberty for people living in a care home setting. They told us they had made five applications for deprivations of liberty safeguards and were awaiting the outcome. Three members of staff confirmed they had received MCA and DoLs training and demonstrated a reasonable awareness of the major issues.

We discussed authorisation to make decisions with the acting manager. She told us that part of the preadmission process was to establish whether the family had power of attorney with regard to health and welfare if the person lacked capacity. We looked at two people's pre admission assessments for people admitted within the previous month and could find no documentation which reflected what we had been told.

We looked at four care records in detail and found mental capacity assessments partially completed. Detail about the specific area for capacity was identified; for example decisions about covert medication but there was a lack of best interest records and no detail about relatives views and whether they had the authority to make those decisions.

Our observations throughout both days of the inspection indicated that some staff understood the concepts of choice, decisions and restrictive care where others did not. We saw people being 'directed' and although people were compliant to these requests, our observations indicated that care was not person centred and did not reflect current good practice with regard to people living with dementia.

In two people's care records we saw a section with an action recorded to 'remove the person from the room' in some circumstances. However, there was no associated documentation to advise staff about how this was to be achieved and no documentation of any collective best interest discussion or decision made that this course of action was in the person's best interest. This is a breach Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff training records and saw that some staff had not received all the necessary training and not all of the relevant staff had completed refresher training in, for example, infection control, moving and handling and fire safety. This meant staff did not have up-to-date knowledge and were not fully informed of current best practice, which could place people at risk of not receiving safe, appropriate care.

The previous inspection had identified that staff were not receiving regular supervision; this included nursing staff who are required to receive clinical supervision as a condition of their professional registration. We asked the acting manager for the records of staff supervision, in particular the nursing staff. We were provided with records which dated back to May 2014. We asked the manager if these were the most up to date and they confirmed they were and formal supervision had not been carried out with nursing staff. When we asked why this was the case the manager said they had "under performed." We noted that the clinical supervisions for nursing staff carried out in May 2014 referred to errors in the administration, storage and recording of medication. There was no evidence that action required had been monitored. Following the inspection of the 22 July 2014 a warning notice with regard to Regulation 13 management of medicines was served. During this inspection similar breaches in this regulation were identified. This demonstrated the manager had failed to follow up or challenge unsafe practice; monitor or supervise staff effectively. All three staff told us they had not received an appraisal or supervision 'for a long time.' This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

The general manager told us they intended to carry out supervision of each member of staff in the near future. They showed us a proforma which detailed areas to be covered in the discussion; this included training, performance and professional development as well as a check on knowledge of polices and procedures. The general manager said they were going to carry out the supervisions in order to establish with staff their roles, responsibilities and the expectations of managers. From this they aimed to establish an overview of staff skills and where additional training or competency checking needed to take place. The general manager explained they intended to develop dedicated staff teams for the units and relocate staff according to skills and experience to ensure a good skill mix in order to meet people's needs more effectively. However none of these arrangements was yet in place.

The general manager told us they had introduced staff meetings and these would become an established pattern but acknowledged prior to them starting in post they had not been taking place regularly.

We discussed staff training with the manager and general manager. The manager acknowledged that training had not been taking place and some staff required updates with regard to mandatory health and safety training such as moving and handling, first aid, safeguarding, MCA, and infection control. The general manager told us they had sourced a new training provider and had a programme of training in place. They told us this included some e learning to ensure people were up to date and competence would be tested during supervision and from observations of practice. The acting manager informed us that staff were now up to date with fire training and further safeguarding adults training was booked. Since the inspection the general manager has kept the commission informed of supervisions and training completed.

A lack of training and supervision increased the risk that people would not receive safe and effective care. The service had a specialist dementia care unit for people living with dementia. Although some staff demonstrated kindness and knew people well our observations indicated that staff did not have the skills and knowledge to provide specialist dementia care which reflected current good practice guidance. Only the general manager had an awareness of the current guidance and research such as The National Dementia Strategy and the Prime Minister's challenge.

The previous inspection raised concerns about available budgeting and quantity of food. We were told the cook in charge was no longer employed and all food was purchased through the service's bank account. We saw new menus had been completed which included more choice. We saw food stocks contained fresh fruit and vegetables. We spoke with the cook on duty and they told us about the changes and that in their opinion the quality of food had improved. They were able to demonstrate an understanding of special diets and fortifying meals to increase calorie intake for those people at risk of malnutrition.

We asked people about the quality of food. One person told us there was 'more than enough to eat.' Another person said 'The food wasn't very nice but now there is a new chef it has improved a lot' They went on to tell us they would like more salads and less chips and they were going to ask for this when salad ingredients would be cheap. They also commented they liked to take their pills with cool filtered water because it made it easier for them to swallow and staff respected this. They said they preferred white bread to brown and the staff now know this. We heard this person request requested cheese on toast for tea rather than the set menu and we later saw this had been respected. A visiting relative told us the food was 'pretty good.'

We observed lunchtime on all three units over the two days of inspection. One the first day of inspection we noted for people living on the dementia unit they were directed to sit down for their meal up 30 minutes before it was served. There was only one kitchen worker serving food to 3 units at the beginning of the lunch period. They served the main courses first to each unit at about midday and then there was a long delay until the pudding came at 12.50 which was then served by another kitchen worker. This meant that people were sat waiting for their desert.

Although there was a choice of main course, staff seemed to make choices for some people. There was no written or pictorial menu available for people to refer to and we were told people made their choices the day before. On one unit there was a chalk board to record the menu but it was incomplete. We were told it was the responsibility of the kitchen staff to complete. We did observe staff asking people what they would like but they did not show people the choice of meal or provide an appropriate description.

Requires improvement

Is the service effective?

On one unit we observed the meal at lunchtime was relaxed and unhurried. The meal served looked appetising and well presented. People were served their meals in the dining room or in their own rooms. During lunchtime we noted that for a period of 15 minutes a visitor was the only person in attendance in the dining room to supervise six people. They said "I like to come in at mealtimes to support them (the staff)." We saw a member of staff assisted one person to make a choice about their meal preference. They spoke to the person clearly and slowly. We saw they observed the person's change of body language and their facial expression to decide what their choice was. However, we saw that other staff were not so skilled and people appeared confused by what they were saying to them. Again we observed information about the menus was not made available in an easy read or a picture format which would help people understand the choices available.

On another unit we observed a member of staff assisting someone with their meal patiently and chatted to them throughout.

We did see drinks and snacks offered throughout the day, however on the first day only orange juice was offered. We were told this was due to an incident which had taken up staff time and delayed breakfast.

Feedback from health care professionals indicated staff made timely referrals. Some health professionals expressed satisfaction with the care provided at the service where as others commented that staff sometimes did not appear knowledgeable about people's health needs or did not follow through advice given. For example analysis of ABC charts and delays in referring the person with a sore mouth. We also noted from one person's records in October 2014 they had seen their doctor for a condition for which ointment was prescribed on a repeat basis. Although the service had taken action immediately we saw from the record that the condition had not improved. The records showed this person still had the condition in January 2015. There was no record to indicate whether the repeat prescription advised in October 2014 was actioned therefore potentially causing delay in treatment.

We recommend the provider considers appropriate training which would enable staff to deliver care and support to people living with dementia.

We recommend a review of staff deployment to enhance the dining experience for people.

Good

Is the service caring?

Our findings

We found the service was caring. People we spoke with were happy with the care and support they received. One person told us “They look after us. All in all it’s very favourable.” Another said “The staff here understand. I’m very fortunate that I’m here. It’s homely.” Other comments included “They make you feel very welcome. I can’t complement the staff more –absolutely brilliant.” And “They care. A number of the girls have become family.”

With the exception of specific incidents referred to in other sections of this report throughout the inspection we witnessed staff being kind and patient with people. Staff appeared to know people well and were able to talk to us in detail about people’s needs; their likes and dislikes. Although we did see staff engaging with people throughout the day, staff concentrated on completing tasks and had little time to engage with people meaningfully. We saw staff speak to people kindly whilst they were attending to them and offering them choice; handing out drinks for instance or assisting to the table. However we also saw people sat or in their rooms for long periods without any interaction from staff unless there were attending them to carry out at task such as personal care or providing food and drink.

We observed staff respecting people’s privacy and dignity. We saw them knocking on people’s doors before entering and bathroom doors were close and ‘engaged’ when people were receiving personal care. Bedroom doors had signs on them to show when people were receiving personal care and we saw these in use. We also saw staff cover people’s knees and ensure people were covered when being transferred from chair to chair or via a lifting hoist. In the main people looked well cared for with attention given to people’s personal appearances.

During the inspection we saw people receiving visitors. We spoke to six relatives who told us they were free to visit at any time and were always made to feel welcome.

There was limited care planning with regard to end of life care planning and little evidence of consultation with people about their wishes. However we spoke with one relative who told us another relative had lived at the home before they died. They told us their end of life care was very respectful, they had been kept fully informed and the staff were very caring.

We asked the manager and staff about the availability of independent advocates for people if they requested it. The manager was unsure if this was available but gave assurances this would be followed up.

Inadequate

Is the service responsive?

Our findings

We found the service was not responsive.

A relative told us they and their family were pleased when their relative settled well in the home. They said, "We feel relaxed as a family. (name) always looks tidy."

Another relative told us their relative had moved to Archery Bower a year ago. They said they were pleased with their relative's care and felt that some of the staff really understood their relatives needs and "had learned how to manage their sometimes challenging behaviour."

We observed two people from a local church come in to deliver communion service, which they did every month. They worked in a lounge with two people and then went to the room to give another person communion privately. One person told us she was catholic and the priest came occasionally.

The previous inspection had found evidence that some people's care records provided conflicting information so it was not clear if their needs had been appropriately assessed and met. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

At this inspection, we reviewed the care plans for five people in detail and specific aspects of care plans for a further three people. The format for care plans included sections to be completed for specific areas of need, for example personal care, mobility, medicine and, nutrition. There were corresponding risk assessments. Some people had pre admission and pre care planning documents in their files. Some people had 'passports' which were intended to contain essential information to travel with the person for example for an emergency admission to hospital. These were kept in plastic folders within the main file.

We found the content of the care plans variable and, in some places, contradictory. Standard sentences had been used which didn't reflect individual need or choice; for example 'requires support for all personal cares.' There was no specific information about personal preferences or choices to direct staff to provide personalised care.

We saw contradictory evidence; for example in one person's pink passport it stated the person received their medicine crushed in food but this did not appear anywhere else in the person's file.

We could see that monthly entries had been made indicating a review had taken place but for all care plans looked at reviews were recorded as 'no change'. For some people we could see there had been changes but this had not been addressed in the record. For example two people had experienced falls yet no review had taken place of risk assessments or care plans.

On 10 February 2015 we observed a conversation taking place between visitors and staff. It was evident that staff did not know that the person was not able to wear shoes and had offered to collect them from their room. We checked the information available for this person who had been newly admitted the day before. Other than a DNAR form there was very little information about the person and a file had not been set up so their information consisted of several leaves of paper held together by a rubber band. Although a pre admission assessment had been completed it contained gaps and had limited information about the person. The form was not signed or dated. However staff from the person's previous home had confirmed that family maintained a close, daily contact with their relative. Clearly, in this instance family could have been a useful source of information to make sure the person's care needs were identified and addressed from the point of admission. Indeed it was the visitors that pointed out the person was not able to wear shoes. This information would enable staff to provide care in line with a person's wishes and would have helped to make the experience of admission as positive as possible for the person.

One person's care plan stated that they enjoyed listening to classical music. However, we observed that their radio was tuned to a pop music channel which they were not engaged with. The exit door from the dementia care floor contained a vision panel. We saw that one gentleman approach this door on numerous occasions to try the door handle. This must have been frustrating for them when they clearly wished to go through the door and we saw their mood clearly deteriorate over this period of time. Staff dealt very well with the person's distressed behaviour but we did not see anyone offer to take them outside.

For one person we saw their 'hospital passport' dated 8 June 2014 indicated they had a poor appetite and were

slow to eat at times. It stated that they were at risk of choking (eating, drinking and swallowing) and required a syrup consistency for fluids. However records did not indicate that their fluids were thickened to assist them to drink safely and we observed their drink was not thickened at lunchtime. When we asked the manager about this matter they stated that the hospital passport was out of date.

The manager explained they would carry out an initial preadmission assessment. Once the person had been admitted a more detailed care plan would be developed. We asked to look at the records for two people who had recently been admitted to the home. We saw plans had not been completed fully and we saw inappropriate care provided to both service users.

In one person's file we saw recorded a care plan detailing the person exhibited aggressive behaviour and safe holding and break away techniques should be used. But in another section of the person's records it stated that the person did not exhibit any aggression.

We spoke to people about how they spent their day and the activities on offer. One person told us there had been "No activity for a long time. That's something we really need." This person recalled a time when "we made bracelets, played quizzes and scrabble with an activities coordinator who was 'great'. This person said they loved singing and they needed something to do in the afternoon. They said "we never get out- that would make a big difference."

A visiting relative commented to us they were sorry their relative lived on the first floor as they felt they would like to get out a bit, just a for a short walk. They said their relative never went out except when the family took them out. They also said they thought there should be more activities. They had been told by staff there was equipment in a cupboard which they had used with their relative but thought it would be nice if jigsaws etc. were left out. They suggested music afternoons and thought people would like to sing. They did say they were pleased that staff allowed their relative to go and 'help' in the laundry – 'it makes them feel they are part of the team.'

We observed a member of staff with a large Connect 4 board. They told us they had been playing this with a gentleman. We saw two people looking through books; one with photographs of the local countryside and the other with a book with photos of themselves. We observed a member of staff engage with this person about the photos.

There was a bird table near the window and some people were watching the birds. One person told us they loved to watch the birds. However most of the time people were sleeping in the lounges with little going on. The TV was on but people did not appear to be engaged in watching the programme.

The service's statement of purpose states they provide a specialist service for people living with dementia. This unit is situated on the first floor with no free access to outdoor space. The environment did not reflect current guidance with regard to dementia friendly environments. For example, dementia friendly signage to assist people locate bathrooms, and their bedrooms was not in place. There was a lack of memorabilia and 'rummage' boxes for people to occupy themselves. There were some small tactile displays on the walls of the corridors but this had no context. The colour schemes and colour contrasts did not take account of current guidance. There was a lack of personal histories in people's care files which would provide information to enhance the relationships between staff and people living in the service. This information would also have helped staff understand people's routines, preferences and any distressed reactions. Staff we spoke with had only received basic e learning in dementia awareness. There were no members of staff with specialist skills and knowledge with regard to provide specialist dementia care. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints record and spoke with the manager about complaints. We saw recorded there had been two verbal complaints since the previous inspections and these had been resolved. People we spoke with, including relatives said they felt able to raise concerns and felt confident that they would be acted upon.

We spoke to the manager about how the service gathered the views of people. They told us they had sent out surveys in October 2014. We looked at a sample of returned surveys and saw a regular theme around dissatisfaction with the lack of activities and quality of food resulting in new menus and food supplies and we were told a new activities

Inadequate

Is the service responsive?

organiser had been recruited. We saw positive comments about staff with one survey stating, ' all the staff are very courteous and keep me well informed" another stated, " I have not failed to recognise the unique and personal care that each resident receives, dependent on their particular circumstances." We asked the manager how they used the information gathered to improve the service. They told us where people had expressed concern she had meet with people individually but results from surveys were not analysed and shared with people or an action plan developed. Relatives and residents meetings were held regularly. The previous inspection had recorded relatives request for a representative from the service to attend one of their meetings. This had not happened to date.

Requires improvement

Is the service well-led?

Our findings

The service was not well led. The service has been in breach of Regulation 10, assessing and monitoring the quality of service provision, HSCA 2008 (Regulated Activities) Regulations 2010 since May 2013. Since that time there have been some systems put in place to meet this requirement but these have not been sustained sufficiently. The acting manager has been in post since March 2014 and has yet to submit an application to register with the Care Quality Commission. This is a breach of the provider's conditions of registration. The provider is required to nominate a person (nominated individual) (NI) to supervise the management of the service and the regulated activities for which the service is registered. Previous inspections have identified failings in this regard, for example we have previously told the provider they must send us a report detailing what action they were going to take to improve the service and meet the required standards. The provider did send us a variety of information about the service but this was not in the form of a detailed action plan.

The NI for this service had recently appointed a general manager. This person was present at the inspection and explained they had been employed to implement improvements and oversee the service and those of two others on the same site. The general manager explained they had been in post for three weeks and had spent this time dealing with immediate concerns and actions but also assessing and evaluating the service in order to develop an action plan. They saw immediate action required in the safety of the building and had secured servicing contracts for gas, electricity and other equipment. They told us they saw an audit of staff skills and knowledge as a priority in order to begin to deploy staff where most appropriate to ensure people's needs were met. They had already identified gaps in training and had developed a training programme and sourced training organisations to deliver this. The general manager discussed their vision and values in providing a high quality of care and explained they had held meetings with staff to share this. We spoke with staff who were positive about the proposed changes and those which had already happened. Staff said 'he's just what we need, already we can see changes for the better; we want a good reputation.' The general manager had taken the decision to suspend all new placements whilst this process was completed.

However, prior to the general manager being appointed the manager and NI had failed to take sufficient action to make the improvements necessary to meet with requirements. Although some of the improvements required were reliant on the provider taking action others were not. For example ensuring staff received regular supervision, auditing and monitoring care planning, risk assessments and medicines management.

On 10 February 2015 we saw there was a file for internal quality monitoring checks along with an internal audit policy, which was reviewed in July 2014. We saw proformas were in place to record a range of checks such as the daily monitoring of fridge temperatures, weekly fire tests and monthly hot water temperature checks. Further audits were in place to check recruitment and personnel files, pressure ulcer reviews, wheelchairs, medicines and health and safety checks.

The manager told us that they had concentrated on management tasks over the past three months. However, we found that the majority of the audits and quality checks were at an early stage of completion. This meant we were not able to fully assess the efficacy of these. Where audits had been completed such as the medicines audits these had failed to identify the issues that we found. For example the manager had completed three months audits to check whether guidance had been completed for PRN (as required medication). We saw recorded on each months consecutive audits recorded one person stating they didn't require PRN guidance however the MAR sheet indicated they were prescribed PRN medication.

The manager told us they were responsible for auditing nursing and care plans. They said however that they had no specific number in mind when they audited the care plans but would do a percentage. This meant there was no systematic plan in place to make sure care plans were audited in a timely way. Where care plans had been audited and failings identified there was no evidence that these had been followed up as actioned.

Many of the audits seen consisted of a 'tick list' with a Yes / No answer or an 'A' which the manager said meant they had been archived. This system was not sufficiently detailed to allow issues to be identified and analysed so that improvements could be made. During our visit we identified issues which should have been identified and

Requires improvement

Is the service well-led?

addressed through the auditing process. Examples included conflicting evidence for an individual over their assessed nutritional care needs and difficulties with eating that had not been addressed.

Despite compliance actions and warning notices being served, systems had not been developed by the provider to be able to systematically identify, analyse and review risks, adverse events, incidents, errors or near misses to minimise the chance of reoccurrence and understand where improvements were needed. However, we acknowledge at the time of our inspection there had only been a short period of time for the newly appointed general manager to implement improvements. Since the inspection the general manager has forwarded the commission weekly updates of action taken to ensure staff were competent, this has included taking disciplinary action and recruiting new staff.

They have sent us details of staff training completed and action taken to improve the safety and security of the building. We are planning to meet with the general manager, the NI and manager to discuss the future management of the service and we will return to the service to check on improvements. However, the evidence found at this inspection meant the provider was still in breach of Regulation 10, assessing and monitoring the quality of service provision, HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

If at our next inspection the provider continues to be in breach of regulations we will consider taking more formal enforcement action

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014** **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014** **The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained and supervised to deliver safe care and support to people

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.** **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 12 (f) and (g) HSCA 2008 (Regulated Activities) Regulations 2014.** **The registered provider failed to ensure the safe management of medicines.**

The enforcement action we took:
Warning Notice