Barchester Healthcare Homes Limited

Ashby House - Milton Keynes

Inspection report

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Ratings

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

Overall summary

Ashby House Nursing Home is registered to provide accommodation and support for 64 older people who require nursing or personal care, and who may also be living with dementia. On the day of our visit, there were 56 people living in the home.

The inspection was unannounced and took place on 22 and 23 April 2015.

The service had a registered manager although they were away from the home on a three month secondment, at the time of our inspection. In their absence, management cover was being provided by an interim manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that cleaning within the service was not satisfactory. People were not protected from the risks of infection as there were ineffective cleaning processes in place.

It was evident that there were not always effective processes in place for the ordering, administration and recording of medicines at the service.

Summary of findings

Risk assessments within people's care records were completed; however these were not always reviewed on a regular basis.

Although there were adequate numbers of staff on duty to support people safely, the service relied upon agency nursing staff to fill vacancies. This meant that staff did not always have an awareness of people's current needs.

Staff received a robust induction when they commenced employment and on-going training, based on the needs of the people who lived at the service. There were however some areas of improvement required within staff training and development.

Care records were not reviewed in accordance with the provider policy. As a result they were not always reflective of people's current needs and requirements.

People felt safe living in the service and said that staff kept them safe and free from harm. Staff had an understanding of abuse and the safeguarding procedures that should be followed to report potential abuse.

Staff were not allowed to commence employment until robust checks had taken place in order to establish that they were safe to work with people.

The registered manager followed the legal requirements outlined in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People had a nutritionally balanced choice of meals and were able to get snacks and fluids throughout the day.

People had access to health care professionals to make sure they received appropriate care and treatment to meet their individual needs.

Staff engaged people in a positive and friendly manner. They supported them as required, whilst encouraging them to remain as independent as possible and maintaining their privacy and dignity.

People and their relatives knew who to speak to if they wanted to raise a concern. There were appropriate systems in place for responding to complaints.

Quality monitoring systems and processes were in place and had been used to determine areas for future improvement.

You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not always safe.

People were put at risk because cleanliness and hygiene standards had not been maintained consistently.

Safe systems and processes were in not in place for the management and administration of medicines.

The provider was relying upon agency nursing staff to fill current nursing vacancies. This meant that staff were not always aware of people's current needs.

Staff had been trained in safeguarding and understood how to report any concerns regarding possible abuse.

Recruitment systems were in place to ensure staff were suitable to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were provided with training to develop their skills and knowledge to enable them to perform their duties effectively. However senior management acknowledged that there could be improvements to the training offered.

Staff demonstrated they had an awareness and knowledge of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where people did not have capacity.

People were provided with choices of food and drink to meet their diverse needs.

People had access to health and social care professionals to make sure they received effective care and treatment.

Is the service caring?

Good

The service was caring.

There was a calm and friendly atmosphere within the home.

People were treated with kindness and compassion and staff engaged with them in a positive manner.

People were treated with dignity and respect and staff worked hard to ensure this was maintained.

People were able to make choices about their day to day lives and the care given was based upon their individual preferences.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised or reflective of people's individual needs.

People who used the service were supported to take part in a range of activities in the home which were organised in accordance with their preferences.

Systems were in place so that people could raise concerns or issues about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Records were not always well maintained or up to date in respect of people.

The service had a registered manager in place, although they were away from the service on secondment.

People were encouraged to comment on the service provided to enable the service to continually develop and improve.

Systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment were in place.

Ashby House - Milton Keynes

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 23 April 2015 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection we also reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We spoke with the local authority and health and social care professionals to gain their feedback as to the care that people received.

During our inspection, we observed how the staff interacted with the people who used the service and how people were supported during meal times and during individual tasks and activities. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who used the service, six relatives and one healthcare professional. We observed a further 14 people who were unable to communicate effectively with us because of their complex needs. We spoke with the interim manager, clinical manager, four registered nurses and six care staff. In addition to this we also spoke with the activity coordinator, administrator and chef, one member of kitchen staff, one member of domestic staff and a staff member from the maintenance team.

We looked at 18 people's care records to see if their records were accurate and reflected people's needs. We reviewed five staff recruitment files, staff duty rotas, training records and further records relating to the management of the service, including quality audits.

Requires Improvement

Is the service safe?

Our findings

People and staff told us they considered the home was always kept clean. People told us that their bedrooms were cleaned to a good standard and were clean and smelt fresh and our observations confirmed this. However, in the communal toilets and bathrooms on both units, we found that the area around the door frames was dusty which meant that they had not been cleaned efficiently. In two toilets, where pipework had been boxed in, the ridge along the middle was brown, dirty and dusty. There were areas where sealant required renewing around the base of toilets which made the areas difficult to clean effectively.

We looked at toilets within the home in the morning and found that some of the seats were soiled. We also found that commodes within the toilets were soiled underneath the rims. We returned after lunch and found that they were still soiled and that staff had not cleaned them. A bath chair on the Memory Lane Unit contained dried faecal matter under the rim. We checked on the second day of our inspection and they remained in the same condition. We saw that the floor space around one toilet was wet and that one of the bins within the toilets did not have a working pedestal or lids, and had not been emptied.

We found that some areas of the home were not being cleaned sufficiently and in some areas, carpets and chairs were stained and dirty. At times there was a strong odour of what appeared to be urine in communal areas. We had to intervene to prevent one person from sitting on a wet chair which had not been noted by staff within the reception area. In the lounge area on Bradwell Unit, there was staining on the wall behind the piano and staff were unsure as to how long this had been present for.

We found hoist slings were placed on the floor of the shower room on the first day of our inspection. This offered no protection against the risk of infection. We also asked staff if people had individual slings for moving and handling. They told us that they shared them between people, which increased the risk of cross contamination and was not good infection control practice. People were not therefore protected from the risks of infection as there were ineffective cleaning processes in place.

We spoke with a cleaner about their responsibilities and they were able to tell us about the processes they used to ensure the home was clean and those they would put in place to prevent infection from spreading. We observed on-going cleaning taking place during both days of our inspection. We found that although on-going cleaning was in operation, there was a need for more robust deep cleaning in some areas and further attention to detail. This would ensure the maintenance of appropriate standards of cleanliness and hygiene.

This was a breach of Regulation 15 (1) (a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that risks to people were assessed on a regular basis to ensure their safety, protect them and manage identifiable risks, such as falls, nutrition and skin integrity. Staff considered that it was important to ensure that risk management was done in a way that did not restrict people's freedom and independence any more than was necessary. We saw that although people had individual risk assessments for identified risks such as pressure care and nutrition, that where the risks were increased, it was not always evident what measures had been put in place to minimise the risks. For example, one person required assistance from staff to transfer using equipment. There was no clear information in the plan detailing what support the person needed or what equipment should be used to provide the support. Another person required regular positional care and there was no guidance within the risk assessment as to what setting the pressure mattress should be on.

The clinical manager told us that as a service they were aware that risk assessments were not always completed in a timely manner, which meant that people may not always receive appropriate care. We found that risk assessments, for example, pressure care and nutritional tools had not been completed when evidence suggested that frequent reviews should take place. In one case, where a person was deemed to be at high risk of pressure and nutritional damage, their care records had not been reviewed since January 2015. Their clinical risk factors determined that they should be reviewed on a monthly basis. Records did not confirm that this was happening at the required frequency. Therefore, risks around people's needs were not always recognised or appropriately assessed. As a result of this, the care and support provided to people could have been compromised.

Requires Improvement

Is the service safe?

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always happy with the way in which their medication was administered. One person told us, "I take loads of pills, they wake me up at 6am in the morning, I am not happy about that." A relative said, "The drug administration is haphazard; I constantly have to ask if [Family Member] has had her tablets. One day I was told that as she was asleep she clearly didn't need pain killers or muscle relaxants. I didn't like this." Staff acknowledged that they needed to make improvements to the medication systems and processes in place so that people were kept safe.

Medicines were not always managed in a safe manner. Most medicines were administered through a monitored dosage system although some prescriptions were boxed. Although staff had systems in place to check the stock of people's prescribed medicines, they could not always evidence if people had received their medicines because of a lack of robust medication audits. We found that staff did not consistently audit the amount of medication held for each person. For example, one person had over 600 tablets which had to be counted daily. In addition, these had not been opened in sequence and more than one box of a 100 tablets was open, which meant that there was room for error to occur when monitoring stock.

We observed the morning and lunchtime medication round. One nurse said, "If I start the morning medication at 08.30am I finish about 10.30am." The same nurse later told us that they aimed to give the lunchtime medication before lunch so as not to interfere with the meal. This meant they were administering medication with only a two to three hour gap for some people which may be contra indicated with some medications. On both days of our inspection, we observed that the medication rounds on both units were taking longer than two hours to complete.

We looked 15 Medication Administration Records (MAR) and found there was often no information recorded to guide staff how to give medicines which were prescribed "when required" or as a variable dose. We asked the clinical manager if this information was available and they told us that it should be detailed within the care plans. However staff were not able to find this information for us. We looked in six care plans and were unable to find any information that would guide staff in the administration of these medicines.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the number of staff on duty were not always positive. Relatives commented on the high turnover of staff and felt that the staffing ratio needed to be adjusted on occasions to help keep people safe. One relative was not confident that the number of staff on duty was enough to keep people safe and meet their needs. We were told, "Staffing is all over the place, they always use agency nurses, I do worry that they won't know [Family Member's] needs." Another relative said, "There are a lot of agency nurses I do worry about consistency as [Family Member] is not very well and we have to keep telling them." People and their relatives acknowledged that whilst staff might be busy supporting other people that the service would benefit from having a more visible staff presence, in case extra assistance was required, particularly at peak times of day.

All of the staff we spoke with told us that they considered there was insufficient staff on duty to enable them to perform their duties as they would like to. Night staff felt that the low staffing levels prevented them from carrying out all of their expected tasks, and from spending quality time with people at night when they could not sleep. A member of the night staff said, "It is 1 or 2 am before we get people to bed." They went on to tell us that as well as putting people to bed and doing supper for them, they were expected to do some domestic tasks. A member of the ancillary staff told us they did not think there were sufficient care staff on duty at times and said, "I hear people calling for staff." We were also told, "Staffing is at bit hit and miss at the moment, we all cover extra bank shifts." Despite staff's comments, they could not tell us how the perceived lack of staff impacted on the care they were able to provide and we could find no evidence that people were neglected because of inadequate staff numbers.

The interim manager and clinical manager acknowledged that there was a reliance on agency nurses because of recruitment problems. Where agency staff were required, the service tried to use staff who were known to them for consistency for people, especially those living with

Requires Improvement

Is the service safe?

dementia. However, when we arrived there was one permanent nurse and one agency nurse who had been on duty overnight. The agency nurse was on their second shift in the home and they handed over to an agency nurse who had never worked at the home before. Although we witnessed a thorough hand-over of the unit, which was later followed up with an induction to the service for the agency nurse, other staff told us that the fact that there was not a consistent group of permanent nursing staff was not an ideal situation. This feeling was echoed by external professionals who told us that they did not believe the staffing level was appropriate to keep people safe. They also told us that the lack of permanent staff made it hard to ensure that required actions were carried through effectively. They advised that they were often called to the home more frequently than required and felt that this was due to the lack of qualified nursing staff available.

We discussed these concerns with the interim manager who told us that a new system was being implemented to measure people's dependency levels against the number of staff hours required to meet people's needs safely. Records confirmed that this was due to be implemented in the near future and staff were hopeful that this would ensure better deployment of staff throughout the service.

People were keen to tell us that they felt safe in the service. One person said, "I feel very safe here. I can get someone if I ring the bell both day and night. This gives me great comfort." Another person said, "I do feel safe here, I trust the staff completely." All of the people we spoke with told us that if they did not feel safe, they would always feel able to tell a member of staff. Relatives were also assured that their family members were safe. One told us, "Overall I am highly delighted, it feels safe here. I leave knowing that I don't have to worry."

Staff were able to talk confidently about the various forms of abuse that could be inflicted upon people and understood their responsibility to report any suspicion of abuse. They shared a common goal in keeping people safe. One staff member said, "Although I'm in the kitchen a lot I am always looking out for any problems when I am out on the floor. We all have a responsibility to keep our residents safe." Staff also demonstrated an awareness of the whistleblowing process in order to keep people safe. One member of staff said, "If I saw anything I didn't like I would soon speak up about it, but that's hasn't happened here." Staff told us that they would raise any concerns to management or external agencies, such as the local authority or the Care Quality Commission (CQC) if they felt that someone's safety was in question. They felt that any concerns they raised with senior staff or would be dealt with effectively. Records indicated that the service had worked with the local authority in analysing the issues that led to the safeguardings.

Staff told us that they had been recruited in a safe way. One staff member who had been recently recruited was able to describe the home's recruitment process. They confirmed they were not able to commence employment until the appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service [DBS] certificates had been obtained. The clinical manager told us that relevant checks were completed before staff worked unsupervised at the home and the recruitment records that we saw confirmed this.

Requires Improvement

Is the service effective?

Our findings

People told us they received care which met their needs but this view was not always confirmed by the relatives we spoke with. One relative said, "They are doing their best but the young carers do need guidance." When we pursued this comment, we were told that not all staff were sufficiently skilled to undertake all aspects of people's care. For example, manual handling. In contrast to this, we were also told, "He is very well looked after; they really know what he needs and just get on with it." Another relative said, "The staff are excellent with [Family Member], they know what they are doing."

Staff received on-going training in a variety of subjects that were relevant to their qualifications and that supported them to meet people's specific and individual care needs. One member of staff said, "I have refresher training every six months on quite a few areas." All staff told us that training gave them a good working knowledge of how to support people and enabled them to develop their skills. One told us, "We are told a month before we need to update our training it is due and it is our responsibility to attend the training provided." The training matrix however confirmed that there were some gaps within staff training, with not all staff having undertaken the provider's core training. Records showed that training was an area that had been highlighted by the provider as requiring improvement.

Some staff confirmed that they received on-going support and regular supervision from the registered manager but others did not seem aware whether they had received supervision. One staff member said, "I do get supervision but I try not to save any worries up, I just talk to a senior."

Some said that this was a useful time for them to discuss learning needs or any problems with a senior member of staff. However, one member of staff said, "Supervision has been inconsistent and with different people so not at all helpful really." We discussed this with the clinical manager and interim manager and were told that supervisions had taken place recently. We saw evidence of supervision meetings for a range of staff and were told that regular supervision sessions for all staff would be scheduled.

Staff had been provided with induction training when they commenced employment. They said that this ensured they were equipped with the necessary skills to carry out their role. One member of staff told us about their induction which also included a period of shadowing an experienced carer. They said, "I would not be expected to do something I was not confident with. There is always someone to ask." Staff considered that the induction programme was useful, as it helped them to understand people's needs and shadow more experienced staff so they could learn from them and understand the expectations of their new role. We saw that an agency worker was offered a service induction and signed to confirm it had been completed as part of their first shift. We reviewed the formal induction programme for both registered nurses and care staff and found that this was very comprehensive and provided staff with a good level of support during their probation period.

Some people and their relatives told us they were not happy with how the service accessed other healthcare professionals on their behalf. One person said, "I often have to wait a long time, the nurse has to see me first and then decide if they should be called." A relative told us, "I don't know why they are so reluctant to call the GP, the nurses don't like me to question that aspect, but I do keep pushing until they call him." Some relatives also found it frustrating that they didn't get feedback if and when other health professionals had been involved in their family member's care. In contrast to this, other people were pleased with the way in which the service accessed additional health input on their behalf, for example the dietician and chiropodist.

On both days of our inspection, people became unwell and staff were concerned about the changes. They contacted healthcare professionals to come and review them and determine if further intervention was required. The records we reviewed, detailed when appointments were scheduled. If action from appointments was required by staff, then this was documented within the records, so that staff could ensure this was carried out.

People told us that staff always obtained consent before providing care or supporting them, to make sure that they were happy for staff to proceed. One person said, "They always check with me if it's ok before doing anything." Staff understood the importance of gaining consent to care and we observed that staff knocked on doors and gained consent before entering; when supporting people to transfer, they asked people if they could help to support them to move.

Requires Improvement

Is the service effective?

Staff told us that they had an awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). They were able to explain the individual steps to be followed to protect people's best interests. For example, to ensure that people were appropriately represented and that any restrictions of their liberty were undertaken in the least restrictive manner. Records confirmed that mental capacity assessments and best interest assessments had taken place. The interim manager told us that further training had been arranged to support staff improve upon this process. Where people lacked capacity, DoLS applications had been appropriately. This meant that people who lacked mental capacity were safeguarded and their human rights protected because the service was following the MCA Code of Practice.

People were very positive about the meals provided within the service. One person said, "The food is decent, I usually find something I like." Another person told us, "The food is ok; you get a choice just before your meal is served." We spoke with the chef who told us, "I observe mealtimes so I can see what people enjoyed and didn't like as much." It was evident that the kitchen staff had a range of information and guidance available to them to ensure that they provided people with the right sort of diet. Where people required a special diet, this was in accordance with the advice given by either the dietician or speech therapist. Information in support of this was clearly recorded in people's care records and risk assessments.

We observed both breakfast and lunch times and found that the meal time experience for people was relaxed. It provided the opportunity for people to socialise with each other. People who wished could have their meals in their own bedrooms and it was apparent that mealtimes were flexible. For example, some people preferred to spend time in bed in the early morning and staff supported them to do this. Staff supported and assisted people where required, to eat their meal. For example, cutting up food and staying with people and talking to them, whilst they ate their meal to make it a more pleasurable experience.

Hot and cold drinks were regularly offered and also provided at peoples' request. Staff ensured they offered people a choice, even if they knew what people liked. For example, we observed one person being offered a choice of tea, coffee, water or juice; even though the member of staff knew that the person's preference was for coffee. People assessed at risk of not receiving sufficient amounts to eat and drink had daily records maintained on the actual amount of food and drinks they had, although these would have benefitted from having the recommended daily amount of fluid for individuals detailed within them for ease of use.

Good

Is the service caring?

Our findings

There were overwhelmingly positive comments about the approach and attitude of the carers by people and their relatives. One person said, “The staff are great I can really talk to them, that’s important to me.” Another person said, “They look after me so well.” Relatives told us about the support their family members received and said that staff were all very friendly. One said, “They seem to know her very well, she likes to wear different necklaces each day and they always remember that.”

People were supported by staff who exhibited kindness and compassion. One person told us, “They are always kind, even when they have a lot to do; they spend time talking to me which I really like.” We observed that senior staff knew people’s names and interacted with them on a personal level, making them feel at ease. They shared a laugh and a joke. We saw that all staff, including ancillary staff, engaged with people. We observed a member of the maintenance team interacting with one person in the garden, talking about things that were of interest to the person. The person smiled and enjoyed the interaction, being relaxed in the company of the staff member. We also saw some examples of genuine compassion, with staff engaging with people at their level. For example, staff spoke with people in wheelchairs ensuring they were at the same eye level and maintained eye contact. One person told us this made them feel valued.

People felt involved in their care and were supported by staff to make their own decisions. They were enabled to remain independent, for example, by choosing what time to get up, have their breakfast and how to spend their day. One person told us, “I feel very involved in decisions about what I do, I have my brains.” On both days of our inspection, it was evident that people were supported to get up at times that suited them and not staff. We observed that care was made individual because people and their relatives had been involved in relevant decisions.

We saw lots of positive interactions between staff and people who used the service. There was friendly conversation and we heard lots of laughter. Staff spoke to people in respectful manner and responded promptly to any requests for assistance. Staff monitored those people who remained in their rooms so that care could be delivered when it was needed. When instant support could not be given, staff responded positively and provided an explanation for the delay. Call bells were answered swiftly and when asked for assistance, staff completed requests with a smile.

Staff told us that there were times when people were unable to communicate their needs. For example, those people living with dementia or at the end of life. Staff said they would respond to people’s body language and we observed that they used appropriate gestures as a means of communication. For people living on the Memory Lane Unit, staff used a lot of smiles and touch, as reassurance when people became anxious. We observed one member of staff walking round the unit, holding the hand of one person, while they talked. This has a reassuring effect on the person and reduced their anxiety and frustration. We also observed carers washing someone’s hair, even though they were very busy, they were kind and gentle throughout. Staff said, “She loves having her hair washed so we just do it as it helps her to relax.” This showed that staff cared about people and took efforts to ensure that appropriate care was given.

We saw that the home had accessible information for people on how to obtain the services of an advocate. Records confirmed that a range of advocate services were available for people to use to ensure that their views were acted upon within relevant decision making processes.

People confirmed that staff always worked with them to maintain their privacy and dignity. They said that staff covered them when providing them with personal care and did not discuss their needs with anyone else. One person told us, “When I am in the shower they are very careful to keep the door shut and keep me covered.” The staff members we spoke with had a clear understanding of the role they played in making sure people’s privacy and dignity was respected. We observed that staff knocked on people’s bedroom doors and bathrooms and waited to be invited in before entering.

Visitors and relatives told us that they were able to visit at any time and made to feel welcome. Staff told us that there were no restrictions on relatives and friends visiting the service. We observed this during the inspection and found that that visitors were made to feel at home with a cup of tea, and the opportunity to meet with their loved one where they wanted. It was evident that the service supported people to maintain contact with family and friends.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not consistently reflect how people would like to receive their care, treatment and support. The interim manager and clinical manager told us that care plans were in the process of being updated to contain more information about people and how they wanted to be supported. Although we saw that family members had been asked for information about people's personal histories, interests and past hobbies, we found that this was not always transferred into specific care plans. The interim manager told us that it would be the role of the clinical managers to work through all care plans, so they were truly reflective of people's current needs.

Despite this, people told us that the care and support they received was right for their needs but not always based upon their wishes. One person told us, "Sometimes they tell me I need to get up but I don't always want to. I do understand that I can't stay in bed all the time but I don't always feel like I am listened to." Other people were however content with their care and said that staff worked hard to ensure that it met their preferences.

People and their relatives confirmed that they were regularly asked for their views about how they wanted their support to be provided, however we found some inconsistency in the frequency of reviews that people had received. We discussed this with the interim manager and were told that this would be dealt with as part of the identified areas for improvement within care plans. The interim manager aimed to ensure that all people received a monthly review of their care plans, in conjunction with any associated risk assessments. More formal reviews were also planned to ensure that people's preferences were taken into account and so that communication between people, their relatives and staff was accurately recorded.

The interim manager and clinical manager acknowledged that they had some improvements to make in respect of the specific information required in some people's care plans. The care plans we reviewed were not always person centred and often did not detail people's specific likes and dislikes. In some records, there was no detail as to the size of sling required for manual handling or the setting that the pressure mattress needed to be set on to ensure that optimum pressure relief was given. We also found that for some people with diabetes, there was no record of the optimum blood glucose level required. Despite this, It was evident during our conversations with staff, that they had a good awareness of people's needs, for example, what people enjoyed doing or what they liked to eat. One staff member said, "I know what she likes; I spend time discussing it with her. I feel really satisfied if I know I am doing what is needed. I go home with a smile on my face." We looked at care records and found that pre admission assessments of people's needs had been carried prior to people being admitted to the service. From this care plans were generated that were specific to people as individuals. However care plans had not always been reviewed on a regular basis or updated as and when people's needs changed. This meant they were not always an accurate record of people's current needs and requirements.

Staff told us that any changes in people's needs were passed on to care staff through daily handovers and the use of communication books. They felt that this enabled them to provide an individual service and kept them up to date with people's true care requirements. Relatives told us that staff and the registered manager kept them informed of any changes in people's wellbeing. We observed this on the day of our inspection, with both relatives and visiting professionals being updated about people's conditions.

We observed that the care and support people received was in response to individual needs and based upon people's best interests. For example, we saw that one person who refused a drink requested one later and it was provided immediately. Another person did not want to be supported to receive personal care, but staff encouraged them and explained the importance of the support they needed and the person accepted the need to receive care.

People had been given appropriate information and the opportunity to see if the service was right for them before they were moved in to the service. A relative explained how they had been to visit numerous homes before they settled on the service for their family member. Staff provided people and their families with information about the service as part of the pre admission assessment which was completed to ensure that people's needs could be met before they were admitted.

Staff worked to cater for people's individual needs, in accordance with their abilities. One said, "We provide a variety of activities but never force people to join in." There was a schedule of planned activities for people to participate in if they wished. On both days of our inspection we found that staff sat with people, engaged in general

Requires Improvement

Is the service responsive?

conversation and also listened to music, which people enjoyed. We observed a St George's Day celebration taking place and saw that people greatly enjoyed the singing and activities that were offered. On the dementia unit, we found that staff sat and engaged with a group of people, and made each person feel valued. When people chose not to engage in group activities of their choice, the activity coordinator told us that they would undertake one to one sessions with people in their rooms.

Staff told us that thought had been given to providing an environment suitable for those people living with dementia and disabilities so as to enhance the care given. We found items that could be picked up by people on the dementia unit. These were tactile and provided stimulation and distraction for people. For example, there was a dolls pram and small items on window sills which could be picked up and carried around the unit, enabling people to feel stimulated and actively engaged in an activity. This also supported staff to provide appropriate care to people.

People were aware of the formal complaints procedure, which was displayed within the home, and told us they would tell a member of staff if they had anything to complain about. One person said, "If you are not happy about anything you just have to mention it." Another person told us, "You can chat to anyone if you are not happy but I have not had any concerns." A relative told us, "I don't let things build up, if I have something to say, I say it. I often email the manager I find this is easier rather than let any niggles build up. She has generally responded quickly." People told us the registered manager listened to their views and tried hard to address any concerns and we saw from the records that actions had been taken to investigate and respond to the complaints. There was an effective complaints system in place that enabled improvements to be made.

Requires Improvement

Is the service well-led?

Our findings

During our discussions with the clinical manager and interim manager it was apparent that there were some issues in respect of the updating of people's records. Staff relied on the information provided within people's pre-admission assessments and care plans, to care for people in conjunction with their practical knowledge. As this information was not current, any agency staff providing care and support would not always have appropriate information upon which to deliver suitable care.

Some people had care plans that detailed their care needs but had not been reviewed since January 2015. Of the 18 care records we reviewed, nine had not been reviewed on a monthly basis, in accordance with the provider's expected processes. For some new admissions, care plans had not been written in a timely manner, for example staff told us that for one new admission they still had to compile two care plans, despite the fact that the person had been living in the service for some time. The clinical manager told us that not all reviews, including six weekly reviews had been completed in line with the provider policy. In some care plans, accidents and incidents had not been cross referenced within the progress and evaluation records, which meant that appropriate action may not have been taken by staff when attending their needs. For example, where bruising was found, where this had not been detailed within the progress records, it was not always easy to determine what action had been taken to address this.

Of the 15 MAR charts we reviewed, we found that seven had gaps within the recording. We saw there were some omissions of staff signatures which confirmed that the staff had administered the prescribed medication. Variable doses had not been routinely recorded and the back of the MAR chart was not always used to record additional information in respect of medication prescribed to be given as required (PRN). For example, if a PRN was refused or not given, the reason was not documented and we did not see what follow-up action had been taken.

This was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these issues with the interim manager and clinical manager who had conducted their own internal audits. These had identified areas where action was required to be taken and had led to the formulation of an action plan. This action plan was shared with us at the beginning of our inspection and staff were keen to tell us that they knew they had some areas to work upon and make improvements.

People told us they knew who the registered manager was although some were not aware that she was currently on secondment. Most people had not had the opportunity to meet the interim manager, although we observed that they were making efforts to get to know people during our inspection. We saw that the interim manager and provider addressed all people by their preferred name, as detailed within their records, which demonstrated they knew the people using the service. Some people told us that they wished the registered manager was a more visible presence on the units, as they would welcome the opportunity to engage on a more frequent basis. Other people told us that the registered manager was approachable and that they felt comfortable talking to them.

Staff told us that the registered manager was approachable and supportive; they felt happy to speak with her both openly and in confidence. However one member of staff said, "New people bring new ideas and sometimes things don't get finished before people move on." We found that although there was leadership in place at the service, because this was in a state of transition, some staff felt the service had low morale. They acknowledged that the service had recent issues, particularly in relation to staffing, but also explained how they wanted to work together to address these and ensure the service provided good quality care.

We found that the interim manager was supported by a clinical manager and the two worked in conjunction with each other in the running of the home. We were also told of the plans for another clinical manager to join the team and were made aware that there was a vacancy to be filled for a deputy manager, to strengthen the management structure within the service. Plans were in place for staff meetings to be held so that staff were kept updated about any changes that would take place and plans for future improvement.

People we spoke with were generally positive about the way in which the home was run. Although records showed that some people had experienced issues and concerns, it was evident that they were supported to express their views through appropriate means. There were procedures in place to obtain people's views and monitor and improve

Requires Improvement

Is the service well-led?

the quality of the service provided. The interim manager told us that annual satisfaction questionnaires were sent out to each person who used the service to request that they and their relatives comment on how the service was performing. We found that an analysis of the results was completed to determine what any action was needed on any areas that had been highlighted as requiring improvement.

We looked at the processes in place for responding to incidents, accidents, whistleblowing and complaints and saw that the provider analysed this information and completed a root cause analysis to determine if there were any patterns or triggers for the accidents. It was evident that this was used for discussion within team meetings and individual staff supervision so that lessons could be learned.

Frequent audits had been completed in areas such as medicines administration, health and safety, fire safety and environmental audits. The interim manager told us these were important in making sure that the service given to people was of good quality. We saw that maintenance records confirmed that health and safety checks were carried out regularly to identify any areas for improvement. Where improvements were required, we saw that actions had been identified and completed. This demonstrated that the mechanisms in place to ensure quality delivery of care were consistent.

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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control There were not effective systems in place to ensure that the premises and equipment used by the service provider was- (a) Clean. (2) The registered person failed to maintain standards of hygiene appropriate for the purpose for which they were being used. This corresponds to Regulation 15 (1) (a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person failed to ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of- (a) An accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. This corresponds to Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines (1)The registered person failed to ensure that care and treatment was provided in a safe way. (2)The registered person did not comply with- (g) The proper and safe management of medicines. This corresponds to Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1)The registered person failed to ensure that care and treatment was provided in a safe way. (2)The registered person did not comply with- (a) Assessing the risks to the health and safety of service users of receiving the care and treatment. (b) Doing all that is reasonably practicable to mitigate any such risks. This corresponds to Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.