Abbey Healthcare (Aaron Court) Limited

Aaron Court

Inspection report

17 Ramsey Way
Leicester
Leicestershire
LE5 1SJ

Tel: 01162415552
Website: www.abbeyhealthcare.org.uk

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Aaron Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Aaron Court accommodates 91 people across four floors, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia and palliative care.

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.'

At our previous inspection in April 2016 we rated the service as 'good'. At this inspection the service had not maintained the rating and had deteriorated to 'Requires Improvement'.

At the time of our inspection visit 72 people were using the service.

The provider's governance systems and processes used to assess the quality of care provided were fragmented. There was a lack of oversight and monitoring was ineffective.

People did not always receive their medicines as prescribed. Risks associated with people's needs had been assessed but risks were not always managed. Care plans lacked information and clear guidance for staff to follow to provide person-centred care. Monitoring records were not always completed in full.

Staffing levels were not adequately managed to ensure there were enough staff to provide care and support to people when they needed it. The system to ensure staff were trained and supported in their role was not effective. Further action was needed to ensure staff training was kept up to date and staff competence and practices were monitored.

People and their relatives knew how to make a complaint but they were not confident their complaints would be fully addressed. The system to manage complaints was not effective. People did not feel confident that action would be taken. There were limited opportunities for people to express their views about the service and influence how the service was run.

People were provided with a choice and variety of food and drink. Further action was needed to ensure people's cultural and specific dietary requirements were met. People at risk of malnutrition and dehydration were not always monitored. People were supported with their health care needs when required.

People were involved in decisions made about all aspects of their care. People were supported to have

maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. Further action was needed to ensure staff training in Mental Capacity Act was up to date.

People were cared for by kind and caring staff. Most staff knew people well; understood their wishes and daily needs. People were supported and made decisions about their end of life care.

People were involved in the development of the care plans. However, people were not involved in a meaningful way to review their care so that they received person-centred care that was responsive. Improvements were needed to ensure staff treated people with dignity and respect.

The provider employed activity co-ordinators but people's experiences about the activities, social stimulation and engagement varied. People's diverse needs were mostly met.

Information was made available in accessible formats to help people understand the care and support agreed. The provider was developing picture menus to help people living with dementia choose what they want to eat.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 at risk of not receiving their prescribed medicines in a safe way. Risks associated with people's needs had been assessed but risks were not always managed and kept under review. Care plans needed more detail to provide clear guidance for staff to follow.

Staffing levels were not adequately monitored or managed to ensure there were enough staff to provide care and support to people when they needed it. Further action was needed to ensure staff followed infection control procedures.

Staff recruitment procedures were followed to protect people from unsuitable staff. Staff understood their responsibilities to keep people safe from harm. Staff knew what abuse was and how to report safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed to ensure staff training was kept up to date, staff practices were monitored and they received timely support for their role.

People's needs were assessed. Staff sought people's consent and understood people's rights. Capacity assessments had been put into place to identify the support people needed to make decisions.

Improvements were needed to ensure people's dietary needs were met and monitored. People were supported to access health care support when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for by caring and kind staff. People had been involved in planning their care. People were not always treated

respect and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed although decisions made were not always documented. People did not always receive responsive and person-centred care that met their preferences. People were supported to make decisions about end of life care.

People's experiences about range of activities, social stimulation and engagement varied.

Although people knew how to complain they were not confident their complaints would be fully addressed. The system to manage complaints was not effective.

Is the service well-led?

Requires Improvement

The service was not well led.

The service had a registered manager but the leadership was not strong or effective. The provider's governance systems to monitor the quality of care and safety were fragmented and did not to drive and sustain improvements. Systems to ensure staff were trained and supported were not robust. Opportunities for people to make comment about the quality of care were limited. Actions were not always taken to make improvements. Lessons were not learned from incidents, complaints and safeguarding investigations.

Aaron Court

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 checked 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.

The inspection was prompted in part by notifications about incidents of falls, hospital admissions, safeguarding concerns and deaths. The information shared with CQC related to the incidents indicated potential concerns about the management of risks, falls, unsafe medicines management, staffing levels and staff training and leadership. Therefore, we explored aspects of current care and treatment provided during the inspection because we needed to be assured that people received safe care and treatment.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

This inspection took place on 24 October 2018 and was unannounced. The inspection team consisted of three inspectors which included a dental inspector, a specialist nurse advisor and an expert-by experience. The expert-by-experience had personal experience of caring for someone who uses this type of care service. This inspection was postponed within an hour of our arrival when we were informed about an outbreak which was contagious.

We returned to inspect the service on 12 November 2018 and this was unannounced. The inspection team consisted of two inspectors, an inspection manager, a specialist nurse advisor and an expert by experience. One inspector and the specialist nurse advisor returned on 14 November 2018, announced to complete the inspection.

Before the inspection, the provider had returned the completed Provider Information Return (PIR). This is the information we require providers to send us as least once annually to give some key information about the service, what the service does well and the improvements they plan to make. This was used to inform

the judgements.

We reviewed information we held about the service. This included feedback received about the service and notifications the provider had sent us. Notifications provide information about important events which the provider is required to send us by law. We received feedback from commissioners from the local authority and health authority, who commission services from the provider, the Independent Advocacy Services and Healthwatch Leicester City, who are an independent consumer champion for people who use health and social care services. They raised concerns about the medicines management, care and treatment provided, care records and the management of the service.

During the inspection visit, we spoke with 12 people who used the service and 14 visitors and relatives of people who used the service. We made direct observations at meal times and 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 the four nurses, two senior care workers, eight care staff, two activity coordinators, a cook, housekeeping staff member and maintenance staff member. We also spoke with the clinical lead, office staff member, registered manager and the regional operations director. We reviewed a range of records. They included 12 people's care records and 28 people's medicines and medicine administration records. We looked at five staff recruitment files, training records and records relating to the management of the service such as policies and procedures, accident and incident reports and quality audits.

Following the inspection visit we spoke with a further two relatives. We also continued to receive concerns from the relatives of people using the service and anonymous concerns about the care and treatment, management of medicines, staffing and the management of the service. We referred the concerns where appropriate to the provider and the local safeguarding authority.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we had received concerns from relatives of people using the service, commissioners and health care professionals about unsafe medicines management. The provider had sent us notification about incidents related to medication errors and omissions and the action that had been taken.

The management, storage and administration of medicines was not safe. An open tub of prescribed thickener (used in drinks where people had a swallowing difficulty) was found in the unlocked cinema room. NHS England issued a safety alert in February 2015 for the need for proper storage and management of thickening powders; this was in response to an incident where someone accidently ingested the thickening powder. We looked at the medicines for this person who had been prescribed thickener which was found in the cinema room. The thickener tubs were over stocked. The nurse could not explain the excess stock as the amount supplied each month should only last for the period prescribed. The dates of dispensing showed a stock rotation system was not in place. The product itself was in date therefore there was no impact on the person. The nurse agreed to look into this.

One person told us "[Staff] bring them [medicines] when they've got the staff on" and added they did not always receive the medicines at the right times. Another person told us medicines were not given on time and they often had to ask staff to given them their medication. That showed people were at risk of not receiving their prescribed medicines on time.

Where people required their medicines disguised in food and drink, otherwise known as covert administration records showed that decision had been made in people's best interests and the GP was involved. However, there was no evidence that the advice of a pharmacist had been sought as to the type of food and drink the medicines could be mixed in and remain effective.

We spoke with health care professionals conducting an audit on people's medicines and medicine administration records (MAR). They had been working with the service to make improvements and some improvements had been made in relation to missing signatures on the MAR. However, further action was still needed to the medicine protocols for medicines administered 'as required' medicines such as pain relief medicines. They told us the protocols were not always a clear and comprehensive for staff to follow.

We also found medicine protocols lacked guidance for staff to follow in relation to how and when pain relief should be given. There was no description or any way of understanding non-verbal signs used where people were unable to express pain or discomfort. A pain assessment tool was not used effectively to assess people living with dementia or word finding difficulties or who were unable to express pain or discomfort. These examples showed people's health had been put at risk because medicines management and administration was not safe.

We found MARs were not fully completed. There were missing signatures and the reverse was not completed when as required medicines were administered. For example, one entry stated 'given' but did not state the quantity or time. Lack of monitoring the quantity administered could result in an overdose. Another person's

MAR chart had been completed to confirm when pain relief medicines had been administered. There were eight entries but none indicated where the pain was. That meant the person had been given medicines more than the four times each day. There was no record to confirm that medical advice had been sought to ensure the appropriateness of this medication.

There was an additional monitoring form for the use of paracetamol. At the top of the chart is the instruction 'chart to be completed on all administrations'. The charts had numerous gaps. There was no explanation or audit to demonstrate if gaps in the MARs were administration or recording errors. These issues were shared with the registered manager and the clinical lead.

We found instances where people had not received their prescribed medicines on time and instructions were not followed. One person did not have eyedrops administered between 30 October 2018 and 5 November 2018. No action had been taken to identify if the person had experienced any adverse effects because of the missed medicine.

People's health conditions were not managed. A person's diabetes had not been managed and they were admitted into hospital as a result. The person's records stated that blood glucose levels should be checked twice daily but only one check had been carried out on three days without an explanation recorded. The charts did not state what the normal blood glucose range was. The chart also showed that the person had had several diabetic hypers [high blood glucose] because the blood glucose was doubled. The nurse told us medical advice had not been sought.

Some people received their medicines via a transdermal patch which is applied on the body. A rotation chart showed where the patch had been applied and alternating the site it prevents possible irritations. There was a system in place to show the site of application and removal of the previous patch but these were not always completed. There was no record that daily checks were carried out to ensure that the patch remained in-situ. This was important because the patch can be accidentally removed and result in people experiencing avoidable pain and discomfort.

People with dry skin or at risk of skin breakdown were prescribed topical creams to prevent skin damage. The charts did not state the frequency of application or where to apply on the body. Where creams had been applied the MARs were not always signed by care staff to confirm this. That meant people were put at risk of developing skin damage.

People's ongoing health care needs were not always monitored or managed. One person told us they had developed two pressure sores in July 2018. The person used a pressure relieving mattress and told us, "Sometimes I have to ask the staff to alter it as it is rock hard." There were no charts to monitor the skin damage in the wound care plan. The person needed to be re-positioned every four hours but the care plan made no reference to what pressure the mattress should be set at. The re-positioning charts on 12/11/2018 showed the person had not been re-positioned for up to seven hours and only moved when they needed to use the toilet.

Another person receiving palliative care had a pressure sore on their back and needed to be re-positioned every two hours as they were assessed as being at high risk of skin damage. The chart did not indicate the person should be kept off their back until the pressure sore had healed, which was good practice. The positioning documented in the chart was not legible so we could not be sure if the person was positioned correctly. The initial pressure sore assessment on 04/11/2018 was 2 centimetres and needed to be re-assessed on 09/11/2018. However, the re-assessment was not done until 10/11/2018. A photograph of the wound was taken on 11/11/2018 and the wound measured 7 centimetres. This meant the person received

improper care and treatment.

The registered manager, nursing staff and senior care staff had responsibility to administer medicines. Records showed staff had attended management training. However, the written assessments were incomplete and one staff member had not attained the required score to pass the assessment. There was no record to confirm staff practices to administer medicines had been observed. This contributed to unsafe management and administration of medicines.

These were evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. Risks to people's health care needs were not managed or monitored. Medicines management and administration was not safe.

People and their relatives expressed concerns that there were not enough staff on duty. They told us they often had to wait to receive their medicines. One person told us they were woken up so that the nurse could provide catheter care. People also told us they had heard staff arguing about which floor they worked on and some staff went home as a result.

Other comments we received included, "They are short staff here. Weekends; it's even short staffed." "Weekends there should be four staff but only two turn up, lot of agency staff but they are not briefed so are just standing by, seems a lot of resentment." And "No, the staff are run ragged. They work hard; we have seen them in tears. They get frustrated because they can't do the things they want to like getting [people] up. Some really good staff have come off care and gone to cleaning [roles]. [Management] doesn't listen to the staff. Weekends; it's worse, they are short most weekends."

Nurses told us that there were sufficient nursing staff since the two new nurses had started. However, other comments we received from staff about the staffing levels were included, "I'm supposed to be working on floor [number] but am covering floor [number]. This happens regularly." "[Registered manager] doesn't come on the floor to see what's happening and doesn't know people's needs." And "Not always a good skill mix of staff. Weekends is really bad even with using agency staff - it's not enough to meet everyone needs."

There was a lack of oversight of staffing because staff moved around despite being designated to work on a specific floor on the staff rota. We saw staff working across different floors at times. Our findings supported the comments received from people using the service, relatives and staff about the management and deployment of staff and staff shortages.

The registered manager told us they continued to use regularly agency staff to ensure there were the required number on duty. They calculated the staffing numbers using the provider's dependency tool based on people's needs. However, it did not take account of people's diverse and cultural needs, the time required to support a person who may need more time where promoting their independence, the support needed at different times of the day layout of the home.

The staff rota from week commencing 18 October 2018 to week commencing 5 November 2018 showed agency staff and nurses were used regularly to cover staff shortages. These ranged from two to six staff (nurses and care staff) per each shift. Despite the provider who had increased the staffing numbers by one staff on each of the nursing floors, people's comments and their experiences showed that there were delays in staff meeting people's needs, especially at busy times of the day and night.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. Staffing numbers and their skill mix was not adequately calculated and monitored to meet

people's needs without delay.

One person said, "I only have one [tablet] in that morning and at night." We saw a senior care worker administered medicines to people individually and signed the records to confirm this. People's MARs had a current photograph and essential information such as allergy information This helped to ensure medicines were administered to the right person.

There was an improvement where prescribed medicines needed to be administered 30-60 minutes before food and other medication. Staff had followed the instructions to administer these medicines and completed the MAR accurately.

On the first day of our inspection visit we were told that had been an outbreak of infection which was contagious. There were no notices displayed at the main entrance and staff had not alerted us or other visitors about the outbreak to prevent the risk of spreading infection. However, after the inspection team had left the service, the registered manager informed us that notices had been displayed to inform visitors.

The registered manager told us staff remained on the designated floor to prevent the risk of spreading the infection. The provider had notified the relevant authorities including Public Health England about the outcome and the actions taken.

On the second day of the inspection visit we asked staff how they managed the outbreak of infection. Their responses were mixed and included "Really, which floor?" and "Extra barrier equipment was provided to the first floor and all staff were reminded about hand washing." This demonstrated that communication between the staff team and management could be more effective and informative.

Staff told us they had attended infection control training and they could refer to the provider's infection control policy. Staff were observed to wearing disposable gloves and aprons when giving personal care. At meal times staff also wore a hair net in addition to gloves and aprons. A staff member told us they had to wear hair nets when serving meals. Hairnets worn prevents the risk if hair falling onto people's food and drink. One person said, "What's happening, I've never seen them [staff] wearing hairnets before."

An audit by the Food Standards Agency in September 2018 had awarded a food hygiene rating of level 2 'improvement necessary' (ratings go from 0-5 with the top rating being '5'). The registered manager told us the action being taken included visual checks of the kitchenettes on each floor to ensure house-keeping staff kept these areas clean.

We found improvements were still needed to ensure the premises remained clean and hygienic for all. Kitchenettes were not always clean; the cupboards and the inside of the drawers were dirty and had food debris. Cutlery used by people was dirty and stained with old dried food. Opened cereal packets were found in a cabinet drawer in the dining room. All opened cereals should be stored in a pest control container. The registered manager assured us action would be taken.

Records showed servicing was carried out on the electrical, gas and fire systems and equipment such as the hoists and pressure relieving equipment to ensure they were safe to use. The maintenance staff carried out random weekly checks and full audits every 6 months on the premises, fire safety and equipment. This ensured equipment was not damaged and safe to use.

Each person had a personal emergency evacuation plan (PEEP), which described the support they would need. Staff knew what action to take in the event of an emergency and where the PEEP folder was kept.

We had received safeguarding concerns which we referred to the local safeguarding authority to carry out further investigations. The commissioners told us they had liaised with the registered manager and the provider to address the concerns about the medicines management, people's needs not being met, record keeping, and staffing levels. Some action had been taken but further improvements were still needed to the management of medicines and staffing.

The provider had sent us notifications about incidents, accidents and safeguarding concerns which they are required to do so by law. Information about how to report concerns and whistleblowing was displayed and accessible to all staff, people who used the service and their visitors. That helped to assure people they would be protected from the risk of harm and abuse.

We asked people whether they felt safe and how staff helped them to stay safe. Their responses were mixed and included, "The staff are fine, not one of them will do anything to hurt you. You will always get the odd one but not here. The staff are marvellous." And "Yes, I feel safe but there are too many people now left in bed that's my gripe."

Staff understood how to identify signs of abuse and preventable harm and knew how to report these. Staff told us they had received safeguarding adults training and were condiment to report concerns to the local authority if required. A staff member said, "I've done safeguarding training and know how to whistle blow. If my colleague bullied or shouted at anyone I would report it to the senior." Another staff member said, "People could be safer if we had the right staff." They had reported the concerns about a staff member's unsafe practices to the registered manager but were unsure if any action was taken.

One person said, "I need more support. I have a rotunda. I feel safe with some [staff] better than others." People were being supported by staff to move around safely when using walking aids. We saw two staff worked together to move a person safely using a hoist. Staff explained what they were about to do, care was taken as the person was moved and checked the person was comfortable before staff left.

Assessments had been undertaken to identify any risks associated with people's safety, which included risk of falling, moving round, choking and developing a pressure ulcer. They took account of people's needs, preferences and any significant history of incidents such as falls.

Risk assessments were linked to people's care plans which described where they may experience potential harm, the equipment required if appropriate and the action staff needed to take to keep people safe. One person's care plan included advice from health care professional and a photographic sequence which guided staff to position the pressure relieving cushions correctly to reduce any discomfort and prevent the risk of developing a pressure sore. Another care plan provided staff with guidance to talk calmly with the person, who may speak in an aggressive manner. Staff awareness and approach was consistent with the information documented in the care plan.

Records showed risk assessments were mostly reviewed. For example, one person had had 10 falls, one fall a month. The risk assessment had been reviewed, the care plan amended and the medication had been reviewed by the GP.

We found other people's risks assessment and care plans needed further improvements. A person was at risk of neglecting their personal hygiene. The care plan described how staff were to support the person but the daily logs used by staff to document when the person had been supported were not always completed. Missing information had not been reported by staff who subsequently supported the person and had not been identified through the care plan audits completed by the registered manager. Therefore, we could not

be sure that the person personal hygiene needs were met.

Staff recruitment processes ensured staff were suitable for their role. Staff files contained evidence that the necessary employment checks such as police checks, references and nurse's professional registration had been completed before they commenced work at the service.

All staff understood their responsibilities to record any accidents and incidents that may occur. Records showed incidents and accidents had been documented. The registered manager analysed these events and other incidents to identify any trends so that action could be taken. However, there was no record of how lessons learned from significant events and external inspections had been shared with the staff team.

Requires Improvement

Is the service effective?

Our findings

People's views about staff being trained for their role were mixed. Their comments included, "Some [staff] are not properly trained, well it doesn't seem like it." "A [staff member] put their hand on the back of my neck to move me – I told [them] to stop and called the nurse." "The seniors don't help. All they do is shout at the carers and the carers are trying to do their best they can. That's why they move to different floors because they cannot get on with the seniors. Heard all the arguments, staff saying they don't want to work on certain floors or work with a certain person."

The information received in the PIR sent to us by the provider stated that staff must complete all mandatory training within the induction period and updates using e-learning. However, the electronic training information showed 81.75% of staff training had been completed. The staff training matrix showed that between 8 to 18 staff training was overdue on topics such as safeguarding adults, fire safety, infection control, food and nutrition health and safety, moving and handling and MCA and DoLS. Up to 22 were overdue the practical training in manual handling. That meant staff training was not up to date and staff were not fully supported in their role.

Staff comments about the training completed were mixed. They included, "I did three-day induction and shadowed carers across all floors. I've done safeguarding, fire and moving and handling before I could use any equipment." "What induction? I should have had three days shadowing but only did one day and put straight onto the floor to get on with it." One staff member told us they were required to complete e-learning training but received their log in details four months later.

A nurse told us they had completed an induction and training for their role. The training included medicines management, safeguarding, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). However, their competency in medicines management had still not been assessed even though they were administering people's medicines.

We looked at the competency assessments for seven staff and nurses with responsibility to administer medicines. All were incomplete. Two staff had not completed the written assessment. One staff member not been assessed as competent and their written assessment was incomplete. Two staff members practices had not been observed. The registered manager practice and competency had not been assessed and there was no record of the written assessment. One staff member had completed the written assessment and had a score of 65. The criteria on the document states "staff must attain a total score of 90 to be deemed competent.

The PIR stated that staff supervisions took place regularly and were used to ensure staff understood the requirements of their role. Nursing and care staff told us the frequency of supervisions and appraisals varied. Supervision provides staff with the opportunity to discuss working practices and identify any training or support needs. One staff member told us they had not had a formal supervision since they had started at Aaron Court over five months ago. Another staff member said, "Only one group supervision six months ago" and "We are not supervised or supported. Management don't believe in supporting the staff."

We asked staff how they were kept informed about changes to people's care and updated on changes being made to the service. Staff said, "Senior will tell us if anyone's needs have changed." "If you're not sure, ask the person, or check with other staff or senior."

The staff team had mixed views about the frequency of staff meetings. A staff member said, "Yes, one [meeting] after a long time." We read the staff meeting minutes from June and August 2018. Although the topics discussed were documented regarding training, staffing and care issues one set of minutes did not state which staff had attended. It was unclear how the wider staff team who did not attend the meeting were informed of the key topics discussed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staff. The staffing numbers and their skill mix was not adequately calculated and monitored and the systems to ensure staff were trained and supported in their role were ineffective.

Some staff had completed the care certificate and attained a professional qualification in health and social care.

We observed the 'daily flash meeting' held by the registered manager with the lead nurses and senior carer from each floor and head of departments such as the chef, activity coordinator, house-keeping staff and maintenance staff. The meeting was brief but informative about any new concerns, risks and details of the planned activities for the day.

People's needs were assessed before they started to use the service. One person said, "Yes, I think a gentleman came from here [to assess me]." The assessment covered people's physical, emotional, cultural needs and preferences. Information gathered from people, their relatives and relevant health and social care professionals was used to develop the care plans. This ensured staff had sufficient information to meet people's need.

People's views about their needs being met effectively were mixed. Their comments included, "Yes, as much as they can when you can't do a lot for yourself" and "Yes, the carers are very good. Some of the seniors not so good. They probably feel pressured."

Some people received care that reflected best practice and guidance. For example, one person's care plan had been updated when their needs had changed and they had made decisions about their ongoing health care. Another care plan included a detailed 'hospital passport'. This document provided health care staff with the necessary information about how to support the person who required medical treatment, such as how the person communicated and decisions made about emergency treatment.

Staff told us they sought advice from the GP and other healthcare professionals when required. Records showed GP and specialist nurses visited regularly to provide treatment and advice when people's health deteriorated. For example, a GP had regular contact with one person with breathing difficulties. The care plan included clear instructions to enable staff to support the person when they experienced breathing difficulties.

Where staff did monitor people's health care needs action was not always taken in a timely manner. As a result, people may not have the best possible health outcomes and a risk that their health could deteriorate. One person's continence care plan stated, 'catheter in situ'. There was no plan of care for the catheter and no record of fluid intake or output, which are important indicators for staff on early signs of risks such as a water infection, which requires early medical treatment to prevent further deterioration in health. There was

no chart to evidence the person received routine checks and care of the catheter.

Another person nursed in bed needed to be re-positioned every two hours during the day and four hours at night and used a pressure relieving mattress to prevent the risk of skin damage. The chart showed the person was re-positioned at the regular intervals, however the mattress setting was not documented or checked to prevent further deterioration. When we brought this to the attention of the clinical lead they updated the care plan and ensured the setting was correct and monitoring charts were detailed.

Staff told us that they documented how much people ate and drank but senior care worker and the nurse would assess whether people's intake was sufficient. On the top of the fluid intake chart for one person stated intake target was '30mls x weight' but the actual target was not documented. However, the person was weighed regularly and was referred to the dietitian when weight loss had been noted.

A person care's plan identified they needed to be weighed every four weeks. The person was last weighed in September 2018. To maintain good hydration and prevent skin damage the person's fluid intake daily target of 1500mls was set. The daily target was not recorded in the fluid intake chart. During a period of 11 days records showed the person consumed a maximum of 900mls of fluid. There was no other record to show what if any action had been taken. We shared our findings with the clinical lead and the registered manager to address this.

There were bowls of fruit in the lounges but we did not see people being offered fruit or encouraged to help themselves. People were offered regular drinks, which for some people were provided in suitable drinking cups. However, some people said this was not always the case. One person said, "They don't come around all the time but they will come around in about half an hour with one." When we spoke with people and their relatives in the privacy of their room we saw there was a drink left within reach.

People's views about the choice and quality of meals were mixed. One person said, "Not good. It's not the best. Same old, same old, very average."

People expressed concerns that their health conditions were not considered when meals and snacks were offered. One person said, "Yes [choice], but if I can't have it because of my digestive system I tell them and they give me something else. I don't go short. We don't have a menu but they come around the day before and ask you [to choose meal from the menu]." Another person said, "Meal quality it is a nice meal, too many pies, puddings, cakes for diabetics." And "Constantly have to ask for sandwiches with brown bread not white bread."

There were limited menu options to meet people's cultural dietary needs. One person told us they ate cereals for breakfast but did not eat the main meals because the meals were not culturally appropriate. Their relatives brought in meals daily which they enjoyed. A relative told us that their family member had been provided with Asian meals which they enjoyed.

People's dining experience varied across the different floors. Menus were not available on the dining table and addressed when brought to the attention of the clinical lead. People chose where they wished to be seated. Staff did not always offer people a choice of drinks. A staff member knew one person preferred apple juice whilst everyone else was given orange juice. All the meals were served individually and portions sizes suited individual appetites.

Most people seemed to enjoy their meals. One person's health condition meant that they preferred finger food so that they could eat independently. We saw staff provided support to people where required;

encouraging them to eat and offering second helpings.

A care staff member knew people's dietary needs and identified people who required pureed meals due to swallowing difficulties, vegetarian and culturally appropriate diets. They told us people's dietary needs had been documented in their care plans. Where people were at risk poor nutrition and dehydration this had been assessed. Any advice received from the dietitian had been incorporated in people's care plans and shared with the catering staff. The cook told us they were provided with information about people's dietary needs and prepared vegetarian meals, pureed and soft textured meals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on the authorisations to deprive a person of their liberty had the appropriate authority and were met. We found appropriate DoLS authorisations had been requested and conditions on authorisations to deprive a person of their liberty were being met.

People told us staff mostly sought their consent before being supported. One person told us, "Sometimes, I have to tell them I need to use the toilet and they will help me." Another person said, "The nurses they listen to you and will do what you want if they can."

Feedback we received from a 'paid person's representative' (PPR) was generally positive and told us staff had a basic understanding of DoLS. A PPR's role was to monitor the implementation of the DoLS.

Although staff training in MCA and DoLS was not up to date they understood the importance of support people to make decisions about their care. A staff member said, "Some people have dementia but if you show them [outfits] they will choose what they want to wear." Another staff member told us some people's facial expressions and body language indicate consent to care.

People's needs were met by the adaptation, design and decoration of premises. Clear signage meant that people could move around independently. People had brought in personal items from their own home when they had moved in which had helped them in feeling settled. Several people showed us their bedroom which had been decorated and personalised to their individual taste. The garden space was accessible for people to use in good weather.

Requires Improvement

Is the service caring?

Our findings

We saw instances whereby people's dignity had been compromised. On the first day of our inspection visit we saw a person walking to the dining area through the main reception area wearing just a thin nightdress and looking dishevelled. Although care staff and nurses were in this area no one attempted to offer a dressing gown to preserve the person's dignity. Another person was still in the sling whilst seated in a wheelchair close to the reception area. After half an hour the person was moved to the lounge, still seated in the sling. A staff member explained the person was waiting to see if their relative would be visiting.

We heard a staff member loudly asking a person "Have you been to the toilet?" in the presence of other people and visitors. Another staff member had a discussion with a person about an issue with their medication at lunchtime in the present of other people. These examples showed that people's dignity and confidentiality had been compromised.

On the subsequent days of inspection, we saw people were suitably dressed, clean and well presented. People told us most care staff treated them with respect. We saw staff were discreet when people needed assistance to use the washroom which promoted their dignity. We also saw staff spoke with people quietly and offered to speak with people in private at a time that was convenient to them.

Despite our observations staff were aware of the confidentiality policy and their responsibilities when handling people's information. People's personal information was stored securely. The provider met the requirements of the General Data Protection Regulation (GDPR).

Staff provided reassurance to people and were heard saying "can I help you with that" and "are you comfortable". A staff member was responsive when they heard someone sounded distress and went to find the cause and offered reassurance.

We saw when people's bedroom doors were closed staff always knocked on the door and identifying themselves on entering the room. At lunch time people were offered and provided with clothes protectors so that their clothing would be protected from spillages.

We saw staff addressed people by their chosen name and knelt to speak with people when they were seated. Staff understood people's behaviours throughout the day, and knew how to support people if they needed to use the toilet or felt anxious. For example, a person was walking arm in arm with a staff member along a corridor singing and dancing. The person was smiling and cheerful. The meaningful interaction had a positive impact on the person's mood and wellbeing.

People told us most staff were kind and caring. Their comments included, "They [staff] are alright" and "Yes, the staff are really good." We saw interactions between staff and people using the service was warm and respectful. We observed staff greeted people using the service and their visitors with a positive caring attitude. That showed people had developed positive relationships with the staff team.

Staff spoke about people in a caring and compassionate manner. One staff member said, "I think care is good here but one carer shouldn't be here" and another person said, "I treat people with the same respect I give my grandad."

Visitors and people's relatives told us they were made to feel welcome. Their comments included, "[Staff] also come and say hello, and tell us how [my family member] has been." "Staff yes, but as in the [registered] manager - she rarely speaks." And "Yes, it depends on who's on shift. Staff like these are lovely but if you go up a step they're not so lovely."

People were involved in making day to day decisions about their care and support needs and how they wished to spend their time. Some people told us they had been involved in decisions made about their care. Any decisions made about their care were mostly documented. Some people had supportive relatives who told us they had been involved in the planning and reviewing of their family member's care.

There was information about advocacy service if people required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Relatives were confident to speak with nurses and the care staff when needed. A suggestion box with comment cards were available in the reception area so that people, visitors and staff could give feedback anonymously, if they wanted to.

We received feedback from health and social care professionals and advocacy service about the staff team which was generally positive. They told us that regular nurses and care staff understood the needs of people and the decisions made about their care and treatment.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were linked to the risk assessments. Some care plans required more information about people's preferences, choices about how they liked to be supported and clearer guidance to enable staff to provide person-centred care. One person told us their preferred time to retire was documented in their care plan. However, on one occasion they had been woken up at midnight to receive continence care. This demonstrated the person was not provided with support in line with their preference.

Good record keeping would enable the provider and the registered manager to assess and monitor people's health and confirm care needs were being met. Care plans did not provide clear agreed goals. One person's care plan stated that 'food needs to be cut up into small piece and struggles lifting heat crockery and cutlery' but there was no detail of alternative cutlery to be used.

The daily report provided an overview of people's wellbeing and any concerns. We found gaps in the records used to monitor that people received responsive and person-centred care. One person's records showed they often declined to eat meals but no record of the actions taken by staff. Another person's record stated there were no concerns at night but the person was 'low in mood' but no detail of any action taken. The handover information for this person referred to signs of oral thrush but no mention of the action taken. The staff member told us that oral health was checked by the nurse but there was no further mention of oral health needs. The person's care plan made no reference to support required to enable the person to manage their oral health needs. The clinical lead assured us they would address this.

People's weights were measured which contributed to monitoring people's health. However, some records did not always show that an assessment had been carried out to confirm if the changes in weight indicated deterioration in health and a GP visit was required.

A care plans stated a person that hourly wellbeing checks were required. A new protection plan was put in place in November 2018 following safeguarding concerns, which required these observations to be carried out at every 30 minutes. However, the records showed these checks were not being carried out as required. The staff member and nurse were aware and said they would start the 30 minutes immediately. That showed staff were not responsive to meeting the person's changing needs despite being aware.

We found contradictory information in the mobility care plan for a person. It stated the person requires two staff to re-positioned them and later said, the person was able to re-position themselves and required two staff to straighten bed clothes. The clinical lead re-wrote the care plan when these issues were identified regarding the care plans.

Staff we spoke with understood the needs of people they looked after and felt they worked well together. However, they also said, "We're not allowed to write the daily reports, they [nurses and senior care workers] do that even though they haven't helped to wash and dress people." And "They [nurse and senior care worker] don't always see people or know what's happened. If I'm worried that something isn't right I tell them to come and look."

A relative said, "I would like to know what the night [staff] are supposed to do. When [they] was on the first floor they used to get [them] up at 6.30am, dressed and stick [them] in the lounge but [they] were never washed and shaved. The carers in the daytime said they would see to [them]."

The meal time experience for people were not always person-centred. People chose where they wished to be seated and were supported by staff to do so. However, all the meals were served with gravy. There were no gravy jugs or other condiments available on the dining table so that people could help themselves.

People's care needs were reviewed by staff. However, the reviews were not always meaningful because people and where appropriate their relative, had not been involved. One person said, "No I don't think they have [involved in reviews] but I'm always voicing my opinion." Another person told us they had been involved in the development of their care plan but not the review of their care. Records showed people's care needs had been reviewed but they did not take account of daily monitoring charts, any involvement of healthcare professionals or people's views. That meant people did not always receive personalised care and their involvement in the review of their care was limited.

Our findings supported the feedback we received from health and social care professionals. They had raised concerns with the registered manager about the lack of personalised care, care records and ineffective monitoring which meant people did not receive person-centred care that was appropriate and timely.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care. People did not always receive person-centred care and care plans did not provide clear guidance for staff to follow. People's ongoing care and health needs were not always effectively monitored.

Some care plans were personalised and had detailed information to enable staff to support people. For example, one care plan stated, 'food to be cut into 15mm pieces or minced' and 'drinks to be served in a beaker with a spout'. One person told us they preferred female care staff to support them with personal hygiene needs. The information described by the person was documented in their care plan and they confirmed they were supported by female staff only.

Care staff and nurses spoke about people in a person-centred way and could describe people's daily routines and preferences. The clinical nurse said, "You have to know the residents really well as some residents can't tell you what is wrong owing to advanced dementia but you can tell by little changes in their behaviours that something is not right."

Information about the service was given to people when they started to use the service. This informed people that they would not be discriminated under the Equality Act, based on their gender, race, religion or sexuality. Staff were aware of people's diverse cultural and lifestyle needs and communication requirements.

One person told us their diverse needs were met by most staff. We saw a staff member spoke with a person in their preferred language which was not English. They told us and showed us a list of words and phrases in the person's first language which staff were to use when offering a choice and confirming consent. That demonstrated staff enabled the person to be involved in decisions made about their daily care needs whilst conversing in their preferred spoken language.

Staff knew people's communication styles and ensured information was available in formats that people could understand. Picture menus were being developed so that people could choose what they want to eat.

This showed the provider was complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People told us a remembrance service was held in the cinema room which they all enjoyed. We saw people were provided with newspapers and objects for stimulation and interests. We saw people had visitors throughout the day.

We asked people about the opportunities to engage in meaningful activities and social engagement. The comments received from people using the service and relatives included, "There doesn't appear to be any activities, certain days there is never any going on when I visit and I come at different time and on different days" and "Activities, they do pom-pom dancing, waving flags around they do have activities, most people seem to like it. Hairdresser here which is quite good." "We've got two activities [staff]. They did all those [arts display] last week. It was flower then autumn leaves then the poppies. Now they are getting ready for Christmas." "I've gone off all hobbies, I've come here to retire."

There was an activity board listing the activities planned for the week including a religious service. A group of people were playing a game of hang-man with the activity coordinator who invited everyone to contribute. Another activity coordinator told us some people were looking forward to going for a walk outside in the morning. However, by the afternoon we had not seen the group had been out. The activity coordinator said only one person had gone out for a walk late afternoon. This was an example of missed opportunity to engage in a meaningful activity of interest to people that would promote their wellbeing.

The activity co-ordinators told us they worked across floors and spent time with people who were nursed in bed or preferred to stay in their room. A folder contained a list of activities that were done with people in groups and individually. The entries were brief, for example, looking at pictures, hand massage or quiz but did not reflect whether people had enjoyed the activity and what else they would like to do.

Prior to our inspection visit we had received concerns and complaints about the quality of care people received. Where appropriate we referred the complaints to the registered manager to investigate using their complaint procedure. However, we did not always receive a timely response about the investigation findings and the actions taken. We also referred concerns to the local safeguarding authority where we found people's safety was at risk.

We received concerns and complaints during and after our inspection visit. The concerns related to people's care needs not being met, staffing and the management. We referred these to the provider and the registered manager to investigate.

During our inspection visit we observed two staff casually sitting in the lounge with their feet on the coffee table. Both were startled when they saw us and got up quickly. We reported this to the registered manager.

There was a clear complaints policy and procedure in place. The comments received from people about the complaints procedure and how their complaints were managed were mixed. One person told us they would tell their relative who would complain to the registered manager. Other comments received included, "Fed up of complaining to the [registered] manager about the [continence] pads and not getting my medicines - feels like I'm being fobbed off." "If you report [complain] something, nothing changes." And "Lot of areas are very good. No complaints generally but a few areas need improving." A relative said, "I was told they don't deal with complaints [at the service] I have to write to the head office."

The complaints log showed the service had received 18 complaints since January 2018. However, the complaints folder contained 25 separate complaints and supporting correspondence, which showed the log was inaccurate. The themes of complaints related to issues regarding medicines, unsafe care, poor hygiene and cleanliness, staffing and injuries and accidents. Although some individual complaints had been addressed, new complaints related to similar issues. That demonstrated complaints were not acted upon sufficiently to drive and maintain improvements for everyone using the service.

This was evidence of a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints because system to handle people's complaints was not effective.

We saw people on end of life and palliative care were supported to remain comfortable. A relative said, "Since [person] has been in here [they] have picked up [improved]. [Person] was on pureed food and now [they] have normal [food texture]. [Person] had a reassessment and referrals so they must be doing something right. [Person] is eating and drinking normally."

The provider had a system and a policy in place about how to support people at the end of their lives. People had the opportunity to express how they wished to be cared for at the end of life. This included decisions made to remain at the home and not be admitted to hospital. A person's records showed they and their relative had been involved in the decision and an advance end of life plan had been developed to show how the person wished to be supported at this stage of their life. The records showed the NHS end of life guidance had been followed to ensure people wishes and preferences would be respected.

Requires Improvement

Is the service well-led?

Our findings

The provider's governance systems and processes were fragmented; they did not drive or maintain improvements. Records showed audits had taken place and issues had been identified, for example, gaps in medicine administration records, inconsistent information in the care plans and incomplete monitoring records and overdue staff training. There were gaps in the leadership team, which contributed to the ineffective governance framework.

Records showed the registered manager carried out monthly audits on infection control audits. The audit from September and October 2018 showed staff had followed good hand washing technique. It was scored as 'partially met' because staff wore jewellery, such as rings with stones and had false nails, which could harbour infection and cause skin injuries. However, there was no detail of what action would be taken to address the issues, by whom or by when. Improvements were not maintained as we saw some staff still wore jewellery and had false nails.

The regional operations director told us that they had made improvement to the care plans. We were shown an action plan which named the staff who would be responsible to make the improvements. However, the issues we found and detailed in this inspection report demonstrated the improvements were limited and further action was needed.

There was a lack of oversight and effective monitoring by the provider. There had been two outbreaks of infection this year. The monitoring record for the first episode was not fully completed. It showed 28 people were affected over three floors but no information about the symptoms and only six people were noted to have recovered as the recovery dates was recorded. Monitoring records, if used correctly could identify themes and information for post-outbreak investigation to support lessons learned. That showed the provider missed opportunities to learn and drive improvements.

The registered manager told us they did 'daily walk arounds' to looks at the premises including people's bedrooms and up to three people's care records including the food and drink monitoring charts. Their findings included untidy and dirty pots in the sink but the daily monitoring charts were adequately completed. We also found improvements were needed to maintain a clean and hygienic environment for all.

We found the clinical lead was responsive to concerns brought to their attention. For example, they reviewed and updated care plans and risks assessments which were inaccurate and investigated gaps in the daily monitoring records.

Further improvements were needed to the care plans to ensure they were personalised and included clear and consistent information and guidance for staff to follow. Monitoring records completed by staff were not always completed in full in relation to food and drinks consumed and people provided with activities of interest to them. Records showed that people's care needs had been reviewed. However, little evidence to show that people views were sought and decisions made were not always documented.

We found shortfalls in relation to risks to people's health and safety. Although the provider had systems to manage risks methods used were not always effective and lessons were not always learnt. Some action had been taken in response to external inspections and other regulators such as the Food Standards Agency. However, these improvements were slow and not always maintained.

Health care professionals had been working with the management team and staff to improve the management and recoding of medicines administered for several months and continued to visit at regular intervals to monitor progress. They told us that there had been some improvements in relation to missing signatures in the medicines administration records. However, our findings showed that further action was needed to ensure the management and administration of medicines was safe.

The registered manager told us they were analysing the survey results and would share the findings including any improvements planned. However, people told us they were not always involved in a meaningful way to influence the running of the service and make improvements. A relative said, "Residents and relatives meeting do not happen. The last one was about two years ago. When I asked the [registered] manager about this she said a new deputy manager is starting soon and [they] will organise it."

The new deputy manager had been appointed to support the registered manager and the overall management of the service.

Feedback we received from people who used the service, relatives and staff said the service was not well led. Not everyone felt leadership was effective and that they could approach the registered manager. Their comments included, "[Registered] manager is not managing this home. She never says hello or pops in – we rarely see her." "[Registered] manager is always in her office; never comes out and I don't how she can care for people with long nails. They may look nice but she could hurt someone." "Management is in crisis. [Registered] Manager does not know residents, never involved in people's care and hides in her office." And "[Previous management] used to do spot check in the middle of the night and at weekends to check people were being care for. That doesn't happen now."

We found systems were not robust to ensure there were sufficient numbers of staff on duty to meet people's needs and staff training was kept up to date. Staff meetings were used to share information. However, meeting minutes did not show which staff had attended the meeting and that staff were encouraged to share ideas, or provided any updates on issues that were raised at the previous meetings. The registered manager assured us this would be addressed for all future meetings.

This was evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. The governance systems were ineffective and there was a lack of oversight and monitoring of the service, the care provided and staff support. People had limited opportunity to influence how the service is run.

The service had a registered manager. They aware of the legal responsibilities in notifying the CQC of significant events and incidents within the service. Notifications received were detailed and showed that action was taken to meet people's needs and risks were managed. The registration certificate, the rating from the last inspection and the inspection report were displayed at the service and on the provider's website.

Following concerns raised about dirty cutlery and crockery, people had been provided with new clean and safe cutlery and crockery to use. The registered manager had conducted an unannounced spot check at night in response the concerns we had referred to them. They had identified some concerns regarding staff

members and conducted a supervision meeting to monitor staff practices. This demonstrated monitoring was effective if used.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care. Care plans did not provide clear guidance for staff to follow. People's ongoing care and health needs were not always effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health care needs were not managed or monitored. Medicines management and administration was not safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The system to handle people's complaints was not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems and process were ineffective and there was a lack of oversight and monitoring of the service, the care provided and staff support. People had limited opportunity to influence how the service is run.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The staffing numbers and their skill mix was not adequately calculated and monitored and the systems to ensure staff were trained and supported in their role were ineffective.