Care Quality Commission

Anchor Trust
Birchlands
Inspection report

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Ratings

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

Overall summary

Birchlands is a purpose-built care home providing accommodation and personal care for up to 52 older people, some of whom are living with dementia. There were 46 people living at the home at the time of our inspection. Accommodation is arranged in seven units over two storeys.

The inspection took place on 12 May 2015 and was unannounced.

There was no registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run. The manager had been in post for several weeks at the time of our visit and had begun the process of registering as registered manager with the CQC.

People were not protected from potential risk of harm by staff. For example, one person felt scared in the home because of the actions of others, but staff had not addressed this.

Staff did not follow correct and appropriate procedures in relation to medicines to ensure people received their medicines safely. There was no guidance to staff for people who may request 'as required' medicines.

Summary of findings

There were insufficient numbers of staff to meet the needs of the people living at Birchlands. We observed numerous occasions when there were no staff around.

Staff did not understand their roles and responsibilities in relation to infection control which meant people may be at risk of infections.

The provider had not ensured safe recruitment practices were followed, which meant they may employ staff who were not suitable to work in the home.

Care was provided to people by staff who were trained, although we found staff had not received regular supervisions so the provider could not ensure they put this training into practice or identify what other support they may require.

Staff did not understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Best interest decisions were not made in line with legislation.

Staff supported people to access health care professionals, such as the GP or district nurse, however we did not always find staff referred people to them in a timely manner.

Although we observed some good examples of kind care from staff, we found people were not made to feel as though they mattered by staff. Staff did not take the time to interact with people and we saw people sitting for long periods of time with nothing to do. We also heard some staff speak to people in an inappropriate manner.

Care plans were not person centred and did not always contain information to guide staff on how someone wished to be cared for. People were not involved in developing a care plan which was responsive to their needs. Information was missing in care plans. For example, in relation to personal care, medicines and risk assessments.

Activities occurred in the home, however they were not specific to the needs of all the people living there. For example, there were no reminiscence items for people who were living with dementia. Staff supported people to take part in various activities but individualised activities had not been considered by staff.

Complaint procedures were available to people. Some complaints had been received by the provider however, we did not find these were always addressed.

We saw evidence of quality assurance checks carried out by staff to help ensure the home was a safe place for people to live and people were provided with a good quality of care. However staff had not acted on the recommendations from some of these checks. For example, ensuring care plans were up to date.

Relatives were made to feel welcome when they visited and they and their relatives met together for meetings to discuss the running of the home. People and relatives were happy with the care provided which included a range of healthy meals and drinks each day.

Staff felt supported by the new manager and felt they could approach them if they had any concerns. Staff knew the procedures to follow should they have any concerns about abuse taking place in the home.

During the inspection we found some 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not follow safe medicines management procedures.

People's risks were not always assessed and acted on.

The provider had not ensured there were enough staff on duty to meet the needs of the people.

People were at risk of infection due to poor cleanliness.

Checks in relation to employing new staff were not completed fully.

Staff were trained in safeguarding adults and knew how to report any concerns.

Is the service effective?

Requires improvement

The service was not effective.

Staff did not have a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act. People's movements were being restricted without the proper authorisation.

Staff ensured people had access to external healthcare professionals however this was not always done in a timely manner.

Staff were trained in their role.

People were provided with food and drink which supported them to maintain a healthy diet.

Is the service caring?

Requires improvement

The service was not caring.

Staff did not take the time to speak with people in an appropriate way or provide them with care to uphold their dignity.

People were encouraged to make their own decisions about their care.

Relatives were made to feel welcome in the home.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported to take part in activities that meant something to them.

Care plans were not regularly reviewed and people were not provided with care responsive to their needs.

Summary of findings

People were given information how to raise their concerns or make a complaint. However, complaints were not always addressed.

Is the service well-led?

Inadequate

The service was not well-led.

Recording keeping was not up to date, person centred or easy to read.

Quality assurance audits were carried out to ensure the quality and safe running of the home but actions from these audits had not been addressed.

The manager did not ensure staff followed training they had received in order to provide best practice care.

Staff felt supported by the manager, but they did not receive regular supervisions.

Birchlands

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.

This inspection took place on 12 May 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

As part of our inspection we spoke with 25 people, 12 staff, three relatives, the manager and two healthcare professionals. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink.

We reviewed a variety of documents which included eight people's care plans, eight staff files, medicines records and policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete 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. This was because we were carrying out this inspection in relation to some concerns we had about the home.

The home was last inspected in June 2013 when we had no concerns.

Inadequate

Is the service safe?

Our findings

Staff did not follow correct medicines procedures. Each person had a medication administration record (MAR) which stated what medicines they had been prescribed and when they should be taken. MAR charts included people's photographs and there was a signature list to show which staff were trained to give medicines. However, when we observed a medicines round, we found a member of staff had completed a person's MAR before they had seen the person take the medicines. They told us this did this because they, "Knew she would take them." This meant there was a risk the MAR chart may be incorrect as a person may refuse their medicines but the MAR had been signed to say they had taken them.

People may not receive the medicines as prescribed. Topical medicine were required by some people. Topical medicine is medication cream which is applied to the body to relieve itchiness or dry skin, for example. We read in some people's care plans they required topical creams to be applied both in the morning and evening. However, the last recorded evidence this was done was 9 May 2015. One person's care plan indicated the person required topical cream, but there was no detail for staff on how often this should be applied. Information was not dated, so staff would be unable to tell when the commencement of creams started and whether or not the need had been reviewed.

People did not receive their medicines when they requested them. We heard one person mid-morning request pain relief. They were told by a member of staff, "I'll ask (the team leader) when I see her." After lunch we asked the member of staff if they had spoken to the team leader. We were told, "I was just about to." This meant someone went without pain relief for two and a half hours. The team leader told us this person had the capacity to request pain relief, however there was no guidance in this person's care plan.

Guidelines were not available for all staff. 'On request' (PRN) medicine guidelines were kept in the MAR charts which were locked away and only accessible by the team leaders. This meant care staff would not know when these medicines may need to be requested. Some PRN guidance was missing altogether, for example in relation to one person who suffered from asthma and another who was prescribed additional pain relief.

The lack of robust practices to ensure people received their medicines safely was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored and audited appropriately. We looked in the clinical room and saw medicines were stored in an orderly fashion. There were policies available to staff, such as policies for self-medication, immunisation and homely remedies (medicines you can buy over the counter without a prescription). Staff recorded fridge temperatures on a daily basis and completed stock control sheets to ensure medicines were counted in and out of the home properly. Staff knew how to record on a MAR if a person refused their medicines. The medicines trollies were locked and attached to the wall in each unit. We read an external medicines audit had been carried out and no actions were identified and internal audits took place each month.

The home was not always clean. We saw a metal frame had been installed at the bottom and top of the main staircase. This was to house some glass sliding doors. The frame was covered in a dusty residue and appeared rusty in places. The stairwell floor was dirty and the edging of the stairs were dirty and stained. There were areas around the home where the carpet had not been properly cleaned and food and crumbs had not been cleared up from underneath tables in some of the units. The floor of the clinical room did not look as though it had been cleaned for some time and the door sill in the main lounge area was dirty. A relative told us their family member's room had cobwebs gathering in the corner for some time and they had to ask staff to remove them.

Staff could not ensure the home was hygienic. The bathrooms in two units had chipped tiles which meant they could harbour bacteria. We saw stained flooring around the base of one toilet. There were damp mop heads stored downwards in buckets. One member of staff told us there were coloured mops for different cleaning requirements, but were unable to tell us which coloured mop should be used for which. People's wheelchairs were very dirty and we saw a metal chair frame in one bathroom which was dirty around the base. In some kitchenette areas we found the floors were dirty, especially around the fridges and dishwashers. The bottom of one fridge was sticky and covered in spilt liquid.

There was a risk of cross-contamination. We asked staff about their process for using the sluice room. Staff

explained they would put a dirty item in the sluice and lock the door. They would then go to the bathroom next door where they removed their gloves and aprons and placed them in the clinical waste bin. When we looked for the clinical waste bin we found it in another toilet area which had been locked because it was out of use. Staff did not hold the key which meant they would not have had access to the bin if this had not been highlighted to them by the inspector. Staff told us they always wore new gloves and aprons for each person, but at times there were problems with ordering of stock which meant they sometimes ran low on items.

Staff not following proper procedures to protect people from a risk of infection was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded formally, but we found gaps and incomplete information. For example, details of the accident, possible causes and ways to prevent further reoccurrence were not always included. We read in one person's care plan they had had a fall in July 2014, but there was no information on what had happened. This person had another fall in May 2015, but staff who recorded this had not signed the record. And a further accident in relation to this person had no information. The folder which contained all the accidents and incidents was incomplete. We read records of seven incidents which had no investigation or outcome information recorded.

People were not protected from potential risk and risk assessments had not always been drawn up to help keep people safe. Risk assessments were not up to date. For example, one person's risk assessment in relation to possible falls on the stairs had not been reviewed since July 2014.

We noted this had been identified during a recent local authority quality assurance visit. The report read, 'more robust risk management plans to manage the risks is required'. A relative told us their family member had been left in the bath whilst a member of staff went to assist other people. We saw a member of staff leave one person (who required support) unaided and unsupported in a bathroom whilst they went to fetch something. One person said in the evenings there were no staff around and that they didn't like it because another person followed them around. They told us this person had recently followed them into their room and they had to hold the door shut to stop them coming in. They added they had complained to staff but their concerns were not taken seriously and, "Nothing gets done to stop it from happening." This was confirmed by another person we spoke with in the unit. We were also told by this person that they had seen a staff member being unkind to another person, but they wouldn't give the inspector details for fear of, "Getting into trouble."

Staff did not respond appropriately to people who had been identified as being at risk of choking. We saw one person being given a glass of juice which had not been thickened, although it was clearly stated in this person's care plan, after involvement from the Speech and Language Therapy team, to, 'provide thickened drinks due to risk of choking'. When we spoke with staff about this we were told, "I didn't give it to her." However they removed the glass and added thickener to it.

Staff not ensuring people were protected from possible harm was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not cared for by a sufficient number of staff to keep them safe and meet their individual needs. There were insufficient numbers of staff deployed on the day of the inspection. The manager told us staff numbers were decided by using the provider's dependency tool. This calculated staffing levels based on the number of people within each 'needs' band (high, medium or low). We were told two team leaders would be on duty each day and seven care staff (one for each unit) with a 'floating' member of care staff to help out. On the day of our inspection only seven staff were on duty as one person had called in sick. The manager said they only used agency staff as a last resort and relied on bank staff to work during staff shortage.

People were not cared for by staff who were available at all times and who may be overworked. There were several times throughout our inspection when we found staff were not available. At one time, there was no staff on one unit for 15 minutes. A relative said their family member had said they could wait up to 20 minutes at times for staff to assist them. Staff relied on people who were able to, to help them support other people. One person told us, "There are enough staff because staff know we can help if need be." Another person said three people needed watching all the time, but this did not happen with staff, they told us they, "Feel responsible for other people sometimes because

Is the service safe?

there aren't staff about." Two other people said there were not enough staff on duty during the evenings and at the weekend and there were frequently long periods of time when no staff were around. One member of staff told us they had been on duty since 7.00am but at 3.30pm had yet to have a break.

People were left on their own unsupported. We saw people being left on their own when staff went to attend to a person in their room or collect the food trolley from the kitchen. We observed insufficient staff on one unit throughout the whole morning. We saw two periods, of 15 and 20 minutes where there were no staff in the lounge area. During the morning an inspector was asked by a member of staff to, "Keep an eye" on one person whilst they went to get this person's breakfast. During the period the member of staff was gone, this person became distressed and was attempted to be assisted by another person. Later during the morning there were no staff available for 15 minutes in the lounge area where four people were sitting as the staff were tidying bedrooms. One member of staff said they felt one member of staff on each unit was sufficient providing a floating member of staff was available. They said they felt they had time to interact with people throughout the day. Although if they were busy this was not always possible. However, we did not observe this. However another member of staff told us they didn't think there were enough staff working in the home. They said there was a floating member of staff, but they were not in that morning. They said if they needed support they radioed the floating staff member. We asked if their request was responded to promptly. They replied, "If you're first to request help then you get it quickly, if you're last, then you're last and you just have to wait."

The lack of staffing was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices may not always happen. Staff recruitment records did not always contain the necessary information to help ensure the provider employed staff who were suitable to work at the home. In some of the records we checked, although we saw evidence of information being requested and DBS applications being submitted, we found the documentation was not included in the file. Disclosure and Barring System checks identify if prospective staff have a criminal record. Some files did not contain two references, health declarations or full employment history.

The lack of robust recruitment processes was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had an understanding of the different types of abuse and described the action they would take if they suspected abuse was taking place. However not all staff were able to tell us where they would find the policy which showed how they should act if they had any concerns or the role of the local authority in relation to safeguarding.

We recommend the provider ensures staff are reminded of their requirements in relation to abuse.

People would continue to be cared for in the event of an emergency. There was a continuity plan in the event the home had an emergency and people needed to be evacuated. Arrangements were in place for alternative accommodation should it be required.

Requires improvement

Is the service effective?

Our findings

Staff did not have a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm. We found applications may not always have been made appropriately to the local authority. For example, applications had been made for all people with a diagnosis of dementia without considering if the person lacked the capacity to make decisions about their care arrangements. Applications which had been submitted contained the same generic statement which showed us individualised capacity assessments and decisions had not been understood or considered by staff. Staff had not carried out proper assessments where restraint was being used. For example, we found no suitable judgement or review for the use of bedrails and the keypad on the front door.

Consent was not being properly recorded or reviewed. Do not attempt resuscitation (DNAR) forms were found in some people's care plans but were not reviewed or updated appropriately. For example, we saw DNAR forms signed by hospital consultants but this decision had not been reviewed once a person moved into the home.

Decisions about people's care were not made in line with legislation. For example, we read in one person's care plan a team leader had written, '(He) has been falling out of bed. It is in the best interest for (him) to have rails for his own security and well-being." This was written in May 2015, however bed rails had been in place since August 2014. There was no evidence of any discussion around this decision or consideration about the person's capacity, best interests or whether a less restrictive option had been considered.

The lack of following legal requirements in relation consent to care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who were trained. Staff told us they had a lot of training and when they first started working in the home they shadowed a more experienced member of staff. One newer member of staff told us they worked in one unit only to begin with to ensure they were comfortable with their tasks. We saw staff were able to carry out their duties unsupervised.

Staff told us they had annual appraisals with their line manager and there were plans to develop staff knowledge. We were told by the district manager an updated course in dementia was being rolled out to staff. However, staff told us they would like more specific training. For example, diabetes. They felt this would enable them to carry out their roles more effectively.

We recommend the provider look at giving staff access to more client specific training.

The health needs of people were not always met as referrals to health care professionals weren't always made in a timely manner. Care plans evidenced the involvement from external health professionals to provide guidance to staff on a person's changing needs. However, a relative told us how they had been asking for a month for their family member to be referred to the optician. We saw one person had different shoes on and when we investigated this with a member of staff we discovered this person was suffering from a corn which is why they had put a more comfortable shoe on that foot. When we looked at this person's care plan we read they had not seen a chiropodist since March 2015, despite records recording this as a need due to this person's diabetes.

We recommend the provider review their policies and procedures in relation to referring people to health care professionals.

Staff followed guidance from healthcare professionals in relation to the care the needed to be provided. This was confirmed by healthcare professionals we spoke with. One healthcare professional told us staff followed any guidance they left for them in relation to people's treatment and on one occasion this had resulted in a person becoming self-caring in relation to their medicines. They (the healthcare professional) said staff accompanied them when they visited the home and they found this supportive and a good way of staff to gain more experience and knowledge.

Requires improvement

Is the service effective?

Staff involved healthcare professionals when people's health deteriorated or changed. One person was feeling unwell and staff told us the district nurse had been called to attend to them. We saw this happen during the inspection.

People were supported to eat and drink enough and said, "The food is good." We saw people were able to sit where they preferred in the dining area. There was a choice of main meal for people and we saw the food looked appetising as it was served up appropriately on plates. People were offered drinks along with second helpings of both food and drinks. Food was offered to people in line with their preferences in their care plans. In the afternoon, people were offered a choice of fruit.

People who required support to eat were provided this. We saw one person being supported to eat their meal by a member of staff in an unhurried way. We heard the member of staff chatting to the person, coaxing them to eat and drink.

People were involved in decisions about what they ate. We heard people being asked which food they wished and we read a catering survey had been carried out in August 2014 to obtain people's feedback and suggestions. However, there were no illustrated menus for people who may find this a better way to make a choice.

We recommend the provider develop alternative ways of showing people meal choices which would meet the needs of all the people living in the home.

Requires improvement

Is the service caring?

Our findings

People said, “Staff are kind” and they were treated with, “Privacy and respect.” Other comments included, “I like the people here” and, “I like everything about here.” They told us they were well cared for and the staff knew their likes and dislikes. One person said they had, “No complaints.” They felt content and staff were nice.

Despite these comments however, we did not feel people were not made to feel that they mattered. We saw two people sitting at a table in one unit when we arrived in the morning (10.20am). We observed these people throughout the day and did not see staff interact with them at any time apart from to provide them with their lunch. At 3.30pm these two people were still sitting in the same chairs at the table. Staff had not provided them with any social stimulation or spontaneous conversation. Both people were escorted to the toilet shortly after 3.30pm by a member of staff who said, “Come with me.” When we checked a while later, we found one person was sitting in an armchair, but the other person was again sitting down at the table.

People were not provided with care that upheld their dignity. We found little evidence that staff were supporting people to have regular baths. We read in care plans that one person appeared not to have had a bath since March 2015. Other people, over the period of 26 days had only received a strip wash or the occasional bath. Staff told us if people refused a bath this was recorded. However, there was no indication to show that people had been offered a bath in the first instance. We heard from one relative how the bath in one unit had been out of action for three weeks. We read in one bathroom, the last time the water temperature appeared to have been checked was May 2012.

We noted in a recent local authority quality assurance visit it was noted, ‘staff to be reminded to uphold resident’s dignity’. We saw divan beds in many rooms with the base of the divan uncovered, making rooms look basic and not homely. We saw one person who required to be moved by a hoist was moved in a safe way by staff, but without dignity as staff had not ensured their clothing was arranged in a suitable way.

Staff did not always talk to people in an appropriate way or in a way they could understand. We heard one member of staff say, “You. Cup of tea?” Another member of staff said, “Listen. I’ll get you some (tea). I can’t give you a time, but I’ll get you one shortly.” A relative told us staff did not take the time to speak slowly to people. One person was asked, “You don’t like it?” in relation to their pudding which was immediately removed by a member of staff with a big sigh. Another member of staff was abrupt and curt in their interactions with people. They gave people ‘orders’ rather than involving them in their care. We heard one person being told, “Put that on because it’s lunch time” whilst a clothes protector was put on them. The person was not asked if they wished to wear it.

People were not always treated in a thoughtful way by staff. We saw people accompanied to t tables in dining area 20 minutes before lunch was due to be served. One member of staff assisted one person who was a wheelchair user. We saw the person’s foot dragging along the floor as they were pulled backwards. A relative told us their family member’s bedding hadn’t been changed for weeks and on occasions their (full) commode sat in their room un-emptied by staff until lunchtime. We heard how one member of staff left vomit on the floor for the next staff shift.

People were not always shown consideration by staff. We watched one member of staff support someone who was a wheelchair user to sit closer to the television, however they placed this person immediately in front of another person who was watching the television. This meant their view was blocked. The member of staff was unaware of this until the inspector pointed it out to them.

The lack of a positive, respectful and dignified approach by staff was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some periods when staff provided caring support to people. For example, one member of staff was seen kneeling at the bedside of one person to support a person to eat who was being cared for in bed (as nursing not provided). They fed them in a sensitive, caring way. Another staff member was observed chatting with three people in the afternoon in a way that was meaningful and engaging to them.

People were able make decisions, have their privacy and independence and this was respected by staff. We saw people choose to sit in their rooms if they wished and heard staff knock on their doors before they entered.

Requires improvement

Is the service caring?

People told us they could get up and go to bed at a time that suited them. One person liked to lie in in the morning and it was noticed this was respected by staff who served them a cooked breakfast mid-morning. Another person said they liked to be up early and they got their own breakfast. They told us they were able to follow their own routines and remain independent. They liked gardening and spent a lot of time outside doing this.

People were shown compassion by staff. We heard one member of staff speak in a calm manner to one person who had become anxious.

Relatives and friends were welcomed into the home and people were encouraged to maintain relationships with people close to them. We saw several visitors to the home throughout our inspection. We heard one person on the telephone to a relative.

Inadequate

Is the service responsive?

Our findings

One relative said they were happy with how the family member had settled into the home and were pleased with everything. They said, their family member had originally come in for respite, but was likely to move in full time.

However, we felt people were socially isolated. We saw people sitting asleep for much of the day and other people sitting in their rooms because (they said) there was nothing to do. People appeared bored. One person said, "I'm not happy" and another told us, "I don't talk to anyone much." One person said they didn't do much during the day and they didn't go downstairs to the activities. We saw many people spent hours sitting at tables or on the sofas and we did not see staff support people to move around the home to improve their mobility. We saw one person sitting in the same position for three hours. They drifted in and out of sleep as no-one apart from the inspector, engaged with them. Another person was supported to a dining table mid-morning and we found they were still sitting there two and a half hours later. Other than to serve up their meals, there was no engagement with this person by staff. Care staff seemed busy with tasks and appeared to have little time to spend with individual residents in conversation. We found the televisions were on in the lounge areas of all units, however during most of the day people were not engaged in watching it.

Activities were not meaningful or individualised. Staff had not taken the opportunity to celebrate VE day which would have meant something to many people. And we saw that photos displayed on the walls were from activities that took place some time ago. Some people told us some of the activities were, "Dull" and they would rather stay in their rooms. One person said there were no outings and the activities were uninteresting. The activities co-ordinator told us they provided group, as well as, one to one activities. They said though because of the number of people in the home who required one to one interaction they were unable to provide this to each person every week. A member of staff said they undertook activities with people in the unit when they had time. Another member of staff told us they had more time in the afternoon to sit and chat with people. However, we saw little social interaction between staff and people throughout the inspection. Activities weren't meaningful for people. Staff told us there was an 'around the world' theme currently taking place.

Each month a different country was selected and activities and food were arranged around this and we saw evidence of this. However, staff were unable to provide us with other examples of meaningful activities which took place suitable for people living with dementia. We noted this was identified in a recent local authority quality assurance visit. The report stated, 'more meaningful activities needed'.

People were not supported to join in activities. A relative said their family member needed encouragement to join in activities or to go out into the garden, but she had not seen staff give that. She heard staff accepted a, "No" from their family member without any further encouragement.

Information was not provided to people in an appropriate way. We saw the activities chart was displayed in each unit. However it was in small print and not suitable for people living with dementia or a sight impairment. Bedroom doors had either a person's name or a door number on them, but they lacked anything easily identifiable for people. We escorted one person back to their unit and their bedroom as they were lost. There was nothing personalised on their door to assist this person in finding their room. There was no signposting, for example different colour schemes, around the home to assist people with orientation and we found no reminiscence items for people to touch, hold or feel. There was no information to people on the day of the week or weather.

The lack supporting autonomy and independence was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Responsive care was not always provided by staff. One person's care plan had no information of what their Alzheimer's meant for them or how they should be supported by staff. For example, in May 2015 there was a record this person had upset another person, but there was no information on how this should be managed by staff. Information on falls and other accidents had been recorded, but these did not show what investigation, cause or follow-up action had been taken. One person suffered from frequent falls and a member of staff told us they needed to be continually watched because of this risk, however there was no information in the care plan which reflected this and how staff should manage this. We heard one person tell staff they were feeling dizzy. Their care plan stated the person was diabetic and signs for low glucose in their blood was, 'fatigue, dizzy, rapid heartbeat'. However

Inadequate

Is the service responsive?

we did not observe staff check this person's blood sugar levels. Lunch had been served 40 minutes later than normal that day, but staff seemed unaware of the potential link of this person's late lunch and their signs of dizziness.

Care plans contained some personalised information, but this was not always the case. We saw some people's care plans had their 'living story' or information on an end of life discussion, but other care plans did not contain this. A relative told us they were not involved in the reviews of their family member's care and was, "Just sent the review which was all wrong." Some people were unaware they had a care plan. We found no evidence of people being involved in planning or reviewing their care.

The lack of personalised person centred care, responsive to people's needs was a breach of Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people knew how to make a complaint or comment on an issue they were not happy about and we found a complaints policy was available for people. There was a complaints log in the home which showed five formal complaints had been made in the last 12 months. We read each had been actioned. A relative told us they had made a written complaint which was currently being dealt with. However one person told us, "There's no point in complaining because you just get yourself in trouble and nothing ever changes." We noted in this persons care plan two complaints had been made, but these had not been transferred to the complaints book and when we spoke with the manager, she was unaware of them.

We recommend the provider ensure staff record all complaints in a formal way so complaints are acted on appropriately and in a timely manner.

Inadequate

Is the service well-led?

Our findings

Robust records were not held in the home. Records were not up to date meaning staff may not always follow latest guidance. We read in one care plan it stated the person was a wheelchair user, but we found they were able to walk using a frame. In another part of the care plan we read this person required a medium sling when being hoisted. This meant it would not be clear to staff whether or not this person was independently mobile. There was a lack of evidence people were weighed regularly to ensure staff monitored them for weight loss. For example, one person's records showed they had last been weighed in March 2015. Waterlow risk assessments were not always completed. A Waterlow risk assessment is a measure of someone's risk of developing pressure sores. We found nutrition records were not reviewed. One person's nutritional needs and requirements had not been reviewed since 2013 which meant staff were not monitoring people to check whether their nutritional needs had changed. Another person's records stated they needed hourly checks throughout the night, but later in the care plan we read this person locked their door at night which meant staff may not be following this person's wishes. Another person's care plan was unclear as to whether or not they were now on daily insulin. A team leader told us this person was, but this was difficult to track back through the records which meant a new member of staff may not work with the most up to date information about a person.

The lack of accurate records held in the home was a breach of Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance audits were carried out to review the delivery of care. For example, audits of medicines and health and safety. We read the provider's quality assurance team undertook regular visits to the home. Following a visit in February 2015, actions identified were; risk assessments in people's care plans were to be audited and more meaningful activities were needed. Actions were transferred to a service improvement plan for the home which was monitored by the district manager. The home had recently been inspected by the local authority quality team and they had made recommendations in relation to activities and dignity. However, although recommendations and actions had been highlighted we found staff had made little or no progress on these.

Staff were not inspired to provide a quality service. Although we heard staff received training, we saw little evidence the manager checked that learning from this training was transferred into daily practice. We read in the supervision records that although we had been told staff should receive supervision every eight weeks, 18 of the 31 staff had last had supervision in February 2015. This meant the provider could not be assured staff were following best practice, promoting the values of Anchor Trust or displaying appropriate attitudes or behaviour.

Staff were involved in the service. We read team leaders, night staff and day care staff had regular meetings. We noted however from the last team leaders' meeting the manager, 'wants to see more team work which isn't happening'. Staff complained of not having any breaks and that they had a lot of tasks to complete. They commented it was difficult to get promotion within the home and staff were often employed from outside.

The home was not well-led and the manager did not always understand their responsibilities. Despite actions being identified from external and internal audits, management had failed to identify shortfalls within the service provided to people, or take appropriate action in a timely way.

The lack of action in relation to providing a good standard of service and supporting staff was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to make suggestions and become involved in the home. There were regular residents meetings. Relatives meetings were held quarterly and questionnaires sent out by the provider to gain feedback. One relative said they were pleased with the communication between the home and themselves and they had nothing to complain about. Other relatives said, "They (staff) have been very helpful and supportive" and, "We like the units with small numbers of people in them."

People were cared for by staff who felt able to raise issues that might impact on people's safety. We saw staff had a whistleblowing policy available to them in order to raise concerns. One member of staff said the manager was, "Very good; very honest." They said she came around every day to say hello to staff and people.

Inadequate

Is the service well-led?

We reviewed information we held in relation to the home and found the manager was submitting notifications to us appropriately. This is a requirement of registration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 **The provider did not have adequate processed in place to prevent the risk of the spread of infections.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not ensured that people were protected from risks of abuse or from improper treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured a sufficient number of staff were deployed in the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not ensured that care and treatment was provided with the consent of the relevant person.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect. The provider had not ensured that people were supported to be autonomous or independent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided to ensure people's needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured accurate and complete records were held. The provider had not ensured that quality assurance assessments were monitored to improve the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not ensured effective recruitment procedures.