Ainsworth Nursing Home Limited

Ainsworth Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was an unannounced comprehensive inspection which took place on 05 and 06 January 2016. The service was last inspected on 12 May 2015 when we undertook a comprehensive inspection. Multiple breaches of the regulations were found and a condition was imposed on the provider's registration to restrict any further admissions to Ainsworth Nursing Home. The service was rated as "inadequate" and placed into 'special measures'. The condition to restrict admissions to the home remains in place and due to one domain being rated as inadequate from this inspection the service remains in 'special measures'.

Ainsworth Nursing Home is situated in the village of Ainsworth, in a rural position. Ainsworth Nursing Home provides nursing and residential care for up to 37 older people including people with mental health and dementia needs. There were 25 people living there on the day of our inspection.

The service did not have a registered manager in place 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 2008 and associated Regulations about how the service is run. There was a manager in place who had applied to CQC to register and their application was in progress.

During this inspection we found some improvements had been made to meet the relevant requirements, however continued breaches of the regulations were found. You can see what action we told the provider to take at the back of this report.

We found people's care records were not as up to date or as accurate as they should have been, reflecting the current and changing needs of people so that staff were clearly directed in the delivery of people's care.

Robust recruitment procedures had not been followed to check the suitability of people applying to work at the service.

Insufficient improvements had been made in relation to risk assessments. One risk assessment we looked at did not reflect the person had sustained four falls in recent times.

We saw there was no readily accessible guidance for staff in relation to the amount of thickener to be added to drinks for those people who required it. It was also identified that the majority of the prescribed thickeners were given by the care staff and not by the nurses who had signed on the MAR that they had given them.

We have made a recommendation in relation to water temperature checks and the frequency at which these are conducted.

We found improvements had been made in relation to fire safety, including the replacement of windows, staff training and fire drills.

We have made a recommendation in relation to the competencies of persons undertaking Portable Appliance Testing (PAT).

Records needed improving where 'best interest' meetings and decisions had been made for people who lacked the capacity to make decisions for themselves.

Records we looked at showed the confidentiality policy had been discussed with staff; however this was not adhered to by one member of staff who was overheard discussing the care and treatment of a person who used the service with another person's visitor.

We saw some language used in care records was derogatory. We saw that people were sometimes referred to as 'wandering' or 'wander some'. We also saw there was a 'wandering' policy in place.

We saw a range of activities were provided however, these were all condensed to the two days when the activities coordinator was on duty. We have made a recommendation in relation to the expertise of care staff in order to keep people who use the service stimulated and engaged.

We found that two specific incidents that should have been reported to us. We checked our records and found that we had not received any notification from the service to inform us of these.

Appropriate action had been taken to protect people potentially being deprived of their liberty. A programme of training was being provided in the Mental Capacity Act 2005 and deprivation of liberty safeguards. This should help staff understand how to promote and protect the rights of people.

Various equipment was available throughout the service, including hoists, wheelchairs and walking aids. Mechanical hoists were inspected on a regular basis by an external company.

We found improvements had been made with regards to staff training and support. Further training and development should be explored in areas of clinical care and support to meet the specific needs of people living at Ainsworth Nursing Home.

We noted improvements had also been made in relation to infection control. There was only two rooms were we noted an offensive smell but the provider was able to give us an explanation in relation to this.

People were offered adequate food and drinks throughout the day ensuring their nutritional needs were met. We saw people were supported to access health care professionals, such as GP's, community nurses and dieticians so their current and changing health needs were met.

We found additional signage had been placed around the home to assist people living with dementia. This included pictorial signs to identify toilet and bathroom facilities as well as photograph's on bedroom doors.

The care records we looked at showed that assessments were completed in relation to the risk of inadequate nutrition and hydration.

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. Robust recruitment procedures were not in place to ensure all relevant information and checks were in place prior to new staff commencing work.

The system for managing thickeners was not safe. We saw there was no readily accessible guidance for staff in relation to the amount of thickener to be added to drinks.

Whilst accidents and incidents had been recorded within the service, there was no evidence to show what actions had been taken as a result, any steps taken to mitigate further risks or any learning from these.

Is the service effective?

Requires Improvement

The service was not always effective. Records did not clearly evidence where people lacked capacity to make decisions for themselves and how decisions had been made on their behalf ensuring this was in their best interests.

Opportunities for staff training and development were in place. Further improvements were needed, including clinical training for nursing staff; to ensure all staff had the knowledge and skills needed to meet the needs of people safely and effectively.

Where people were being deprived of their liberty the manager had taken the necessary action to ensure that people's rights were considered and protected.

People were provided with a choice of suitable food ensuring their nutritional needs were met. Relevant advice and support had been sought where people had been assessed as being at nutritional risk.

Is the service caring?

Requires Improvement

The service was not always caring. We saw people were not always treated with dignity and privacy. We saw one staff member stand in front of a person to stop them from entering the conservatory.

We saw a number of staff members entered a person's bedroom whilst they were sat in their chair. We saw that staff members did not speak to the person whilst they were in the room.

We found information available in communal areas to inform people who used the service how they could contact advocacy services.

People who used the service, relatives and staff members told us the atmosphere in the service had improved.

Is the service responsive?

Requires Improvement

The service was not always responsive. We found limited improvements had been made in relation to the activities and opportunities for people particularly on the dementia care unit.

During this inspection we examined the care records for six people. We found they continued to lack accurate up to date information.

Systems were in place for reporting and responding to people's complaints and concerns.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance audits that were in place were not sufficiently robust to identify issues we found during this inspection.

We looked at a number of policies and procedures within the service. We found two of these contained information relating to Scottish legislation rather than English legislation and were therefore inappropriate.

Staff we spoke with told us that they had attended staff meetings since our last inspection.

Ainsworth Nursing Home

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 05 and 06 January 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We received this prior to our inspection and used the information to help with planning.

We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We received a response from the local commissioning team who informed us they had recently undertaken a quality assurance visit and had found the service were making progress to meeting their action plan. They had no current concerns with the service.

We spoke with three people who used the service and five relatives. We also spoke with three care staff members, the activities coordinator, two cooks, the maintenance person, the deputy manager and the manager.

We looked at the care records for eight people who used the service and the medication records for a number of people. We also looked at a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found robust recruitment processes were not in place to ensure people were kept safe. During this inspection we found sufficient improvements had not been made. We found the policy and procedure to guide them still needed updating to reflect all checks required. This is important so that checks are completed making sure applicants are suitable for employment.

We examined the personnel files for five new staff who had been employed since the last inspection. We found names of applicants and dates were not recorded on references prior to being sent to referees, application forms for two people were incomplete; did not include a full employment history or provide details of the referees, there was no evidence on two files of a Disclosure and Barring Service (DBS) check. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Interview records had not been completed for each applicant or lacked information about the discussion held. These records help to demonstrate that those people appointed to work at the home have been assessed as having the qualities, skills and are deemed as suitable to work with vulnerable people.

People were not protected by robust recruitment practices ensuring only those suitable to work with vulnerable people were employed to work at the service. This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see checks were now being undertaken to ensure that the registered nurses who worked at the service had a current registration with the Nursing and Midwifery Council (NMC); ensuring they remain authorised to work as a registered nurse.

We looked at staff rosters and spoke with people and their visitors and staff about the staffing levels provided. Most of the people we spoke with told us they felt there was sufficient staff on duty to support people. One relative told us, "I know that staffing is an issue with everyone and I am not complaining. My wish list would be to have more staff." Staff we spoke with told us, "Staffing levels are okay" and "Bank and agency staff are not used very often. The home has been very lucky with staff."

At our last inspection we found information contained within risk assessments did not accurately reflect the current needs of people. They also did not contain sufficient information to help guide staff so that appropriate action was taken to minimise risks to people. During this inspection we found insufficient improvements had been made.

Eight care records we looked at showed that risks to people's health and well-being had been identified, such as moving and handling, falls, pressure ulcer prevention and bed rails. We saw one falls risk assessment had been reviewed and a registered nurse had documented that the person had not fallen since the last review. Inspection of the accident and incident records showed this person had fallen on two occasions since this had been reviewed. The risk assessment did not reflect the falls the person had sustained, if the person was to be monitored or if a referral to the falls team was necessary. Another person's

records showed they had sustained falls on a number of occasions, three of which were in a period of three weeks. From a discussion with the manager and a review of records there was no evidence to show that contact the falls team for further support and advice or how to further minimise the risks.

The provider had not taken all reasonable steps to help manage and reduce the risks ensuring the health, safety and welfare of people. This was a breach of Regulation 12 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine and care records we looked at showed two people were prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes food, for people who have difficulty swallowing. Care staff were responsible for supporting people with their nutritional intake, including the use of thickener, however there was no clear guidance about how thickeners were to be used or assessment to minimise the risk of people choking. One staff member we spoke with told us the amount of thickener they used for one person, however this differed from the information contained in the records we looked at. We were told that no further discussion had been had with the speech and language therapist to confirm the changes that had been made. This meant the person may not have been receiving the correct amount of prescribed thickener placing them at risk of choking.

It was also identified that nurses had signed on the MAR that they had given prescribed thickeners, despite this being done by care staff. It is important that this information is available for care staff and recorded accurately to ensure that people are given their medicines safely, consistently and as prescribed. This was a breach of Regulation 12 (1) and (2)(a) (b) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the service was not managing people's medicines safely. During this inspection we found that improvements had been made.

We saw that policies and procedures for the management of the medicines were readily accessible and that qualified nursing staff took responsibility for the administration of people's medicines. Nursing staff had completed recent training supported by the supplying pharmacist and assessments of their competency in managing and administering medication had been assessed by the manager to ensure their practice was safe.

We checked the systems for the receipt, storage, administration and disposal of medicines. We also looked at the medicine administration records (MARs). We found that appropriate arrangements were in place to order new medicines and to safely dispose of medicines that were no longer needed. Medicines were kept in a locked trolley in a locked medicine room and only registered nurses had access to them. We saw that controlled drugs (very strong medicines that may be misused) were stored safely in accordance with legal requirements and they were administered and recorded correctly.

The MARs we looked at showed that staff accurately documented on the MAR when they had given a medicine. It was identified from the MAR sheets that some medicines were to be given 'when required' or as a 'variable dose' of one or two tablets. We saw that information was available to guide staff when they had to administer medicines that had been prescribed in this way. Records also clearly showed what dose had been administered.

We were told and saw information to show that one person managed some of their medication. A risk assessment had been completed detailing how the person was to be supported in managing their medication and suitable safe storage had been provided in the person's room. This helped to ensure the

person was kept safe.

We spoke with staff about safeguarding and if they knew how to respond to any concerns they may have. Comments we received included, "I would raise safeguarding concerns with the manager. I would whistle blow if nothing was being done", "I make sure people are safe by watching and making sure I know where they are. Making sure people are clean and toileted". One staff member told us that if they felt that any service user was not safe they would report this to the manager. If they were not satisfied that this was dealt with then they would report it to CQC.

Training records showed that all but five of the 33 staff members had completed training in safeguarding adults recently. The service had a safeguarding adult's policy in place. However, this was a policy developed by another company and made reference to Scottish legislation rather than English legislation and was therefore not appropriate to be used within the service. The service did have the local authority safeguarding adult's policy in place.

The service also had a whistleblowing policy in place that had been reviewed in recent times, which gave staff clear steps to follow should they need to whistle blow (report poor practice). Within the policy the telephone number for the Care Quality Commission (CQC) was detailed. Staff we spoke with told us they were aware of the whistleblowing policy and knew what to do if they had any concerns. They told us they would approach the manager or another member of the management team and felt confident to do so.

At our last inspection we found that some bed rails that were in place did not have the correct protectors on them. We found some of these were too small leaving gaps where limbs could fall through. During this inspection we found the service had purchased new protectors and these had been put in place on all the bed rails we checked.

Various equipment was available throughout the service, including hoists, wheelchairs and walking aids. Mechanical hoists were inspected on a regular basis by an external company. The last dated inspection was 16 January 2015 and it was deemed that all hoists were safe. At our last inspection we did not see any evidence that wheelchairs and walking aids were checked on a regular basis to ensure they were safe and appropriate for use. We found these checks were still not being completed during this inspection.

The bathing policy in place within the service stated that temperature checks were to be completed prior to a person being submersed in the water. This had been reviewed by the manager on the 27 August 2015. Records showed that water temperatures were checked by the maintenance person once per month. However, the manager confirmed that checks were not being undertaken on a daily basis prior to people bathing and that the checks the maintenance person did were the only ones in place. This meant there was a risk that people may be submersed in water that was above the recommended temperature as the services' own policy and procedure was not being adhered to. We recommend the service considers current best practice guidance and its own policies and procedures in relation to water temperatures and the frequency at which these should be monitored.

We checked records to ensure that portable electrical equipment had been tested (PAT) to ensure its safety. We were informed that the maintenance person was responsible for all PAT within the service. Current guidance states that only a suitably competent and skilled person who has undertaken training is able to undertake safety tests on electrical equipment. From our discussions with the maintenance person and the provider and a review of records, we saw no evidence that this person had undertaken any training or was deemed competent to undertake these tests safely. We recommend the service considers current best practice in relation to the testing of portable electrical equipment and evidence is available to support a

person's competence to undertake this role.

After our last inspection, we were informed by the local fire safety officer that the fire service had taken enforcement action at Ainsworth Nursing Home. This was due to a lack of general fire precautions, inadequate fire risk assessment, lack of clear fire safety policy and lack of fire safety training for staff. Prior to this inspection we were informed by the local fire safety officer that improvements had been made within the service and the enforcement action had been lifted.

We looked at all the records relating to fire safety. We saw the service had a detailed fire risk assessment in place dated 31 July 2015. At our last inspection we found people who used the service did not have Personal Emergency Evacuation Plans (PEP's) in place. During this inspection we found these had been put in place and contained information on each individual's mobility. These should ensure that people are evacuated effectively during an emergency situation. Training records also showed that all but two members of staff had completed the recent fire safety training.

We looked at all the maintenance records relating to fire safety and found that regular fire drills took place within the service and fire escapes were checked on a regular basis. One relative told us they had also been involved in a fire drill within the service during their visit. At our last inspection we found that a number of windows could not be opened due to them being painted shut. During this inspection we found that these windows had been replaced with new ones.

Whilst accidents and incidents had been recorded within the service, there was no evidence to show what actions had been taken as a result, any steps taken to mitigate further risks or any learning from these.

We noted an improvement in the cleanliness throughout the service. Offensive odours that were present on our last inspection had been dealt with and we did not notice any malodours during this inspection. We checked a number of hot and cold taps throughout our inspection and found that ones that were previously not working had been fixed and were in full working order.

Training records showed 24 of the 33 staff had completed training in infection control and health and safety. Information showed that further training had been planned for the remaining staff.

One staff member we spoke with told us they had undertaken training in infection control and knew their responsibilities in relation to this, for example wearing personal protective equipment (PPE) and hand washing. However, on the day of our inspection we noted two staff members entered the kitchen without wearing PPE. We spoke with the manager regarding this who told us they would address the situation immediately. On the second day of our inspection we noted that an apron dispenser had been fitted outside the kitchen for staff to access aprons before entering the kitchen.

Requires Improvement

Is the service effective?

Our findings

We looked at how people were consulted and consented to their care and support. We found a number of people living at Ainsworth Nursing Home had complex mental and physical health care needs and relied on others to make decisions on their behalf about their care and support.

We noted in two people's records reference was made to relatives of people having a 'power of attorney'. This meant people had delegated the responsibility to their relatives to act on their behalf. However information was not clear if this was specific to health and welfare decisions. We saw evidence of a 'power of attorney' on one person's file; however this was not in relation to care. This information is essential to ensure decisions made on behalf of people are lawful.

We looked at how decisions were made for those people who had been assessed as lacking capacity to make decisions for themselves, ensuring this was in the person's 'best interests'. We noted that up to date capacity assessments had not been carried out when decisions were being made. This is important as some people may have fluctuating capacity or may be able to make some decisions about their care and support, but need help in other areas.

On three care files examined we saw a record of a best interest meeting and decision. A best interest meeting is where other professionals and family if relevant, together with staff decide the best course of action to take to ensure the best outcome for the person. The records we looked at showed families had been consulted with however there had been no involvement from external health professionals. We found capacity assessments and records of best interest decisions did not clearly show how the service had tried to enable people to make decisions and what specific decisions were being made on behalf of the person.

Assessments and decisions for people lacking the mental capacity should evidence the principles of the Mental Capacity Act 2005 have been complied with so that people's rights are protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found opportunities for staff training, development and support was not as effective as they should have been. During this inspection we looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Ainsworth Nursing Home. We spoke with the manager, nursing and care staff and looked at records. The manager told us that a programme of induction, staff supervision, training and team meetings were in place. We saw minutes of recent staff meetings and records to confirm induction, supervision and training had been provided.

At the previous inspection the manager told us that a new induction and training programme. We saw new staff had received an induction on commencement of work which included an introduction into the service, fire safety procedures and an overview of people's needs. New staff also spent time shadowing experienced staff to enable them to learn the role prior to going on to the rota. This was confirmed by those staff spoken with. One staff member told us, "The induction was okay. It took about an hour but I shadowed staff before working on my own. I picked things up quickly as I had been working in the care sector prior to this job."

Staff we spoke with told us they had received training whilst being employed at Ainsworth Nursing Home. Comments we received included, "The training is getting better", "I have just started my NVQ level two which I am excited about", "We do lots of training", "I have done training in challenging behaviours, dementia, safeguarding and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)" and "I am doing my NVQ level two". However, one staff member told us they had not done any training in relation to dementia but they had researched this topic themselves on the internet. They told us, "I will research something if I do not know about it". Another staff member told us they had very little knowledge of dementia and they would benefit from training in this area.

The manager told us that training was sourced from external providers and the local authority training partnership group supported by the local authority. We looked at the staff training records, which showed what training staff had completed or was required. Records showed that training had been completed or was planned in areas such as moving and handling, fire safety, safeguarding adults, MCA and DoLS, control and restraint, first aid, food hygiene and infection control. There was no evidence to show that staff had received training in the specific needs of people such as mental health needs and dementia care.

Staff we spoke with told us they had regular supervisions. Comments we received included, "I have supervision every six to eight weeks with the manager. We discuss issues with work, service users, colleagues and training. I have had an appraisal" and "I have supervision every two months with the manager". Records showed that supervision meetings had taken place. The manager told us separate meetings with care staff were completed covering personal and development needs and areas of care and conduct. Records confirmed what we were told. We did not however see evidence of clinical supervisions being undertaken with nursing staff to discuss their clinical practice, current good practice guidance and any development needs. Supervision meetings are important as they help staff discuss their progress at work as well as discuss any learning and development needs they may have.

Qualified nursing staff had not been supported by the provider in developing or updating clinical skills to meet the assessed needs of people living in the service, such as wound care, catheter care and clinical observations.

Opportunities for staff training and development helps to ensure the specific health and well-being of people are safely met by staff with the relevant knowledge and skills needed to do so. This meant there was a breach in Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who used the service told us they thought most staff, in particular experienced ones, were extremely competent in their roles. One relative we spoke with told us, "Staff know all the little quirks of people."

We spoke with staff to ask them how they got to know people. One person told us, "You get to know people so well because of the amount of time we spend with them each day". All the staff we spoke with were able to describe people's likes and dislikes.

We were told that 'handover' meetings between the registered nurses were undertaken on each shift. We saw records to show that handovers were recorded. This was to help ensure that any change in a person's condition were properly communicated and understood. We were told that the care staff received the information from the nurse before they started their daily work schedule. However, we were informed by the provider that care staff members do not look at care files to gain any information; they rely solely on handovers and communication books.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 authorisations to deprive a person of their liberty were being met. The manager told us and we saw information to show where authorisations had been granted by the supervisory body (local authority) to deprive people of their liberty. This helped to ensure people's rights were protected.

We saw a policy and procedure was available to guide staff in the Mental Capacity Act 2005 (MCA) and DoLS procedures however this referred to legislation in Scotland and was not specific to local guidance.

We were told that training was provided in MCA and DoLS. Training records showed that 24 of the 33 staff had completed training in DoLS. The manager told us that training in MCA had been planned for 15 staff and that arrangements for the remaining staff to complete the course would be made. This training is important and should help staff understand that where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure their rights are safeguarded.

We looked at how people who used the service were given choices. Staff we spoke with told us they gave people choices in many ways. One staff member described how she would hold up a choice of clothing and ask the person which one they would like to wear. Another staff member described how people could go to bed when they chose or could get up when they wished. During our observations we noted people were given choices such as, if they wanted tea or coffee, rather than this being placed in front of them.

Records we looked at showed people had access to a range of healthcare professionals in order for their health care needs to be met. Records we looked at showed that visiting professionals included GP's, dietician and tissue viability nurses. However, we noted some people had fallen on a number of occasions and there was no evidence to show that the service had considered contacting any healthcare professionals for further advice and support in order to reduce the risk of further falls occurring.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We looked at the kitchen and food storage areas and spoke with kitchen staff.

We found the kitchen was clean and well organised with sufficient fresh, frozen, tinned and dried food stocks available. We saw records were completed in relation to temperature checks, cleaning schedules and meals served each day. The cook was aware of people's dietary needs and how to fortify foods to improve a person's nutrition.

The service had four weekly menus in place which had recently been updated. Meal choices were offered at breakfast, lunch and tea time. Suppers were also provided. We saw refreshments were provided throughout the day with snacks served in the afternoon and evening. We saw jugs of juice were available in each of the communal areas as well as bedrooms, where people spent time in their rooms. This helped to ensure

people had sufficient hydration.

The care records we looked at showed that assessments were completed in relation to the risk of inadequate nutrition and hydration. We saw that additional monitoring charts were put in place and where necessary and additional support and advice was sought from the person's GP or dietician, where necessary.

Kitchen staff spoken told us they received regular training updates and were expected to complete all training provided for staff. Records confirmed what we had been told and showed that up to date training had been completed in food hygiene, health and safety and infection control procedures. Following a food hygiene inspection on November 2015, the home was rated a '4'. A rating of five being the highest awarded.

We spoke with relatives about the fixtures and fittings within the service. Comments we received included, "There have been many improvements especially with the physical environment that have taken place over the last six months to bring the place up to standard", "There have been lots of visual, cosmetic changes, for the better really. Shabby carpets that needed to be replaced and painting has been done." One staff member we spoke with told us, "The environment is cleaner and brighter."

During our last inspection in May 2015 we found areas of the home were poorly maintained. We had been told by the provider prior to our visit that a programme of refurbishment was taking place. As part of this inspection we again spent time looking around the home. We found some improvements had been made.

We were shown the providers business plan, which outlined improvements being made to the home planned for 2015 and 2016. Whilst looking around the home we found rotten windows had been replaced, several rooms had been repainted, new fencing had been fitted around the garden area for the dementia care unit and a new boiler had been fitted.

We did note that some rooms still needed attention, not all of the new windows were fitted with restrictors, stained flooring still needed replacing and bedding and linen used remained worn and faded. We were told these would be addressed as part of the on-going programme of refurbishment. When speaking to one person they told us their bedroom had recently been decorated. However we noted that the wallpaper was torn in one area and the ceiling was stained with water marks. We found two bedrooms had a strong malodour. We discussed this with the manager. We were told they were aware of the issues and work had been planned to address this.

We saw the service had sufficient aids and adaptations available to promote comfort and aid mobility and independence. The bedrooms of some people had been personalised with belongings from home.

We found additional signage had been placed around the home to assist people living with dementia. This included pictorial signs to identify toilet and bathroom facilities as well as photograph's on bedroom doors. The use of pictures and other visual aids helps to promote the independence and orientation of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We saw care records were kept in locked cupboards on each of the units. This ensured information about people was kept secure.

The service had a confidentiality policy in place. We saw evidence in the 'clinical' supervisions carried out with care staff that the homes confidentiality policy had been discussed with staff; however this was not adhered to by one member of staff who was overheard discussing the care and treatment of a person who used the service with another person's visitor. This meant that no due regard had been given to the person's privacy and was a breach of confidentiality.

We visited four people being cared for in bed. They were clean, comfortable and well cared for. Staff carried out regular checks to help maintain their comfort and regular refreshments were provided. The relative of one person being cared for in bed told us, "I haven't any complaints at all. [Name of service user] always looks comfortable and clean.

During our observations we noted on one occasion a staff member entered a person's bedroom without knocking, keeping the door open using the door guard (an approved door wedge). On another occasion a different staff member entered the same person's bedroom, again without knocking and kept the door open using the door guard. We were aware the person was awake as we had spoken to the person moments earlier. On this occasion the staff member placed fresh drinks in their room. At no point did the staff member speak to the person before leaving the room and closing the door. We also witnessed two staff members supporting a person to access the toilet in the main reception area of the dementia unit. One of the staff members left the bathroom and did not close the door properly, resulting in the door being left open whilst the person was in an undignified position.

Whilst observing on the dementia unit we saw one person get up out of their chair and walk towards the conservatory. The staff member present in the lounge got up and walked past the service user, turning just past them and stood still right in front of them. The staff member did not speak to the person but continued to stand in front of them until the person turned around and walked the opposite way. We passed all the above information on to the manager and provider who did not inform us of how they would deal with this to ensure this practice did not occur again.

At our last inspection we saw some of the language used by staff when writing care plans and recording notes in care files was negative and not respectful of people. Staff had described people as wandering or wander some, suggesting they had no purpose in what they were doing or where they were going. During this inspection we found the same care plans in place with negative comments. Another comment we saw described a person as on occasions 'becoming resistive and difficult'. We also saw the service had a 'Wandering Persons' policy in place. This does not promote respectful attitudes amongst staff members; policies and procedures should be designed to support them in their roles.

People who used the service were not always treated with dignity and respect and people's privacy was not

always respected. These matters are a breach of Regulation 10 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the relatives we spoke with told us that staff were caring. Comments we received included. "The day staff are like family", "Staff are wonderful, they are caring and you can have a bit of fun with them", "They do look after my relative", "Staff are helpful. It is like family now because I come every day" and "There is a real sense of caring for everyone that comes in and it extends to the family."

Comments we received from staff included, "I show I care for the service users by engaging with them. I like to make them laugh, even if it is at my expense. It is part of my job really", "The new staff have made a positive impact on the service" and "I think putting a smile on someone's face means a lot to me". One staff member told us their relative had lived at Ainsworth Nursing Home for 15 years and when they visited they thought the care was good, making them want to work at the home.

On the occasions we did observed staff interacting with people who used the service we saw these were kind, patient and caring. We observed some staff took time to sit and chat with people who were sat in the main lounge areas.

One person who used the service told us, "I am quite happy here, I do not have any responsibility. Most of the staff seem responsible." Relatives we spoke with felt that the atmosphere within the service had improved in recent times. One person told us, "It is a far better atmosphere, things have definitely improved". When asked what they personally felt had improved they told us, "Everything in itself has improved, better management, it is professional". Other comments we received included, "I feel there is a good atmosphere now. The staff seem to be doing their very best and they are more relaxed" and "They seem to have more time. It's a different place, the atmosphere; I can't put my finger on it but it has changed."

Staff we spoke with also told us the atmosphere in the service had improved. They told us, "There have been lots of improvements" and "The atmosphere is calmer and happier."

Whilst we did not see evidence that anyone who used the service had an advocate, we found information available in communal areas to inform people who used the service how they could contact advocacy services.

Requires Improvement

Is the service responsive?

Our findings

We looked to see if people's needs were assessed prior to them moving to Ainsworth Nursing Home. We saw on the care records we looked at that a detailed assessment had been received from the commissioning team. This helped the service decide if the placement was suitable and if people's needs could be met by staff.

We asked relatives if they had been involved in the development of care plans. One relative we spoke with told us, "I am very involved in his care planning, particularly where his health is concerned. He is my priority and he comes first."

We noted on all the care files we examined that the person had been involved and consulted about their care and support. A record had been made of their views.

We asked staff how they got to know people they were caring for. One staff member told us, "It's good to read up on people so that you get to know about them, always making sure what people's needs are." Another staff member told us, "I like listening to their life stories, you learn a lot about someone by talking to them." However, most of the staff we spoke with confirmed they did not look at care plans and relied on handovers from senior staff members. We spoke with the manager and registered provider about this. They confirmed that whilst care staff members had access to care plans they did not look at them and that care plans were written by the nurses and only these people used them.

At our last inspection we found care records did not contain accurate up to date information about people's needs and how they wished to be supported. During this inspection we examined the care records for eight people. We found the same care records in place and that they continued to lack accurate up to date information.

We were told the needs and behaviour of one person had changed and was currently under review. An examination of their care records did not reflect what we had been told. Another person had recently been discharged after a long hospital stay. Their care plan did not clearly reflect the reason for their admission or that an assessment of their needs or an updated plan had been undertaken following their discharge to show how their needs could be met.

We noted that information about those people subject to a deprivation of liberty safeguard (DoLS) had not been detailed in people's plans of care. We saw the DoLS for one person identified a condition which the home needed to consider due to the persons behaviour and risk of leaving the building. This person's care plan did not make any reference to this or clearly show what staff should do should an incident occur.

This was a breach of regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans must be in place and should be accurate to ensure safe and effective care is provided in a consistent way.

At our last inspection we saw that there were limited opportunities for people to engage in activities and a lack of stimulation for those people living with dementia. We checked the action plan the service had submitted to us prior to this inspection and found that no consideration had been made to ensuring activities for people who used the service had improved. During this inspection we saw that some improvements had been made.

The activities coordinator had worked six and a half hours per week at our last inspection. During this inspection they told us they now worked two days per week (12 hours in total) in order to provide more opportunities to undertake activities. The activities coordinator also worked in the kitchen to assist the cook. However they told us they would like to spend more time doing activities but felt that when people live in a care home they are limited to doing particular activities compared to if they were living at home, for example going out on more trips. From our observations throughout both days by the inspection team we saw no activities were undertaken when the activities coordinator was not on duty. Following the inspection visit we received anonymous information about the lack of opportunities for people which reflected our findings on the day.

The activities coordinator told us the activities on offer to people who used the service included; listening to music, chair exercises, hand massages, carpet bowls and ball catch. We also noted an activity entitled 'touch and feel' which we were told involved people touching objects with different textures, such as hard and soft. We were also told that a singer came into the service every month and monthly coffee mornings were held to which family and friends were invited. We also saw a photograph of a summer garden party being held.

One relative we spoke with regarding activities on offer within the service told us, "Activities are appropriate given the capabilities of the service users, they don't have the concentration." Another relative told us they did not think the activities on offer stimulated those people living with dementia. At our last inspection the activities coordinator told us they found it difficult to engage people in activities that were living with dementia. During this inspection we continued to find limited stimulation for these people.

On the first day of our inspection we saw a sing-along session was being undertaken on the dementia unit and on the residential/nursing unit we saw people were colouring pictures. On the second day of our inspection we noted that the activities coordinator had taken a person into the local town to do some personal shopping. The activities coordinator also told us they did research on the internet to find new activities they could put in place. When we asked what kind of things they had found or put in place they were unable to tell us.

We were also told by the activities coordinator that lots of activities were undertaken on a one to one basis with people who used the service; particularly those being cared for in bed or living with dementia. They told us they would give people hand massages (some of whom particularly enjoyed this), chatting to them and reading the newspaper or poetry to them. However we did not see evidence of other dementia friendly resources or adaptations in the communal areas. This meant there were continued lost opportunities to stimulate and relieve the boredom of people who used the service on a daily basis.

We recommend the provider considers widening the expertise of the care staff to ensure that service users are stimulated and engaged in activities as much as they wish each day.

We asked staff how they were kept up to date with any changes that occurred within the service, including the needs of people. Staff told us that the nurse or person in charge would inform them of any changes and handover sheets were used to record information on a daily basis. One staff member told us, "Management let us know any changes in the service users. All the information comes from the manager."

We asked staff members how they gave people who used the service choices. Comments we received included; "Always ask people what they want and give them choice. Try to let them make their own choices rather than make it for them, giving them enough time to do so and not rush them," "I respect people's choice of food, clothes they want to wear and where they want to eat their meals" and "Service users would let me know whether they like something or not, even if they don't speak I would be able to tell by their expressions."

We looked at how complaints were managed in the service. One family member told us, "If there is anything I don't hold back." They continued to inform us that they had to raise an issue recently in relation to her relative's blood sugar levels being high on a regular basis. As a result the service had contacted the diabetic nurse and their medicine was changed.

We looked at how the manager and provider addressed any issues or concerns brought to their attention. We were told and saw records to show that one complaint had been received and responded to in line with the complaints policy since our last inspection.

We reviewed the homes complaints procedure which was included in the 'service user guide'. A copy of the guide was available in each person's bedroom and therefore easily accessible. Information clearly outlined the process, timescales for response and relevant agencies that can be contacted.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in place who had applied to CQC to register and their application was in progress.

During our inspection we asked the manager to identify areas where they felt improvements had been made since our last inspection when we served a notice of decision to restrict any further admissions to the service. The manager told us they felt they had made improvements in relation to the environment, staffing levels, supervisions, training, quality audits, service user files, uniforms for staff, handover and communication sheets, personal hygiene of people who used the service and the availability of juice for people. Whilst we found some of these areas had improved further areas of concern were found during this inspection which have been highlighted within this report, including safety, staffing, consent, training, clinical supervisions, privacy, dignity, activities and care plans.

At our last inspection we found that there were no formal quality assurance systems in place. During this inspection we saw medicines were audited on a weekly basis by the service and an annual audit was undertaken by the pharmacist. These were sufficiently robust to identify any issues or concerns in relation to the management of medicines.

We saw that weekly audits were undertaken in relation to accidents/incidents, complaints, staff recruitment, hospital admissions and staff inductions. Monthly audits were also completed in relation to infection control, beds, mattresses, rooms and curtains. However, we found that these were not sufficiently robust to identify some of the issues we found during our inspection. We did not see evidence that any other audits were undertaken, such as care records.

The lack of robust and regular auditing meant that the service had no effective systems in place to continually monitor the service provided to ensure people received safe and effective care. This is a breach of Regulation 17 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff if they knew how to access policies and procedures in place within the service to inform their practice. One staff member told us, "I know where all the policies and procedures are kept and I can access them at all times if needed." Another staff member told us they knew about the policies and procedures and where they were kept however could not mention any apart from the grievance policy. There were no systems in place for management to ensure that staff had read and understood the policies and procedures in place.

We looked at a number of policies and procedures in place within the service including safeguarding, dignity, staff induction, infection control, privacy, recruitment, staff supervision and DoLS. We found two of the policies we looked at made reference to Scottish legislation rather than English legislation and some of

these policies did not reflect what the service was doing in practice.

This meant that staff did not have access to up to date information that reflected best practice guidance to support them in their roles. This is a breach of Regulation 17 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at all records relating to accidents and incidents. Registered persons are required to notify the Commission, without delay, of specific incidents which occur within the service. We found the accident records for two people who used the service which we should have been notified of. However, a check of our records showed that no notification had been received from the provider. We discussed this with the manager and provider who were unclear of what accidents/incidents they were required to notify us of.

This was a breach of Regulation 17 (1) and (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service failed to notify us of incidents that should be reported to the Commission.

We asked people if they thought the manager was approachable. Relatives we spoke with told us, "The new manager is very efficient, I can tell her anything," "The manager is very approachable" and "Management are approachable."

Staff we spoke with told us, "The manager is fair and approachable, professional and confidential. I could talk to her about anything and know she would not disclose inappropriately," "Manager and provider are approachable, you can raise anything with them," "I've no concerns, I've worked here a long time and enjoy it." One staff member told us they thought the manager was good and demonstrated good judgement. They also told us, "She is very caring and a bit of a perfectionist. She pushes us hard but in a good way."

We were told by the manager that required staffing levels comprised of two nurses and five carers throughout the day (8am to 9pm) to support the two units. Night cover comprised of one nurse and three care staff. These staffing levels were also confirmed on the minutes of a relatives meeting in July 2015. We were told the manager was available 'on-call' should additional advice and support be necessary. However an examination of the staff roster for the week of the inspection did not reflect these levels were maintained. Records showed that six out of seven days there was four carers and two nurses on duty throughout the day and five out of seven nights there were two carers and one nurse on duty. Following our inspection we received further information of concern around staffing levels which reflected the issues we found during our inspection.

Records did not reflect that sufficient numbers of staff were deployed at all times. This was a breach of regulation 17 (1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two relatives we spoke with during our inspection told us that Ainsworth Nursing Home was in an ideal location for them as they lived locally, this made it easier for them to visit their family member. Ainsworth Nursing Home is the only service located within this area.

We asked relatives if they had ever completed a survey provided by the service. One relative told us they recalled completing a survey in June 2015. Records we saw showed a survey had been undertaken in September 2015, however the results of this had not been collated. This meant the service had not taken steps to assess and implement actions from the results of these.

Staff we spoke with told us they had attended staff meetings in recent times. One staff member told us, "I have attended staff meetings. We discuss issues around staffing, rotas and any other operational problems."

Records we looked at showed that staff meetings had been held for trained nurses and care staff members. We saw that topics discussed included the most recent CQC report, confidentiality, documentation, best interests, cleanliness, team work, environment and activities.

One relative told us they had attended a relative's meeting in November 2015, to discuss the recent CQC report and rating. However they informed us that these meetings do not occur often and they had not seen any notes from the previous meeting. Records we looked at showed that relatives meetings had been held on the 17 and 31 July 2015 following the findings of our last inspection. Topics for discussion included the most recent CQC report, staffing and cleanliness. The manager provided no further evidence that any other meetings had been held.