

Silverdale Care Homes Limited

Ashbourne House 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?

Good



Is the service well-led?

Requires Improvement



Overall summary

This was an unannounced inspection, which took place on the 1 and 2 July 2015.

Ashbourne House Nursing Home is based in Middleton and is registered to provide care and accommodation and nursing care for up to 29 older people. Accommodation is provided on two floors, accessible by a passenger lift. The home is on a main road, close to

public transport and the motorway network. There is a small parking area to the front of the property or on road parking. At the time of the inspection there were 26 people living at the home.

The service is managed on a day to day basis by a support manager and the area manager, who is also the registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

‘registered persons’. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.’

We identified breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

We found relevant checks had been completed prior to new staff commencing their employment, ensuring they were suitable to work with vulnerable people. However opportunities for staff training and development needed improving to ensure staff had the knowledge and skills relevant to their role.

The registered manager acknowledged that CQC had not always been notified of incidents in relation to the well-being of people, particularly the deprivation of liberty safeguards. This information is important and helps us to monitor that appropriate action has been taken to keep people safe.

We saw effective systems to monitor, review and assess the quality of the service were not in place to help ensure people were protected from the risks of unsafe or inappropriate care.

We saw that sufficient numbers of staff were available during the inspection. However clear and accurate records were not maintained to reflect sufficient numbers were available at all times.

We found the system for managing medicines was safe; however the storage of topical creams and information to guide staff on PRN (when required) medication needed improving to ensure that people received their prescribed medicines safely and effectively. **We have made recommendations about improving practice so that people receive all their prescribed medicines safely and effectively.**

We found areas within the home needed improving, particularly in relation to the malodour throughout the main corridor and the reception area. We were told that the provider was in the process of making improvements

and the identified issues would be addressed. **We have made a recommendation about the provider referring to best practice guidance to minimise the risks of cross infection.**

Care files contained sufficient information to guide staff in the delivery of people’s care. Information about people, whilst easily accessible to staff, was not always held securely to ensure confidentiality was maintained.

Opportunities for people to participate in activities in and outside the home were being developed. The provider had recently appointed a new activity worker who was exploring activities based on people’s interests and preferences.

We found the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

Systems were in place for the reporting of and responding to information of concern. People and their visitors were confident they were listened to and that the registered manager would act on their comments or concerns. Visitors said they were kept informed about the well-being of their relative.

People told us they felt safe and received the care they needed. People and their visitors did express some comment about the attitude and care offered, which they felt could be improved. During our inspection we observed staff to be kind and caring towards people and responded to people’s requests.

Staff were able to demonstrate their knowledge and understanding about the safeguarding procedures and what action they would need to take to keep people safe. We were aware of issues which had been reported to the local authority. The registered manager was working in cooperation with the local authority to address any issues.

People were offered ample food and drinks throughout the day ensuring their nutritional needs were met. Where people’s health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed.

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?

The service was not always safe.

Staff rotas did not reflect that consistent levels of staff were provided to meet the individual needs of people.

People were protected against potential risks as safe systems were in place with regards to fire safety. However people's laundry was not safely handled and stored, to help minimise infection hazards and potential risk of harm.

People were supported with the administration of their prescribed medicines. Information to guide staff with 'when required' medicines and the management and storage of topical creams needed improving.

Staff spoken with were aware of what action to take if they witnessed or suspected potential abuse so that people were protected and kept safe. People told us they were safe and received the care they needed. Relevant information and checks were completed when recruiting new staff.

Requires Improvement



Is the service effective?

The service was not always effective.

Further opportunities for staff training and development were needed to ensure staff had the knowledge and skills to carry out their role safely and effectively.

The provider had sought relevant authorisation where people, who lacked the mental capacity to make decisions for themselves, were being deprived of their liberty. This ensures people's rights are protected.

Suitable arrangements were in place to meet people's nutritional needs. Relevant advice and support had been sought where people had been assessed at nutritional risk.

Requires Improvement



Is the service caring?

The service was not always caring.

People and their visitors spoke positively about the care and support offered by staff. Some people did feel however there were areas of improvement in relation to the attitude of staff. Staff were seen to be kind and supportive of people and responded to their needs.

Whilst people's care records were easily accessible to staff they were not always kept secure so that confidentiality was maintained.

Requires Improvement



Is the service responsive?

The service was responsive. Care records contained sufficient information to guide staff on how people wished to be cared for.

Good



Summary of findings

The new activity worker was exploring ideas and opportunities so that more meaningful activities to help promote people's health and mental wellbeing could be provided.

Suitable arrangements were in place for the reporting and responding to any complaints or concerns. People and their visitors were confident any issues brought to the registered manager's attention would be dealt with.

Is the service well-led?

The service was not always well-led. The service had a manager who was registered with the Care Quality Commission (CQC).

The registered manager had not notified the CQC as required by legislation of all events, which occurred at the home with regards to the well-being of people.

Systems were in place to assess and monitor the quality of the service provided but they were not robust enough to identify the issues of concern we found during the inspection.

Requires Improvement



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

This inspection took place on the 1 and 2 July 2015 and was unannounced. The inspection team comprised of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spent time speaking with four people who used the service, four visitors, a nurse, three care staff, the activity worker, the chef, the registered manager and the deputy manager.

We looked at the environment and the standard of accommodation offered to people and during the mealtime period we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at four people's care records, four staff recruitment files and training records as well as information about the management and conduct of the service.

Before the inspection, the provider completed 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 had also received information from the local authority commissioning team and visitors to the home about concerns with people's care and support. We also considered information we held about the service, such as notifications.

Is the service safe?

Our findings

People we spoke with told us that they felt safe living at Ashbourne House. People told us, “I feel safe here because there’s good care. If you are injured you can always call them”, “I feel safe here because I’m left to my own devices but there’s help if I need it, “Everything is safe here for me” and “I’m as safe as I can be here.” People’s visitors also felt their relatives were kept safe. One visitor told us “[relative] is safe here because they have handrails and staff around to help her.” Another commented, “My relative is safe in here. He’s had a couple of falls but they do try to get him to use his frame when walking.”

During the inspection we spent speaking with people, observed and spoke with staff and examined staff rotas to see if sufficient numbers of staff were available to meet people’s needs.

All the people we spoke with felt that staffing levels were not always sufficient to meet their needs. People’s comments included, “I do have to wait for help. Not long but you do have to wait. There’s enough staff work here and they are well trained”, “Sometimes they are short staffed. They do their best. There are a lot of residents for them to care for. They need more staff for the people who need a lot of help. There are a lot of changes in the staff and I don’t like that”, “They have a high turnover of staff”, “It varies how many staff are here. They are very busy at dinner times and bedtimes. They’re also very busy in the mornings. They come quickly when I ask for help. They’ve got other residents to look after so they put me to bed when they can” and “Staff come fairly quickly if I need help.”

People’s visitors were also aware of changes in the staff team. One visitor said, “For the last month staff have been very regular and there have been no changes. They know what to do with my relative.” Whilst another visitor expressed, “They are very understaffed. A lot of the older staff were very good and they’ve now left. The turnover of staff is fairly recent. I don’t think there are enough staff to meet people’s needs because some people are severely disabled. Sometimes I have to wait ten minutes for a member of staff to let me into the building.”

Information received from the provider prior to our inspection showed that over the last 12 months 18 staff had left employment however a further 13 had been employed. We were told by the registered manager, and an

examination of staff rotas confirmed the information, that there was still a shortage of nursing staff to support the service. Agency staff were being used on a regular basis to cover vacancies. The registered manager told us that the same agency nurses were used so that continuity of care could be offered. They also said they were actively trying to recruit more qualified staff.

We discussed the staffing arrangements with the registered manager. We were told that a national dependency tool was used to review staffing levels within the home. The registered manager told us that staffing levels comprised of a qualified nurse throughout the day and night. In addition there were five care staff on the early shift (8 till 2), four on the late shift (2 till 8) and four at night. During the inspection staffing levels reflected what we had been told and this was confirmed by those staff spoken with. Two staff told us, “The staffing levels are fine.”

However an examination of the rotas for the four weeks prior to the inspection, records showed that these levels were not maintained. For example: on three occasion there was no nurse identified for the night shift, four occasions where no day nurse was identified and on 20 occasions there were only three night carers identified. The registered manager advised us following the inspection that night care staff had reduced to three due to the current occupancy levels.

We were told that agency nurses had been used to cover shifts where necessary, however only five agency shifts were recorded on the staff rotas. We also saw that the full names of people were not recorded on the rota’s to clearly show who was covering the shift and there were no hours recorded for the registered manager to show they were in day to day charge of the service. Following the inspection the registered manager advised us that separate rotas were completed for agency staff. These were not provided along with the staff rotas during the inspection.

The provider should ensure that a complete and accurate records is maintained to evidence that sufficient number of staff are available at all times to meet the needs of people safely. This was a breach of Regulation 17(2)(c) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014.

We looked at the systems in place for managing medicines within the home. We saw there was a medication policy and procedure in place. Medicines, including controlled

Is the service safe?

drugs, were stored securely. The medicines in current use were kept in a locked trolley in a locked medicine room. We were told that the medicine keys were always kept with the nurse responsible for the management of medicines. Appropriate arrangements were in place to order new medicines and to safely dispose of medicines that were no longer needed.

People we spoke with were aware they had prescribed medicines and were supported by staff to take them. People told us, "The staff who give me my medicines are very experienced. I know what medicines I have. I have had a doctor's visit. I was given antibiotics by the doctor. They do explain my medicines to me", "I get my medicines in the mornings. I can ask for tablets if I've got pain but I try not to take them if I can manage" and "I'm on some medicines but I don't know off the top of my head what they are. I get my medicines more or less at the same time every day."

We looked at the administration of people's medicines and checked a random sample of medication administration records (MARs). On one person's MAR we identified this person had refused their night time medication on a regular basis. We discussed this with the nurse who said that the person was generally asleep when night time medicines were administered and therefore staff did not want to disturb them. The records did not accurately reflect that the person was asleep at the time of administration and had not refused to take their medicines. We asked if this matter had been discussed with the person's GP so that alternative arrangements could be considered, for example, if medicines could be administered at a different time or if this medicine was still needed by the person. The nurse agreed to follow this up with the person's doctor.

Whilst looking around the home we saw that prescribed creams were kept in people's bedrooms so they were easily accessible to care staff when assisting people during the morning and evenings. In three rooms were found items were unlabelled and did not identify who the item had been prescribed for, one item did not have a lid and had leaked on to the wardrobe shelf and in another we found a topical cream belonging to different person. We found there was no continuity in the way items were stored; some were kept in the en-suite, some on wardrobe shelves or in the bottom of the wardrobes mixed with clothing. Records to show that creams had been applied were completed by care staff, these were stored on the 'nurse's station' and not kept in people's rooms so that charts could be signed at

the time they were applied. People using the service are placed at unnecessary risk of harm when medicines, such as prescribed creams are not stored securely. **We recommend the provider refers to best practice guidance to ensure all medicines are stored securely.**

We saw that protocols in the administration of PRN 'when required' medicines were in place. Whilst information described the medicine and dose, they did not include information about symptoms/triggers to guide staff when such medication maybe required, particularly for those people not able to verbally express their needs and to assist agency staff working at the home. **We recommend the provider refers to best practice guidance and reviews practice to help ensure people get their medicines when they need them. This helps to protect the health and well-being of people.**

The nurse on duty told us that two people received their medicines covertly. This means that medicines are disguised when being administered to people. We saw written agreement on one file to show the person's GP had agreed for this to be given covertly. The registered manager told us that agreement for the administration of covert medicines for the second person had been agreed as part of the deprivation of liberty safeguard in place. Agreement from the person's GP is important because some medicines cannot be given in this way as it may alter the way they work.

Prior to our inspection we had received information of concern about the malodour in the home. We had also been made aware that the local authority health protection agency had completed an infection control monitoring visit in May 2015. The home achieved 79% compliance. Shortfalls were identified in the environment, people's rooms, waste management and laundry facilities.

During our inspection we spent time looking at all areas of the home including communal areas, bedrooms, bathrooms and toilets. It was clearly apparent that there was a malodour, particularly along the main corridor and the reception area outside of the laundry, where a number of people sat relaxing. The registered manager told us they were aware of the issue due to the flooring. They told us quotes had been sought for new flooring to be fitted along the corridor and reception area.

We looked at the laundry facilities provided at the service. Whilst the laundry worker told us there was a designated

Is the service safe?

'clean' and 'dirty' area we found soiled and clean items were not clearly segregated. Infection can be transferred between contaminated and uncontaminated items of laundry. Incorrect handling and storage of laundry can pose an infection hazard. **We recommend the provider refers to best practice guidance and reviews practice to help ensure the risk of cross infection is minimised.**

We spoke with the domestic worker on duty. They told us that over the last 18 months systems had improved within the home and they had received training relevant to their role. An examination of training records confirmed what we had been told. They said following discussion with the registered manager, cleaning records had been amended to include all relevant information. People's visitors told us, "The cleaners are very good but the home could do with updating" and "It's clean in here."

We looked at the system in place to safeguard adults from abuse. We were made aware by the local authority that several issues had yet to be resolved following previous concerns raised with them. A further four alerts had been raised between March 2015 and June 2015. These were currently subject to investigation and the registered manager was cooperating with the local authority. The registered manager showed us a monthly audit sheet detailing any allegations made, the name of the person involved and the outcome. We were told that following a recent incident, disciplinary action had been taken with the staff member involved.

We looked at staff training records. These showed that safeguarding training was provided on an annual basis. However the dates recorded showed that the majority of staff needed fresher training. We spoke with three staff who said they had completed safeguarding training. We asked them to tell us what they would do if an allegation of abuse was made to them or if they suspected that abuse had occurred. All three staff said they would report any concerns to the nurse or manager on duty. We saw that a policy and procedure to guide staff was available, however 10 pages of the 22 page document were missing.

Risks of system and equipment failure had been minimised by a programme of servicing and maintenance of

equipment. For example, we saw up to date servicing certificates were in place for the fire alarm and extinguishers, hoisting equipment and call bells. We noted that the five year check to the mains electric circuits was out of date. This was due for renewal in April 2015. The registered manager told us that a further service had been arranged for the 8 July 2015. This meant the safety certificate had expired some three months ago. To ensure the safety of everybody with the home it is essential that the servicing of facilities such as the electricity installation are undertaken in accordance with the time frames laid down by legislation.

The service had a fire risk assessment and a business continuity plan for responding to emergencies or untoward events, such as outbreaks of infection, fire and the failure of equipment used in the home. Both documents were in need of review to check that information was accurate and up to date.

On examination of three care files we found that general risk assessments were completed in areas such as nutrition, risk of falls or pressure care prevention. Assessments were reviewed and evaluated on a monthly basis. Additional monitoring, such as food and fluid charts, falls or pressure relief were completed. This should ensure that any changes in needs are addressed promptly so people's health and well-being is maintained.

We looked at the recruitment process followed by the registered manager when recruiting new staff. There was a policy and procedure to guide them on the relevant information and checks to be completed, ensuring the suitability of applicants to work with vulnerable people. We examined the files for four staff. Records included an application form that included an employment history, written references, copies of identification and a disclosure and barring check (DBS). We saw records to show checks were also completed on nursing staff with regards to their registration with the Nursing and Midwifery Council (NMC).

The registered manager told us that relevant information was also gathered in relation to agency staff who worked at the home to ensure their suitability. An examination of records confirmed what we had been told.

Is the service effective?

Our findings

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Ashbourne House. We spoke with the registered manager, a nurse, care staff and examined training records. We also asked people their views. One person told us, "I think the staff are well trained. They know what to do."

Staff spoken with told us they completed an induction on commencement of their employment and received periodic supervisions to discuss their work. Regular team meeting were held so that information and ideas could be shared. Records examined confirmed what we had been told. We asked the registered manager about the arrangements for clinical supervision of the nursing staff, as the registered manager is not clinically trained. We were told that one of the nurses took responsibility for this and that additional support was provided from nursing staff across the other services owned by the provider. We did not ask to see evidence of clinical supervisions during this inspection.

Information provided prior to the inspection showed that improvements in training and development had been identified. This included plans to enrol staff in vocational courses in health and social care as well as other areas such as, learning disabilities and End of Life care. In house training is to be facilitated by the registered manager along with the implementation of e-learning. Staff will also be identified as 'leads' in specific areas such as safeguarding or end of life, so they can improve on their knowledge

Staff spoken with confirmed they had completed in house training, which involved watching videos and completing workbooks. However an examination of training records we found some staff had yet to complete some areas of training, such as moving and handling, health and safety, infection control, MCA and DoLS, safeguarding adults, whilst others required updates in training. We did not see any recent evidence of nursing staff having completed clinical updates in areas such as catheter care or pressure care prevention. We were told and saw evidence to show that competency assessments had been completed on nursing staff in relation to the safe management and administration of medication.

This meant there was a breach in Regulation 18 (2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary training to carry out their role.

The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We spoke with the registered manager and deputy manager. They were aware of their responsibilities in making application to the supervisory body (local authority) where people assessed as lacking the mental capacity were potentially being deprived of their liberty. We were told there were 11 people who were currently subject to a DoLS authorisation. The registered manager had developed a matrix so that the authorisation and renewal of DoLS could be monitored.

We were told by the registered manager that a person recently admitted to the home was being supported on a 1-2-1 basis due to the level of support they needed. The registered manager had contacted the funding authority to discuss this due to the level of concern. We discussed with the registered manager the need for a DoLS for this person due to the level of support being provided. On the 2nd day of our inspection the registered manager confirmed that an urgent authorisation had been submitted to the supervisory body. This helps to ensure that people are not unlawfully being deprived of their liberty and any decisions are made in the persons best interests.

We saw policies and procedures were available to guide staff in areas of protection, including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). An examination of training records showed that 13 staff had completed the annual training provided, however this needed renewing. The remaining 16 care staff had yet to complete the course. We spoke with three care staff. They were not aware of the MCA and DoLS procedures. This training should help staff understand that assessments should be undertaken, where necessary, to determine if people have capacity to make informed decisions about their care and support. It should also help staff understand that if a person is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe.

Is the service effective?

We looked at how people were supported in meeting their nutritional needs. We asked people for their views about the food served at the home. People told us, “The food is very good I like most of the food”, “Staff are very careful to give me the food I like”, “The food is alright. I like the fish and chips on Friday evenings. I'm weighed regularly” and “The food is pretty fair. I get enough to eat and drink and they weigh me regularly.” One person's visitor told us, “[relative] has gained weight and staff tell me she's a good eater.”

We looked at the kitchen and food storage area and spoke with the chef about the arrangements for ordering of food. We were told regular deliveries of fresh, frozen, tinned and dry goods were made. The chef had a good understanding of the nutritional needs of people and was fully aware of guidance provided from dieticians or speech and language therapist about people's specific dietary needs. Suitable arrangements were made for those people who required a special diet such as pureed food or where ‘thickeners’ needed adding to their food due to swallowing difficulties. One person had a halal diet. The chef was able to show us what meal provisions were available to meet their cultural needs. This meant the individual dietary needs of people were considered and planned for.

We saw that a four weekly menu was in place and a picture board was displayed in the reception area showing the menu for the day. We found this did not clearly show what options were available for each meal. We raised this with the registered manager who said this would be looked at. We saw the main meal was served in the evening with a lighter meal at lunchtime. We were told if someone requested an alternative, then this would be provided.

We observed people during the lunchtime period in both of the dining rooms. We saw there were a number of people who needed encouragement and support from staff to eat their meal. We found the mealtime was disorganised and

did not provide a relaxed environment for people to enjoy their meal. We discussed our findings with the registered manager and deputy manager who said they would explore ways of improving this.

Records examined showed nutritional risk assessments were completed. Where concerns had been identified increased monitoring was in place. Where it had been identified that people's needs had changed, additional support and advice was sought from the dietician or speech and language therapists.

Prior to our inspection we had been advised by the provider that a system to promote good hydration had been introduced. Water and juice was provided throughout the day, jug lids were colour coded to indicate when they had been provided and were in need of refreshing. We saw this system was in place during the inspection. However we found good practice was not being followed as we saw a care worker making changes to the lids but did not provide fresh water or juice. This was raised with the registered manager and deputy manager.

People also had access to other healthcare support from their GP, a chiropodist, community nursing team and the interventions team who support people living with dementia. People told us, “I've seen a doctor for my chest and he's given me some pills” and “I have trouble with my feet. The nurse bandages them when necessary because they get swollen.” People's visitors told us they were kept informed of any changes in their relative's health.

Ashbourne House comprises of 29 en-suite bedrooms on two floors. On the ground floor people had access to a large lounge, conservatory and two separate dining rooms. Some bedrooms had been personalised, whilst others were bare. Some of the furniture and soft furnishings were showing signs of wear. We discussed this with the registered manager who told us and provided information to show us that a programme of refurbishment was taking place.

Is the service caring?

Our findings

We asked people about the staff and whether they were spoken to politely and appropriately. One person said, “The staff are very kind. They treat me with respect. Staff do listen to me and change what I don't like.” Another person added, “The staff are as kind as can be expected. No staff are deliberately unkind. They've never upset me.”

Two people however expressed concerns about the support offered particularly by some younger, more inexperienced members of the team. One person said, “I wish they had older staff here. I don't like being ordered about by people old enough to be my granddaughter. They haven't much experience.” Another person commented; “The older staff treat me with respect. There's a lot of tomfoolery among the younger staff. Some of the younger staff let off steam too much. If there's a ball game going on they throw the ball at each other. They can be overfamiliar with each other.”

On the first day of our inspection the weather was extremely hot. Suitable arrangements had been made to ensure people were hydrated. We saw people were offered regular drinks and ice cream. People were seen spending time in the enclosed garden; a gazebo had been erected and sun cream was offered to protect people.

We spent some time observing how staff interacted with people. Staff were seen to be patient and kind and maintained eye contact with people when speaking with them. One staff member we observed and spoke with was able to give good examples on how to protect people's privacy and dignity. They were enthusiastic about their work and clearly understood their role and responsibilities.

During the lunchtime period we heard and observed one member staff say to the person they were supporting, “finish this, then we'll take you for a wee and a lie down”. Then from behind they removed the apron the person was wearing and used it to wipe their face. This interaction was not dignified. We shared our findings with the registered manager and deputy manager. The registered manager advised us that following meal times, people were assisted to the bathrooms to wash their hands and face, if necessary.

We asked people and their visitors to tell us about their experiences and the views on the quality of care and support provided by staff. People told us that staff helped

them in meeting their personal care needs, so they were kept clean and maintained their appearance. People told us, “We have a hairdresser every week and the staff wash my hair for me”, “I have a bath about once a week but I have a wash down every day”, “I like a shower. I have one every other day. When I'm having a shower staff help me. I tell the staff what I want to wear” and “I have a shower two or three times a week with help from staff.” However one person said, “I have a shower twice a week but I have to insist on this.”

One person told us their daily routine was relaxed, adding, “I like to get up about half past eight and have my breakfast. Normally I can get myself dressed. They (staff) would help me but there's usually no need.” Another person said, “They respect my privacy when getting dressed and undressed and keep my door closed. They let me be as independent as possible. I do tell staff what I like and don't like.”

People's visitors told us they were made welcome when they visited the home. One person said, “Staff do talk to residents They don't ignore them. They welcome me and ask me do I want a drink or a biscuit”, “I'm made welcome when I come” and “A lot of staff are new and I don't know many of them.” However we were also told that on one occasion they had found people “sat in a pool of urine” and had to inform staff so that assistance could be offered. Another visitor told us, “Most of the time my relative is kept clean but occasionally I've found him wet.” A third person added, “The care is “OK”. Staff are friendly and genuine but there are “silly little lapses.”

We spoke with the registered manager and deputy manager about people's care. We were told that a toileting programme was in place for people at set times, 11.30am and 3.30pm and that where there was a change in people's needs they would be referred to the continence advisor. The registered manager told us that people are assisted according to their needs and this would be reflected in their care plan.

Whilst looking around the home we saw that people's wardrobes were untidy with unfolded clothes left on shelves or the on the floor of their wardrobes. We also found in one room wet clothing had been left on the en-suite floor and in a second room an open bag containing a soiled continence pad had been left. The registered manager advised us that staff had been

Is the service caring?

supporting people with personal care. Items should be removed without delay to ensure good infection control practices are followed as well as protecting people's dignity.

We were told and saw people's records were stored securely in a lockable cupboard. However additional records, such as daily records completed by care staff were kept on the desk near to the main lounge, which was also accessible to people and their visitors. Whilst information needs to be easily accessible to staff, records should be

stored properly. We discussed records being stored in the desk when not being used by staff so that information about people is kept confidential. We were told this would be addressed.

Suitable arrangements were in place when people needed support to attend appointments or in the event of an emergency. We were told staff would provide an escort unless the person was to be supported by a family member. One person's visitor told us they had been contacted following an incident involving their relative and met the ambulance at the hospital. They said that if they were not able to attend staff would have escorted their relative to hospital.

Is the service responsive?

Our findings

We looked at what opportunities were made available to people offering variety to their day. We spent time speaking with and observing people and spoke with the activity worker about their role.

Some people, due to their physical and health care needs were not able to take part in some of the group activities. Some of the people we spoke with told us they were not interested or did not like the activities provided. People said; “We don't have any trips or outings, I wouldn't go on them. I'm quite happy as I am. I prefer to watch people. I don't like taking part in activities. I like lazy, lazy days!”, “I don't take part in activities but I have played dominoes on occasions. I don't want to take part in ‘childlike’ activities but if they have dementia I suppose that's what they like”, “I like reading biographies. My bedroom is a bit too small to watch TV comfortably and I don't listen to the radio” and “I watch TV every day. I have one in my room. I sit and chat with staff. I'm quite content as I am.” One person's visitor also commented, “I've not seen my relative doing any activities. There were interactive music activities a while ago but I've not seen anything recently.”

The activity worker had only been in post three weeks. They told us they were exploring people's likes and dislikes from their care plans and life story books. They had also spent time speaking with people about their preferences and were arranging resident and relative meetings to explore ideas. The activity worker had enrolled on a national vocational course relevant to their role and had been supported in developing a plan of activities for people. The activity worker said that whilst they had some care experience they felt they would benefit from some further training in communication, particularly with people living with dementia. It was anticipated this would be addressed within the planned training.

We looked how people and their relatives, if relevant, were involved in decisions about moving into the home and in the development of people's care and support plans. We were told that one person who had recently moved into the home was not local to the area. We spoke with the deputy manager and reviewed the person's records to see what assessments were completed prior to agreeing their placement. We saw comprehensive assessments had been

provided from health care professionals and the previous care provider. The deputy manager said they had also spoken at length with people including the person's family so that all relevant information was gathered.

We looked at this person's care records. Records examined for three other people were found to contain sufficient information about people's support needs and areas of identified risk. Care plans and assessment were kept under review to ensure information was accurate and up to date. However care plans focused on “problem or need” rather than what the person was able to do for themselves. We saw that ‘life story books’ were available for each person living at the home. Where possible people's relatives had been asked to complete them, providing personal information about their relative, their life, hobbies and interests. We saw one book which was very detailed and provided excellent information about the person. Other copies were less detailed. We were told that these would be updated by the activity worker.

We saw that nursing staff held regular reviews with people and their relatives. A brief was completed confirming if people were happy with the care and support being provided. When asked, two of the three visitors we spoke with told us they were consulted with about their relative and kept informed of any changes. One person said they had not seen their relative's plan or been asked their opinion on their relative's care.

We asked people if they knew what to do and who to speak with if they had any issues or concerns. People told us, “I'd insist on seeing the top man or woman if I had a problem I needed putting right”, “I'd complain to the person in charge if I had to” and “If anything bothered me I'd take it up with the boss. It's a woman but I don't know her name.” We saw that information about how to make a complaint was displayed in the reception area and accessible to both people and their visitors. Information guided people about the process and who they could contact both within the home and outside agencies, such as the local authority adult care team, if they needed to raise a concern.

We spoke with the registered manager and looked at the complaints log. Records showed that no recent complaints had been raised directly with the service. However we had been contacted prior to our inspection by people raising concerns. One visitor told us, “If I had any issues I would

Is the service responsive?

have confidence in the manager and feel she would deal with issues straight away.” A number of compliment cards had also been received and were displayed in the reception area.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. We were told their role had changed with additional responsibilities as an area manager supporting the three services owned by the provider. This meant they were not at the home on a full time basis. A full time deputy manager had recently been appointed. It was anticipated they would take on the responsibility of the day to day management of the service and register with the CQC as the registered manager.

We were told the registered manager was currently working towards a QCF (NVQ) level 5 in leadership for health and social care.

We asked people for their views about the management and conduct of the service. One person told us; “The manager isn't here all of the time but when she does come, she sorts the staff out. I think the manager's leadership skills are good. She tells them direct. I do think staff need this because they wouldn't change if she wasn't dominant. She needs to be firm in order to get staff to do what she needs.” Other comments received included; “I would like to know who the manager is. I'd like to thank them for the good staff attitude and good accommodation”, “I do feel I can talk to the manager. She's very approachable” and “I know who the manager is. If I ask her for something she will go out of her way to get it. She keeps staff in order.” One person said they were not aware of who the manager was.

People's visitors knew the home manager. They told us; “I can talk to the manager. She listens and would act if I wanted something for my relative” and “The manager isn't here as often as she used to be. I think she's been promoted to area manager.”

Staff spoken with told us there had been lots of improvements over the last two years. They felt morale was improving now the team was more settled and said they felt confident in raising issues with the registered manager. Staff also commented, “We work as a team”, “It's a really good home and ran very well” and “There's good communication between us all.”

Prior to our inspection we reviewed our records to check events such as accidents or incidents, which CQC should be

made aware of, had been notified to us. Whilst some information had been received up to April 2015 we identified during the inspection that notifications advising us of people being deprived of their liberty had not been reported to CQC. **This meant we were not aware if appropriate action had been taken by management to ensure people were kept safe. This meant there was a breach of Regulation 18 CQC (Registration) Regulations 2009.**

We looked at how the managers were monitoring the quality of the service. The registered manager showed us an internal audit matrix which identified what areas were monitored and the frequency of the audits. We saw some information to show that checks had been completed in areas such as care reviews, risk management report in relation to the environment, mattress checks and medication. We did not see any audits in other areas such as care records, staff training and development or infection control. We also found that policies and procedures, a business plan, fire risk assessment and the contingency plan had not been reviewed and updated to ensure accurate and update information was provided. **Without effective monitoring of the service, shortfalls found during our inspection had not been identified by the provider. This meant there was a breach of Regulation 17(2)(a) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014.**

We saw that opportunities were made available for people and their visitors to comment on the service or share ideas and information. People told us they were aware resident/relatives meetings were held. One person told us; “I went to a resident's meeting last month. I found it worthwhile. The management did listen and act on what was said. I think these meetings are worthwhile. One person's visitor added; “The home has a yearly report and they had a relative's meeting last month. It was advertised on the notice board in the hall but I forgot to come.”

We also saw a small number of feedback surveys which had been returned. It was recognised that improvements could be made in relation to the activities offered. This had been addressed with the appointment of an activity worker.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems to monitor, review and improve the service provided were not sufficiently robust ensuring people were protected against the risks of unsafe or inappropriate care and support.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider should ensure that a complete and accurate records is maintained to evidence that sufficient number of staff are available at all times to meet the needs of people safely.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary training to carry out their role.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The provider had failed to inform CQC of events that involved the well-being of people. This meant we were not able to see if appropriate action had been taken to ensure people were kept safe.