HC-One Limited

Ash Grange Nursing Home

Inspection report

80 Valley Road
Bloxwich
Walsall
West Midlands
WS3 3ER

Tel: 01922408484
Website: www.hc-one.co.uk/homes/ash-grange

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 16 and 19 August 2017. The inspection was prompted in part by a notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of people's care needs. This inspection examined those risks.

Ash Grange Nursing Home is registered to provide accommodation for 42 older people some of whom are living with dementia. On the days of the inspection there were 39 people living at the home.

There was a registered manager in post. 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.

People were not safe. There were insufficient levels of staffing to meet people's health and care needs. Risks were not consistently identified, assessed or managed which meant some people were at risk from avoidable harm. People were not always protected from the risk of abuse because incidents were not always reported to the local safeguarding authority. People did not always receive their medicines as prescribed.

People received support from staff that did not always understand how to meet some people's care needs. Staff did not always seek people's consent before providing care. Principles of the Mental Capacity Act 2005 had not been followed when people lacked the capacity to make specific decisions. People did not always have their food and drink managed safely. Staff did not always follow the guidance provided by healthcare professionals when supporting people.

People were not supported in a caring manner. Staff did not always support people in a dignified way and people's rights to privacy were not always respected by the staff. Staff did not have time to build meaningful relationships with people. Some language used by staff to describe people and their care needs was not dignified. People were not involved in making choices about how they wished their care and support to be delivered.

People did not always receive care that was responsive to their individual needs. People sat for long periods of time without any stimulation. There were minimal activities available to people; staff were rushed, task focused and missed opportunities for interaction with people. People and their relatives knew who to contact should they wish to raise any complaint or concern. However the provider had failed to investigate complaints or respond appropriately to people's concerns.

Systems used to monitor the quality of the home were not effective at identifying concerns and protecting people from risks to their health, safety and well-being. The provider had failed to notify us of events as

required by law. Communication systems used within the home were not effective in managing risks to people.

During this inspection we identified 8 breaches of the Health and Social Care Act 2008 and one breach of the Care Quality Commission (Registration) 2009. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs safely. People were not always receiving the care and support they needed. Risks had not been assessed and managed to reduce the risk of avoidable harm. People were not always protected from harm. People did not always receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive support from staff with the skills and knowledge required to meet their health and support needs. People did not always have their rights upheld in line with the Mental Capacity Act. We could not be assured people were getting sufficient food and fluids to maintain their health. People's health was not always monitored effectively.

Is the service caring?

Inadequate

The service was not caring.

People did not always receive their support in a caring way. People did not have their privacy and dignity respected. People did not always get a choice of how their care was delivered.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was responsive to their individual needs. People were not supported to take part in activities relevant to their individual needs and interests. People and their relatives knew how to raise complaints however effective systems were not in place to investigate concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor the quality of care people received were not effective in identifying issues highlighted during the inspection. Although the provider had sought feedback from people and their relatives there was little evidence this had been used to drive forward improvements. The provider failed to notify us of incidents as required by the law. People did not always feel the service was well-led.

Ash Grange 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.

The inspection took place on 16 and 19 August 2017 and was unannounced. The inspection was prompted in part by a notification of an incident following which a person using the service sustained a serious injury. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However we did consider the potential concerns raised about the management of risk of supporting people with their care needs. We also responded in part due to notification of concerns raised by the local authority.

On the first day of the inspection the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the team consisted of two inspectors and a specialist advisor. The specialist advisor was a qualified nurse.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We also asked for feedback from the commissioners of people's care and the local NHS clinical commissioning group to find out their views about the quality of the service. We also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with 13 people who lived at the home and 10 family members or visitors. We spoke with the registered manager and eight members of staff. This included nursing staff, nursing assistants, care staff and the cook. We also spoke with one visiting professional.

We carried out observations throughout the home to help us better understand the experiences of people living at the home to review the quality of care people received. 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 looked at the care records for 11 people. We also looked at other records relating to the management of the service including staff files, complaints logs, accident reports, audit records and medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2016 we rated the provider as 'requires improvement' under the key question 'Is the service safe?". This was because there was not always enough staff to meet people's needs in a timely manner. At this inspection we found the required improvements had not been made and the care people received had deteriorated due to lack of staff. The provider was now not meeting the requirements of the law.

During the inspection people and their families raised concerns about the standard of care due to there not being enough members of staff available to meet their health and care needs. One person told us, "The poor staff don't know whether they are coming or going." And, "There is not enough staff. We had a spell when the buzzers weren't being answered. I know staff can only do one thing at a time but it was unacceptable." Another person said, "Sometimes you have to wait up to half an hour to an hour if [staff] are busy." A relative said, "There are not enough staff. Sometimes there are no carers or nurses on the floor and I and another family member have to help people. If they are short staffed it affects the toileting." Another relative commented, "Staffing levels are poor you can never find anyone. You can sit in [person] room and pull the buzzer for the toilet and wait over 20 minutes for someone to answer." People told us this had often resulted in people having to sit in wet or soiled pads for considerable time.

Staff told us they did not feel there were adequate numbers of staff to support people which meant sometimes people's health and care needs were not met. One member of staff told us, "I don't have time to do everything that I need to do in a day to meet people's needs." Another member of staff said, "Sometimes you are really rushed it is so busy you can't get to people as quickly as you would like." A third member of staff said, "We do need extra staff so we can respond to people's needs. Sometimes the buzzers are going all the time and staff are rushed. People do have to wait." Staff told us the times we observed people having to wait for their care needs to be met was typical for the home.

Our observations confirmed what we had been told. We saw there were not enough staff to give people the care they required or to respond to emergency situations or incidents. For example, a member of the inspection team saw a person was unresponsive in a communal area of the home. Staff had failed to recognise this until we intervened. After which staff alerted the nurse and contacted the emergency services. We saw numerous occasions where staff were not available in communal areas of the home to respond to people's requests for help. For example, one person who required assistance when mobilising in order to prevent them from falling stood up and walked unaided because there were no staff available in the communal area for a period exceeding 20 minutes to support them. This meant they were at an increased risk of falling and sustaining an injury. We saw numerous occasions where people called for support but staff were not available to assist. For example, one person called out to a member of the inspection team, "Can you help me. I am wet through and in pain. Please help me." We spoke with a member of staff who said they would attend to the person's needs straight away. A further person was calling from their bedroom for staff to assist them with getting up and for their personal care needs to be met. A member of the inspection team found a member of staff to help them. However it took a further one hour and 20 minutes for this person's personal care needs to be met. This meant the person became increasingly anxious and distressed.

We discussed with the registered manager how they determined there were adequate numbers of staff to meet people's needs. We were told that although staffing levels were based on people's individual dependency needs they felt additional care staff were required. They told us they had requested an increase in care staff hours from the provider and an additional six hours had been agreed. Although an additional member of care staff was working on the second day of our inspection, we found people's needs were still not adequately met and staffing levels remained inadequate. We again requested the provider immediately ensured sufficient staff resources were available to meet people's needs. The provider said they would increase care staff hours within the home to ensure they met people's needs.

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

Prior to the inspection we received information about a number of serious incidents which had occurred at the service. Based on this information we looked at how people's risks were managed in order to protect people from avoidable harm. We found people were placed at risk of harm as staff did not understand people's risks and how to manage them. Staff did not take reasonable action to protect people from avoidable harm or the risks associated with their specific conditions.

We were notified prior to the inspection by the provider that one person sustained a serious injury while they were receiving care. We requested further information about how the incident occurred. During the inspection we reviewed this person's care records and details of events leading up to the person sustaining a serious injury. Evidence gathered identified the person was harmed through lack of appropriate care. This incident was currently being investigated by other agencies who will share the outcome of their investigations with us. We will use this information to identify if we need to take any further action.

We identified further examples where people had been placed at risk of harm. Some people required food and medicines to be administered directly into their stomach through a tube. We noted one person's nutrition and fluid intake instructions from dieticians said they required 1797mls daily in order to meet their needs. However, instructions for staff in the person's care plan meant the person received about 200mls in excess of what was recommended. We spoke with the nurse on duty who had noted the instructions were incorrect. We looked at this person's daily intake charts and found the amount of nutrition and fluid the person received did not correspond to either of the amounts advised. We also saw the person was receiving food through their stomach while they were lying almost flat. This was contrary to instructions in the person's care plan which stated, 'Aspiration risk; sit upright whilst peg feed in progress'. This meant the person was at an increased risk of the feed going into their lungs resulting in serious harm.

People's risks around hydration and nutrition were not being assessed or managed appropriately to ensure their safety. For example, one person who required support to receive adequate nutrition only received limited fluids throughout the second day of our inspection. We saw this person did not have any support to have sufficient fluid for over six hours. Staff had not responded appropriately to the person's poor fluid intake during the day which placed them at increased risk of dehydration.

We saw a relative adding thickener to a family member's drink in a beaker. We looked at the person's care records and saw they were at high risk of choking and required fluids to be thickened to a specific consistency so it could be taken with a spoon to reduce the risk of choking. We spoke with a member of staff who observed the relative preparing their family members drink. The member of staff confirmed they knew the fluids were not prepared correctly and told us, "[Relative] always feeds [person] and gives them a drink. [Relative] told me they know what to do." We explained to the member of staff the drink was not at a safe consistency putting the person at risk of choking. We asked the member of staff to speak with the relative

and prepare the fluids to the right thickness. The person's risk of choking was not being managed effectively which meant they were at risk of immediate harm.

We found during the inspection the provider had not ensured appropriate levels of clinical staff were available to meet people's health needs. Ash Grange was staffed by one registered nurse who was unable to meet people's health needs in a timely manner. For example, a number of people had sore skin and lesions which required regular dressing by the registered nurse. We found the registered nurse did not have opportunity to meet these people's care needs in a timely manner because they were busy meeting the nursing needs of other people. This demonstrated people were at risk of harm through lack of timely care.

Risks to people's health and wellbeing were not managed in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they got their medicines when they needed them. One person said, "I go looking for them if they are late [with medicine]. I have to remind them I need my [medicine]." A relative said, "Some tablets [person] has three or four times a-day. They usually have them within half an hour of the time they are due." We looked at six Medicine Administration Records (MAR) and spoke to a member of staff about one person's medicines. They said, "[Person] not yet had medication I will give it when [person] is ready." We looked at their MAR and saw staff had signed the MARS in advance before the person had received their medicine. The person had also refused their epilepsy medicine on eight occasions. However we saw no evidence the person's doctor had been contacted by staff for advice or followed instructions that the person's medicines could be given covertly when required. The person had not received their prescribed medicines consistently which could have a detrimental impact on their health and wellbeing. Other people's MAR we looked at included people who had medicines 'when required'. MARs were completed accurately and we found medicine stock levels tallied with what was recorded on the people's MAR. We saw guidance was available for staff to ensure people received their 'when required' medicines consistently. We observed a member of staff supporting people to take their prescribed medicines. We saw they approached people by name offering their medicine from a pot and assisting people to take their medicines with a drink. Medicines were stored appropriately to keep them safe and maintain their effectiveness. Staff told us they had received training and had their competency to administer medicines checked by nursing staff.

People told us they felt safe at Ash Grange. One person said, "I feel safe. All the doors are locked at night. They don't open the door until they look at [CCTV] and they've seen the people. We got buzzers." Another person said, "Everything makes you feel safe. All of it. [Staff] will do anything for you." We saw people were relaxed with staff and were happy to approach them. Staff we spoke with understood their responsibilities in recognising and reporting abuse. One member of staff said, "I would make sure persons are safe and report my concern to the manager." However, we found people were not always safe and protected from harm. Even though staff were aware of how to raise safeguarding concerns, we were not confident that incidents of harm had been reported appropriately to other agencies. We found two incidents when people were at risk of, or had experienced harm which had not been reported to the local safeguarding authority. This meant we could not be sure that all safeguarding issues were responded to correctly by staff and people would be protected from harm.

The regulations state people must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. We found one person was subject to restrictions of their liberty without the legal safeguards in place. Staff followed the wishes of a person's relative and did not give a person their prescribed medicine. Records showed the person did not receive their medicines when required. Staff did not respect people's right to fair and just treatment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems the provider had in place to ensure staff were recruited safely. We saw pre-employment checks were completed including identification checks, references and Disclosure and Barring Service (DBS) checks. The DBS helps providers reduce the risk of employing unsuitable staff from working with people who use care services. This meant people were supported by staff that had been recruited safely.

Inadequate

Is the service effective?

Our findings

People had mixed views whether staff had the skills and knowledge required to meet their needs. One person said, "Staff seem to know what they are doing." While another person told us, "I had to train them on how to put my sling on. I had to show them because they did not know." Staff we spoke with told us they received training relevant to their role. However, some staff told us they thought it wasn't sufficient to enable them to meet all people's needs. One member of staff said, "Lots of staff here just don't understand dementia." We found examples of where staff did not have the necessary skills or expertise to effectively communicate with some people to understand their need. We saw one person who was distressed. We saw several staff attempt to support the person. Although the person's care records stated they could not communicate their needs in English and required different methods of communication, we did not see staff communicate in accordance with the person's stated communication styles. This resulted in the person becoming more anxious which had a negative effect on their well-being.

People living at the service required support with various conditions such as dementia and complex risks associated with their nutritional needs. We found the provider had not made sure staff had the correct skills and knowledge to ensure people received safe care when supporting them with their care needs. We looked at how four people whose care records identified as needing pressure relieving mattresses were supported. Pressure relieving mattresses are designed to relieve pressure points on people's skin. We found that staff had not set three peoples' mattresses correctly. This put people at increased risk of developing further sore skin and would be uncomfortable in bed. We looked at the daily notes of one person who required regular repositioning in bed. We saw from these records that one occasion they were not repositioned for a period of 11 hours. The person's' care record contained no information for staff about when the person would require repositioning or their correct pressure relieving mattress setting. Without the correct written guidance available people were put at risk of inadequate care because staff did not have sufficient knowledge to support them appropriately.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about the support they received in their roles. One member of staff said, "I do feel supported and we do have supervisions and staff meetings." Staff told us the management team were approachable and they could speak with them if they had any concerns about their role or the people they were caring for. Staff said they completed an induction when they started in their role which included the opportunity to shadow more experienced members of staff and get to know the people living at the home. We saw staff that were new to care were required to undertake a nationally recognised induction programme called the 'Care Certificate'. This is a set of standards that staff should cover as part of their induction training to equip them with the basic skills and knowledge to care for people safely. Staff told us on occasion's the provider used agency staff. They said they did not always feel they had the required knowledge to support people safely. On the days of our inspection agency staff were not being used. However, we found the care records and daily handover were not sufficient to ensure they would have enough information available to meet people's needs.

People told us staff sought their consent before providing care. One person said, "Staff will ask me before they do something." We found staff did not always understand how they gained consent from people. For example, we saw staff moving people on six occasions to other areas of the home without talking or gaining their consent. We saw on several occasions that people were taken by staff to attend to their personal needs without the person's consent being sought.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's rights were not always upheld and staff were not working in line with the MCA. Where people lacked capacity to make specific decisions about their care, principles of the MCA had not been followed. We spoke to staff about the MCA and found they did not understand the principles of the Act. For example, staff were asked about people's capacity to understand and make decisions and they gave mixed responses. One member of staff said, "Some people living here cannot make decisions for themselves and we have to do it for them." We asked staff about the principles of the act and how it affected how they delivered care to people. A member of staff said, "Don't know what this means for people." This showed the provider did not ensure staff worked within the principles of the MCA or had made sure staff had sufficient knowledge to ensure people received their care in accordance with the MCA.

We found where decisions had been taken for people, staff had not always completed assessments to identify if people had the mental capacity to make these decisions for themselves. For example, we found one person had bed rails in place but an assessment of the person's capacity to consent to the use of bedrails had not been carried out. These bedrails prevented the person from leaving their bed unassisted.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA and whether there were any conditions on authorisations to deprive a person of their liberty were being met. We saw 23 applications had been made to the supervisory body for a deprivation of liberty. The applications had not been considered and approved by the supervisory body at the time of the inspection.

Most people said they enjoyed the food. One person said, "Meals are good I like the food." Another person told us, "You can pick what you want. You can have a piece of cake. Horlicks at night with a biscuit." A third person commented, "The food is alright. Teatime is always sandwiches. There is not always an alternative." We observed mealtimes and saw people were offered different choices of meals.

Some people living at the home had their food and fluid intake monitored and recorded. This was to ensure those people who were at risk of dehydration or malnutrition received enough to eat and drink. We saw staff recorded people's daily amounts. We found risks in relation to people's nutrition and hydration were not being properly assessed or managed to ensure their safety. We found people were put at risk because staff had not followed treatment and care plans in relation to nutritional needs.

People and their relatives told us people received support from healthcare professionals when required. One person told us, "I have seen all the specialists. I have seen a dentist and a doctor." Another person said,

"The doctor came in yesterday and has put me on antibiotics." We saw from care records healthcare professionals were contacted by the staff. We saw intervention from doctors, nurses and SALT. Staff told us people had access to healthcare professionals. However we found for some people where health advice was given, this was not always followed. We found staff had not followed instructions given by healthcare professionals such as from the Speech and Language Therapy (SALT) and as a result people were at risk of harm. For example, one person's SALT assessment stated that a person required thickened fluids. However, their care records stated 'normal fluids'. We found this affected the quality and safety of care people received and put people at risk of harm.

Inadequate

Is the service caring?

Our findings

Staff did not maintain people's dignity and privacy. People told us and we saw they had to wait long periods of time for staff to meet their care needs which meant people were often left in an undignified state. One relative told us their family member's personal care needs had not been met for a period in excess of five hours and they had soiled themselves. The person's care records we looked at confirmed this. Staff did not pay sufficient regard or priority to maintaining people's dignity and self-respect.

We saw another person's dignity was not maintained because staff were not available to support them. We saw the person's clothes had risen up through their movement which meant they were exposing the lower half of their body. This also caused distress to another person who had witnessed the incident. We saw throughout the inspection that staff would leave people's bedroom doors open so they could monitor them. However, we saw occasions where people were not appropriately dressed or had equipment exposed such as catheter bags. We spoke to staff about this but they did not recognise the need to maintain people's privacy or consider how this practice affected people's dignity.

Staff used inappropriate and unacceptable language to describe people's care that did not promote their dignity. For example, one member of staff referred to people who required support with their meals as 'feeders'. We also observed occasions where staff shouted across the lounge areas to each other about people's needs. Staff often referred to people by their room numbers when discussing their care needs with each other. Confidential information about people's daily care was also displayed on a board in a communal area of the home. The provider and registered manager had not ensured people's privacy and dignity was maintained and had not taken action or recognised the undignified treatment and language people were exposed to.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views on whether they felt staff were kind and caring. One person said, "They are good carers. Everyone is good. Nothing is too much trouble for them." Another person commented, "Some are cocky, mardy, some are funny depending on the day they are having." A third person said, "Some of the language is bad. I hear some of the gossip. I tell them off." A relative told us, "Some [staff] rush and treat [person] like a job." We saw some occasions where there were positive interactions between staff and the people they were supporting. For example, we saw a member of staff asking if a person was okay and chatting about what they did when they were younger. However, this was not consistent, as staff were often very busy and focussed on completing tasks; this meant they did not have enough time to engage with people and promote their social interaction. Staff we spoke with confirmed they were often rushed and did not always have the time to respond to people's needs in a timely manner. For example, we saw staff did not have the time to respond to someone who was clearly distressed until we intervened. On another occasion we saw a member of staff standing over a person while they were supporting them with their meal. They did not have time to sit level with the person as they had to attend to other people's care needs. The member of staff did not use this opportunity to engage with this person and appeared disengaged.

Staff did not have the time to build relationships with people; opportunities for staff to spend time with people were limited. For example, a person who had recently been admitted into the home told us staff had not spent time with them and they felt 'lost'. They continued to tell us "I don't know what's happening." Staff we spoke with were aware how this person might be feeling but said they had limited time to engage in a meaningful conversation and offer them support to settle in and feel welcomed. We saw numerous occasions where people were sat in the lounge areas of the home for over 30 minutes without any interaction from staff. One person said, "I just sit in the chair all day." We saw there were missed opportunities for staff to interact with people because they were rushed and did not have the time to spend with people. Staff had not considered how people would like to or wished to spend their time. We found the provider's systems did not ensure people were supported in a caring manner and staffing arrangements in place impacted on the quality of care people received.

People told us they did not always have an opportunity to express their views or be involved in decisions about how their care needs were met. We saw staff did not ask people about how they preferred their care to be given or asked permission before providing support. For example, we saw one person who required equipment to mobilise was being supported by staff using a wheelchair. The person told us, "[Staff] just wheel me down from my room; I am not sure where my frame is." The person continued to say they were not offered a choice of how they wanted to be supported with their mobility. The person's care record stated they used a walking aid to mobilise but did not mention the use of a wheelchair. The use of a walking aid such as a frame would have promoted the person's independence and choices of where they went in the home. Although staff we spoke with said they had decided the person required a wheelchair because they were unsteady on their feet there was no evidence the person had been involved in this decision. Another person's relative requested their family member was supported with their personal care needs by female staff only following an incident of concern. We saw this information had not been included in the person's care record and staff spoken with could not confirm if the person was being supported in line with their wishes. This did not ensure the person's wishes about their dignity would be respected.

We looked at how the provider respected people's beliefs and wishes when they were at the end of their life. We looked at one person's care record who the registered manager said was receiving end of life care and found there was no end of life care plan in place. This meant staff did not have the information to refer to about the persons care and support needs nor did they have information about their wishes or choices regarding their end of life care. Staff we spoke with had little understanding about good end of life care practices and the impact these may have on a person's and their family's wellbeing and comfort. This showed that people could not be confident that they would receive the appropriate care in line with their views and wishes at the end of their lives.

Inadequate

Is the service responsive?

Our findings

People told us they did not always get their needs met in the way they preferred or in a way that was responsive to their needs. They told us that due to staff always appearing busy and task focused they were not always asked about their preferences or how they would like their care to be delivered. One person told us, "I want to get up but I have to wait [staff member] said this was because I don't get up yet and they are too busy." A member of staff confirmed they could not respond promptly to people's needs. They said, "Some people are not getting up when they want to because there are not enough staff available." Another person told us they wanted to go out for a walk but staff had told them there were not enough staff to take them out. We saw numerous occasions where staff moved people around communal areas within the home without checking first with the person where they would prefer to be. We observed one person ask staff if they could go to their room because they did not want to sit in the lounge. A member of staff said, "There is no one available to take you." The person asked a further two members of staff and waited 40 minutes before they were taken to their room. This showed us people's choices were not respected by staff.

People and staff told us there were set times and days when certain care activities took place. For example, set toileting times within the day and bathing days rather than care being provided according to people's wishes and needs. We saw the running of service was based on delivery of care tasks and routines and people's choices were limited. This meant people were not involved in making decisions about their care and support. People did not receive care and support in a way they preferred. At the time of our inspection care reviews were being carried out by the local authority to ensure people's needs were being met appropriately by the staff at the home. The reviews were being completed in response to recent concerns about the quality of care people received at the home.

People and their relatives had mixed views on whether they had been asked to contribute to their care plan. One relative said, "Family were involved in developing [person] care plan and staff will contact us if they have any concerns about [person]." Another relative said, "I am not involved in any care plan reviews." Staff we spoke with did not consistently understand people's needs. As a result of this, staff were unable to respond appropriately to people's needs which left people at risk of harm. Systems in place were not robust to ensure care plans contained information for staff about people's latest needs and preferences.

We spoke to one member of staff who told us, "Care staff don't tend to look at care plans", and said information about people's needs was shared at handover meetings. We observed a morning handover where staff received updates on people's health and care needs. It was communicated during this that one person was in bed with bed rails in place and had been observed by staff attempting to get over them. This meant they were at risk of immediate harm. Although this information was shared with staff at the start of the shift we found insufficient action was taken by staff throughout the day to ensure the person did not fall out of bed. We saw on occasion staff give conflicting information to each other about the risks around people's mobility needs and being resistant to care. We found one person who was resistant to care did not have a care plan or guidance for staff about the action staff should take in order to support this person. This did not ensure that staff would take the appropriate action to keep the person safe. When staff were aware of the risks associated with people's specific conditions, such as choking, we found they did not always

respond in accordance with people's care plans and ensure food was prepared at a consistency which kept people safe.

We looked at eleven people's risk assessments and none of them contained sufficient guidance for staff about how they were to respond to people's care needs and reduce the risk of harm. For example, one person's weight needed to be monitored. The person had been living at the home for a period of 17 days and during this time they had not had their weight monitored. This placed the person at risk of harm. Another person required their food and medicines to be administered directly into their stomach through a tube. We found there was no nutritional care plan in place for staff to refer to in order to support this person safely with their needs. The lack of an up to date care plan meant the person was not receiving their nutrition in line with recent advice from a visiting health professional. We could not be assured staff would respond in line with people's current care needs and wishes and as a result people were at risk of inappropriate care being provided.

We found people were not supported to take part in activities or hobbies that interested them. One person said, "There is nothing to do I sit around all day." Another person told us, "There's nothing to do here. The odd times I do go out. There are no activities. I sit in my bedroom I watch television or sit in the [garden]." A third person said, "It's just so boring here." Most people spent time in the lounge or their bedroom with little interaction from staff and without anything to engage them. Most people living at the home were reliant on staff supporting them to take part in activities. We saw very few occasions where staff offered activities for people to take part in. We saw some people occupied themselves watching television or spending time in the garden while others sat and watched them. We saw there was an activity notice board within the communal area of the home which indicated the activity for the first day of our inspection was one to one time and arts and crafts. However, we saw no evidence of this taking place. Throughout the two days of the inspection we saw people were offered very little stimulation and the majority of people were not engaged in activities that interested them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had opportunity to attend meetings and told us if they had any complaints they would speak to the staff or the registered manager. They told us they knew the process of how to make a complaint if they were unhappy about any aspect of the service they received. However, although people and their relatives knew the process for raising concerns they felt their concerns had not been dealt with appropriately. For example, a person's relative told us that when they had tried to speak with the registered manager about some serious concerns they were told to write them down on a 'feedback card'. They continued to say the matter was not managed satisfactorily. A person told us, "They don't listen to my complaint. They [are not] bothered about doing anything." The provider had a complaints process in place for the management of complaints and we saw a computer tablet and feedback forms were accessible to visitors in the reception areas of the home.

We looked at the complaints system and found although there was a system in place it had not been used effectively to record people's concerns. Although we found two complaints had been logged with the provider we were unable to find any documentation about other complaints people and their relatives told us they had raised with the registered manager. We also found concerns raised by people and their relatives from meetings and questionnaires had not been addressed by the provider. For example, we saw people had raised several concerns about the length of time it took for call bells to be responded to and staffing levels. However we saw no response had been made to address these issues despite the concerns having been raised on several occasions. The provider had failed to investigate complaints and take the required

actions to respond appropriately.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The Good Governance regulation states systems and processes must be operated effectively to assess, monitor and improve the quality and safety of the service provided. We looked at how the registered manager recorded and monitored information to identify areas of improvement required within the home. We found the provider's system to assess the number of staff required to meet people's health and care needs was not effective and had failed to address significant failings in the quality and safety of service provided.

Although the registered manager had increased staffing levels; systems in place had not identified that staff levels were still not adequate to meet people's health and care needs. We also found the provider's communication system was not effective at ensuring staff knew people's latest care needs and preferences. One member of staff told us, "Handover is all wrong there is no crossover of staff. While we are doing handover there's no one on the floor." When equipment was put in place to keep people safe, sufficient checks were not undertaken to ensure it was used effectively. We found several examples of bed rails and pressure relieving mattresses being used inappropriately and putting people at increased risk of harm.

The regulation also states the provider should maintain accurate and complete records in respect of each person using the service. We found systems in place did not ensure the care records we sampled were reflective of people's individual risks and provide sufficient detail about how staff were to meet their latest care needs. For example, care records were not being updated promptly with latest guidance from SALT and dieticians which was impacting on people's care. The registered manager did not have adequate systems in place to monitor daily records. They had not identified when records had not been completed accurately or reviewed for signs that a person might be at risk of becoming unwell. In one instance no action had been taken when staff had identified in a person's care records that they had refused fluids for a period of time and were showing signs of possible dehydration. We found systems had not been established to ensure risks to people were effectively assessed, managed and reviewed. Risk assessments sampled were not reflective of people's current risks and needs putting people at risk of receiving inappropriate care. Systems and checks in place did not ensure staff had access to accurate information or knowledge to mitigate any risks and protect people from harm.

We found the provider had not used people's feedback to make improvements to the quality of the service people received. We found no evidence to show the issues raised by people who used the service and their relatives had been acted upon. This did not enable people to influence and have a say in how the service was run. We also found at this inspection the improvements we required from our last inspection had not been acted upon such as staffing levels and maintaining up to date records.

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

Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events about incidents that had taken place. A statutory notification is a notice informing CQC

of significant events and is required by law. During the inspection we became aware of incidents of potential abuse that had not been reported to CQC as required by law.

This was a breach of Regulation 18 Care Quality Commission (Registration) 2009.
All organisations registered with CQC are required to display the rating awarded to the service. The registered manager had ensured this was on display within the home.

We received mixed views from people and their relatives whether the home was well-led. Everyone said staff did their best but had concerns about the care and staffing levels within the home. People and their relatives told us they felt comfortable to speak with the registered manager however one relative said, "The registered manager is approachable but not proactive they do something if you tell them." Another relative said, "I think [registered manager] is good although I don't think he likes confrontation. He doesn't always follow through. He says the right things." And "He is approachable." Staff told us the management team were accessible to them. One member of staff said, "The registered manager is approachable, operates an open door system. I feel confident to approach him." Staff told us the home had a clear management structure in place and they knew who to go to if there were any problems or needed any advice. Staff told us they had supervisions and team meetings which were used to share information and to give guidance and direction to staff as well as planning and discussing people's support and care. Staff also demonstrated an understanding and awareness of the provider's whistleblowing policy and felt confident they could raise any issues with the registered manager and these would be addressed. This showed staff were satisfied with the support they received in their roles.