Avon Lodge UK Limited

Avon Lodge

Inspection report

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Date of inspection visit: 15, 16, 17 September 2015
Date of publication: 25/11/2015

Ratings

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

Overall summary

This inspection took place on 15, 16 and 17 September 2015 and was unannounced. Avon Lodge is a residential care home that provides personal care and support for 36 people, some of who have dementia. At the time of the inspection there were 34 people using the service.

At the time of our inspection the service did not have a 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 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

There was a manager who had been in post for three months and was planning to apply for registered manager status with the Care Quality Commission (CQC).

The majority of staff were unable to tell us how they would recognise and report abuse. Staff had received training in safeguarding. However, the home's training

Summary of findings

records showed that for some staff this had been in 2010 and 2011. People were potentially at risk of abuse because staff were unaware of how to recognise and report abuse.

There was a high incidence of falls at the home. There was no evidence that people's risk assessments or care plans had been updated to reflect this. There was no analysis of why the falls had occurred or any evidence that action had been taken to address people's risk of falling. The measures to mitigate risk were not in place.

There was no guidance for staff on people's needs when requiring manual handling. We saw one person was moved without using appropriate equipment which placed them at risk of harm.

There were no Mental Capacity Act (2005) assessments for any people living at the home, in any area of decision making. We looked at 11 people's care files. There was no evidence of best interests meetings or plans. The home's training records showed that staff had received training on the MCA. Only two staff were able to explain what the MCA was and how it could impact on the lives of the people that they worked with.

Six out of the 35 people who lived at the home had Deprivation of Liberty Safeguards (DoLS) in place. We were told that the home was going to apply for other people but did not see evidence of this process and there was no list of people who potentially required a DoLS. Most staff were unable to explain what DoLS meant in theory or practice.

There was evidence of regular staff supervision and appraisals.

People were not consulted on their choice of food and there were no menu plans in place for people to see. People were unaware of what was available and said that there was often no alternative. There was no evidence of regular residents meetings. Cultural needs were not always being met and people were not supported to attend their chosen place of worship. This was not recorded in care plans.

The home did not have an activities coordinator. There were no organised activities within the home. People did not go out. People were left in the main lounge without any stimulation for most of the day. People were not consulted on their preferences and wishes.

We saw some kind and positive interactions between people and staff. People were treated with dignity and respect by care staff. We saw that most staff sought consent from people before carrying out care. We also saw instances where people were not asked for consent or processes not explained to them before care was being carried out.

Care plans were task orientated, not person centred and did not address individuals wellbeing. They were updated monthly on a ruled sheet of paper. Updates were not clear and not carried over to the summary section. This meant that staff had to read through several sheets for each section to be clear on whether areas of care had changed. People, where they were able, were not involved in planning their care. Where people were unable to have input into their care plans, there were no records of best interests meetings or decisions. This meant that care plans were not person centred and people's views and opinions not taken into account.

There was no evidence that complaints were responded to. There was no evidence of learning or changing practice to improve care and communication.

There was one policy on medicines at the home written in 2012. However, there were no other policies and procedures. The manager had to request policies from head office throughout our inspection. Staff did not have access to up to date company policies and best practice.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of regulations 9, 11, 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken at a later date.

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider’s registration of the service, 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Staff did not know how to recognise and respond to allegations of abuse.

People were supported to have their medicines safely and on time.

There was a high incidence of falls at the home. However, there was no evidence of analysis or learning to improve care.

Risk assessments were updated monthly but were not detailed or person centred.

There were sufficient staff to support people and appropriate recruitment practices followed.

Manual handling best practices were not followed.

Is the service effective?

Requires improvement

The service was not effective. Staff were unable to explain what the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS) were, or how it could impact on people's care and their working practice.

No person in the home had received an MCA assessment.

Staff had regular supervision and appraisals. However, staff did not always feel that they had input into these processes.

People were not consulted on their choice of food and there were no menu plans on display for people to see.

People did receive prompt referral to speech and language therapists (SALT's) if their needs changed.

Is the service caring?

Requires improvement

The service was not caring. People were not given choice on when to get up and go to bed.

People's cultural needs were not being met.

Regular meetings with people who use the service were not being held.

There were some positive interactions and effective communication between staff and people.

Relatives were able to visit whenever they wanted.

Is the service responsive?

Requires improvement

The service was not responsive. People's care plans were not written in a way that was person centred or tailored to meet individuals needs and preferences.

Summary of findings

People were not involved in creating their care plans.

There were no activities in the home. People were not encouraged to be part of the local community.

Complaints were not responded to in an effective way.

Is the service well-led?

Inadequate

The service was not well led. There is no registered manger in post.

There was a lack of trust and support between the manager and care staff.

There were some audit processes in place but no evidence of learning from these.

There was one policy on medicines available in the home. However, there were no other policies and procedures. Staff did not have access to guidance.

There was no evidence of reviewing when training was due or needed refreshing.

There was good joint working with healthcare professionals. However, this was not always documented.

Avon Lodge

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 15, 16 and 17 September 2015 and was unannounced. We planned this inspection as a result of concerning information that we had received.

The inspection was carried out by two inspectors, a pharmacy inspector 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.

Before the inspection we looked at information that we had received about the service and formal notifications that the home sent to the CQC. We looked at 11 care records and risk assessments, nine staff files, 25 people's medicines charts and other paperwork that the home held. We looked at policies in place at the service.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 27 people who use the service 11 staff, eight relatives as well as the General Practitioner (GP) and district nurse who visited the home at the time of our inspection.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said "yes, I feel very safe here, everybody is friendly". A relative told us "She's safe and seems to be alright". Another relative said, "Resident's come in here and after a couple of weeks they seem to give up but the staff look after my [relative] very well. I think he is in a safe place and I'm comfortable about things when I leave here."

However, of the eleven staff we spoke with, only three were able to tell us how they would keep people safe and understood how to report concerns if they felt people were at risk of harm. Staff did not understand what safeguarding meant in practice for themselves and the people they worked with. Staff were not able to tell us how they would recognise and report abuse. Staff did not have access to local safeguarding policies and procedures as the provider's safeguarding policy was not available in the home. Staff training records showed that only three staff had completed safeguarding training recently. Some staff had not received safeguarding training since 2010. The manger was able to tell us what safeguarding was and how to report concerns to the local authority.

We looked at the accident and incident book and noted that 36 people had had falls since the last week of February 2015. Two people had fallen on two occasions. We asked the manager if he had analysed why the falls were occurring and he said that he had. However, there was no written information in people's care plans and risk assessments to demonstrate that the reasons for the falls had been analysed and, where appropriate, mitigating or preventative action had been taken. The manager was unable to tell us what the outcome of his analysis of the falls was.

We looked at 11 people's risk assessments. All of the risk assessments had been reviewed on a monthly basis. The majority stated 'no change'. Where there was a change to risks people faced, this information was not easily available. There was no clear overview of risk factors. We saw one risk assessment that was detailed in one area, for one person. This gave staff clear guidance on what the risk was, what could happen and how to mitigate the risk. However, the other risk assessments we reviewed were not detailed. They did not tell staff what could happen if risks occurred and how to mitigate those risks effectively. People's risks were assessed when they moved into the home and we saw that on two people's files, new risks had been added when something was identified. A staff member would need to read through several pages to be clear on what the change was.

At 10:40am on day two we observed a person who had been left alone in their room. The person was distressed and had urinated on the floor. We called staff and were informed that the person had had a surgical procedure the day before. We spoke to the manager who said that he had checked on the person at 07:00am that morning. The person had not been checked on between 07:00am and 10:40am and had had nothing to eat or drink. We asked the manager what had been put in place to ensure that the person was cared for following discharge from hospital and if there were regular observations in place for that person. We were told that there was nothing in place and there was no documentation that showed the person had received regular care. The person's risk assessment had not been updated to reflect their recent healthcare needs. We made a safeguarding alert to the local authority about this matter.

We conducted a Short Observational Framework (SOFI) at lunchtime on day two. A SOFI is a way of observing people and their interactions when they may not be able to tell us themselves. We saw a person being brought in in a wheelchair by two staff. The person was transferred from the wheelchair to an arm chair by two staff picking the person up under their arms, turning them and putting them in the armchair. The person appeared to be pain during this process. The staff did not talk to the person to ask consent or explain what they were doing. Staff told us that a hoist should be used to transfer this person from their wheelchair to a chair, but they said "it doesn't always happen." Another staff member told us, "Some people cannot weight bear but instead of using hoists they [the staff] use their hands." The manager said that it was not common practice for staff not to follow manual handing guidance and that staff should use a hoist. The home's training records showed that seven staff had received manual handling training in August 2015, although there was no certification to support this. Five staff had not completed manual handling training since 2013.

There were sufficient staff to provide care. We saw, and rotas confirmed, that there were four staff in the morning and four staff in the afternoon with four waking night staff.

Inadequate

Is the service safe?

We looked at nine staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role. The manager told us that the home did not use agency staff and they were in the process of recruiting some new staff. We saw two files of people in the process of recruitment and found that satisfactory procedures were being followed.

We looked at medicine records for 25 people and saw that the home used the blister pack system, provided by the local pharmacy. A blister pack system pre-packs tablets for each person for a specific period of time, usually one month. People's medicines were recorded on a medicines administration record (MAR) sheet. We reviewed 15 people's medicines to check the accuracy of the records. All of the records and medicines correlated. All of the medicine was signed for on the MAR sheet. We saw that several people were prescribed medicines to help them sleep. Recent reviews of people's sleeping tablets had been carried out and some people had had them discontinued or prescribed as required. Records showed that sleeping tablets had been administered at 7pm rather than at bedtime as prescribed. The manager told us that when he started working at the home three months previously, there were a lot of people on sleeping tablets and they were being administered as prescribed. He had requested reviews for all people on sleeping tablets and we saw evidence that this was happening. People were receiving their sleeping tablets at bedtime as prescribed. One relative told us, "He [the manager] helped us arrange to take [their relative] off sleeping pills, and now he's off them."

The home had a policy and procedure in place for medicines which was written in 2012. There were no protocols for 'as required' medicines for when it was appropriate to give these medicines. For example: 'give two 500mg paracetamol tablets if the person needs pain relief'. We saw that one person was asked if they were in pain. They were given 'as needed' medicines and the MAR signed. Of the 11 care plans we looked at, there was no information about 'as needed' medicines for people. We saw no signatures of care workers trained to manage medicines according to the homes policies and procedures. Staff had not signed the policy to say that they had read it. The home's training records showed that senior staff members, who were allowed to administer medicines, had received local training in the current medicines administration system. However, records showed that one staff member had not received this training since 2011. Four others received training in early 2014. Staff lacked an understanding of the medicines they were administering. The MAR charts frequently referred to brand names of medicines, but when we talked to staff they were unfamiliar with the medicine and what the medicines were used to treat. There were no reference books for staff to learn about the medicines such as the British National Formulary (BNF).

We saw that the home employed two domestic staff and the home was clean and tidy overall. On the first day of inspection we saw a large clinical waste bag full of used incontinence pads left open on a bathroom floor. When we spoke to staff they said that this was not normal practice. The waste bag was promptly removed. Hoists were clean. However, we saw that people did not have individual slings and we were told that slings are re-used for different people. This could cause cross infection and is not best practice. We saw evidence of regular maintenance checks for the hoists.

Requires improvement

Is the service effective?

Our findings

Staff told us and records confirmed that they had regular supervisions and yearly appraisals. We looked at eight staff appraisals and nine staff supervision records. Staff told us they could talk about what they wanted to in supervisions and discussed people's on-going care needs. Appraisals were basic and lacked detail, with no goals noted for the coming year. We asked staff if they had input into their appraisals. One staff member told us, "I did not have any input, he [the previous manager] wrote things down, told me to read and sign it." We saw that staff had an induction when they started their role to help them understand people's care needs prior to working with them. The induction included an introduction to the home, people who lived there and their care needs. Staff shadowed experienced staff for a week before being allowed to work on their own.

We observed staff members asking permission before delivering care when they were getting people up in the morning. Staff knocked on people's door before entering and told them who it was. We saw one person being asked what clothes they wanted to wear that day and another if they needed help going to the toilet. Staff showed an understanding of people's basic personal care needs and had a good rapport with the people they were working with. We observed people being treated with dignity and respect in most circumstances.

The home had not carried out Mental Capacity Act 2005 (MCA) assessment in any area of decision making. We were told by the manager and staff that all people living at the home had cognitive impairment. Of the 11 care files we looked at seven noted dementia as a diagnosis. Care plans and care file documentation noted that some people did not have capacity. However, this had not been assessed by the home. When we spoke with staff and asked how they thought it was decided that people did not have capacity, several said "Well, they've got dementia." When we spoke with the manager he was unaware of the importance of ensuring that people were assessed and was unable to explain how MCA decisions could impact on, or be part of people's care plans.

All staff we spoke with were unable to explain what the MCA was and how it could impact on the people that they worked with. The manager explained that the home had 'safeguarding of vulnerable adults' training and that this covered safeguarding, MCA and Deprivation of Liberty Safeguards (DoLS) in one day. The home's training records showed that staff had completed training on the MCA. However, of the 11 staff we spoke to, only two were able to explain what DoLS was or how it impacted on people's care. Staff did not have access to the home's MCA and DoLS policies.

Six people had DoLS applications or authorisations. A staff member was responsible for DoLS applications and they confirmed that they were going to apply for DoLS for most of the people at the home.

We saw that the front door was kept locked and people had to ask to be let out. The home had not completed MCA or DoLS assessments for people to find out if people were safe to go out alone or not. This means that people were being deprived of their liberty. Staff told us, "It is for their [people's] safety, they have dementia."

When a DoLS application is granted the external body must assess the person's capacity. This means that the person's capacity is assessed for the specific issue that the DoLS is being requested for. Home's need to conduct MCA assessments for other areas of decision making. We saw no evidence that this had happened.

There was a rolling four week menu plan in the kitchen. However, people who lived at the home did not have access to it. They were not provided with a copy of the menu and it was not displayed within the home. One person told us "You've got to eat it haven't you? There's no alternative." Another person said "I had to eat it, I couldn't do anything else." We asked people if they knew what the meal they were eating was at lunch time, people said that they did not know. One person said "Chicken? Was it chicken then?" We asked the manager why people were not consulted on food choices and the menus not clearly displayed. He was unable to tell us why this was not happening but agreed that it should. The homes 'statement of purpose' notes that 'service users have a choice of meals' and 'service users are consulted when drawing up new menus'. A statement of purpose sets out what the home offers people and how they can expect to be treated. Staff told us that the chef consulted people every day on food.

Requires improvement

Is the service effective?

People were given drinks at breakfast, lunch and dinner and there were set times for tea breaks during the day. Outside of these times people did not have access to fluids. Staff told us that people ask if they want drinks.

We conducted a Short Observational Framework (SOFI) during lunch time. We saw that some people waited up to 30 minutes for their meals. Some staff placed the persons' meal in front of them and explained what the meal was. However, most staff put the meal in front of people with no communication at all. We saw one person being assisted to eat, this was done at the right speed and an appropriate amount given. However, there was no communication with the person and the staff member was looking around the room and talking to other staff. We saw one person ask what their meal was. The staff member was unable to tell them and went to the kitchen to find out before returning to the person to tell them. One person who required assistance was given their meal but the staff member did not return to assist the person for ten minutes. There was very little communication between people and staff throughout the lunch period. We saw that people who needed adapted cutlery and crockery had access to it and were able to use it.

We saw Information for people who required special diets and had been assessed by a Speech and Language Therapist (SALT) was available to staff. There were clear signs in the kitchen for each person noting what type of diet they needed, how food and drinks should be prepared; such as mashed or pureed and how the person liked to be assisted with feeding. There was also guidance for people who had diabetes and food allergies. We checked care plans and the guidance for staff had been carried through and written according to SALT assessments. The manager told us, and we saw evidence, that people were referred to SALT's for assessment if their needs changed.

The chef told us that he always made sure that people's needs were catered for and we saw the chef preparing a meal for someone with specific dietary needs.

Monthly weights of residents were recorded. However, it was noted that 13 residents had lost weight in the last three months. There was no record of how this was monitored, managed and whether action had been taken. The manager told us that they made the appropriate referrals to the GP and dietician. However, this was not recorded. None of the people identified were on a food and fluid chart to monitor daily intake.

One person had been advised by the SALT team to be only given thickened liquids until further investigation regarding swallowing. Food and Fluid charts were available up until 15 September 2015 for this person.

We looked at 11 people's care files and saw that there was a section to be updated when people had healthcare appointments. These were not always up to date and on-going healthcare needs not always recorded. Staff told us that they knew how to refer people if there were concerns about their health or for routine checks such as opticians and dental care.

People were not always being supported to maintain good oral hygiene. The majority of bedrooms that we checked had a toothbrush that had become dry and hard and either no visible toothpaste or toothpaste that was dry. We saw that some care plans stated that people needed support with oral hygiene but we saw no evidence or documentation that this was happening. There was no guidance for staff on how to help maintain oral hygiene. We saw in two people's care files that they had dental appointments. However, outcomes of this were not carried through into care plans.

We spoke with the GP who visits the home on a weekly basis. He told us that the manager was "very good" and made sure that people were seen when necessary. We also spoke with the district nurse who attends the home regularly. She told us that people were referred promptly and that they [the district nurses] keep detailed records at the home of people they are treating. We saw records for people that were being seen by the district nurse. We spoke to the manager and asked if he ensured that people had access to healthcare, he said that he always made sure that this happened but did not know why records were not updated.

The home had not been adapted to make it dementia friendly. Most people's bedrooms had their picture and name on the door. However, some did not. There were no items such as memory boxes or things in people's rooms to help orientate themselves. We looked at 25 people's bedrooms, all but four showed no signs of personalisation such as photos, items that mean something to people or personal belongings. Staff training records did not record any specific training in dementia awareness. Twelve staff had completed national Vocational Qualifications (NVQ's). Staff told us that the NVQ's included training on working with people who are living with dementia.

Requires improvement

Is the service caring?

Our findings

We visited the home early in the morning as we had received concerns about people being got out of bed from 04:30am onwards. We arrived at 05:45am and found that there were six people up and dressed with a further two being brought into the main lounge by 06:00am. We spoke with people who were up and asked if they had wanted to get up. One person said, "yes, I get up to pray" another told us "I like getting up early". However, other people said "I hate it here, they wake me up", "I didn't want to get up", "It's a prison here" and "the night staff do not give me a choice." Three other people told us that they had told care staff that they were not ready to get up and asked them to go away but had been helped out of bed and dressed by staff anyway. Another person said, "Yeah, I wake when I want to." We looked at 11 people's care files and found that people's waking and sleeping preferences were recorded when they moved into the home but had not been updated since moving in, one since 2005. Their preferences were not reflected in their care plans and we did not see evidence that people were involved in decision making where they were able.

The manager told us that when he started, three months previously, this had been a problem and he had talked to the staff about not getting people up unless they wanted to get up. We saw that the homes 'statement of purpose' said that 'service users may choose the time they rise and go to bed...the time they get washed and dressed'. A statement of purpose sets out what the home offers and how people can expect to be treated. The notes from a staff meeting in September 2015 showed that this had been discussed. However, it has not yet been carried through into practice.

We saw some positive interactions between staff and people who used the service. We observed staff being caring and supportive to people who became distressed. One person was wandering and a staff member supported her to sit down, asked how she was feeling and had a chat. Another staff spoke calmly and reassuringly to a person who had become tearful and spent time with her until she had calmed down. Care staff knew people well and were able to tell us what people's preferences were. We saw staff talking with people about their histories and life experiences throughout the inspection. One relative told us "I think it's excellent, my relative has great care." Another said "they all seem very caring."

We observed that people were generally treated with respect. However, we saw that at times people were not treated with respect. For example, inappropriate moving and handling, lack of communication when care was being carried out at meal times and not always supporting people who were distressed.

We also observed that some people were not supported when they became distressed. One person was brought into the lounge by a staff member. The person was distressed and they were placed into a chair with no communication and left for over an hour. The person calmed themselves down and then slept for an hour. One person told us "The staff aren't the best but they don't get paid much do they? You don't get much interaction with the carers really."

One person told us that they wanted to visit a place of worship. They became quite distressed because they said they had not been able to go. We spoke with the manager who told us that they had tried but no one would take the person as they "behaved badly" and were "embarrassing". The manager said that he did not "want to make his staff take them." The person's care plan did not reflect their cultural needs or detail how staff could support them.

Staff told us that relatives could visit whenever they wanted and relatives we spoke with said; "We can visit whenever we want" and "It's never a problem when we want to visit". We observed family and friends visiting throughout our inspection.

Requires improvement

Is the service responsive?

Our findings

Whilst relatives could visit, people told us they were bored and did not go out. We saw that there were no organised activities within the home. During three days of inspection we did not observe one person going out, except to a medical appointment. People were brought into the main lounge in the morning and often did not move all day. One person told us "I stay in bed, what else is there to do here? Nobody comes to see me." Another person told us "I sit here and read, I've read all these books now. I do miss going out." One relative told us, "there's not enough for them to do, she just walks and walks. The odd sing-a-long, that's all I've seen them do." Another relative said "All they do is sit around the TV, I think he [the relative] is becoming isolated. There should be more activities to draw their attention."

We observed that people who were unable to communicate were often left on their own with no input from staff or stimulation. One member of staff said that they tried to do something each day with people and we observed a sing-a-long where the staff member incorporated movement into the session. This was the only activity that we witnessed. There was no activities coordinator within the home and staff told us that there were no organised activities. Staff said they "tried their best" to do things with people. Other staff told us "there are not enough activities, the people don't move a lot." People did not attend day centres or go out with staff. We observed that staff knew people well and talked to them about things that they [the people] enjoyed. However, none of the 11 care plans we looked at included information on what people enjoyed doing, what activities they liked or what their preferences were.

Care plans were not sufficiently detailed and well-organised and at times contradictory. Care plans had been written when the people first moved into the home and separated into sections for each aspect of care. Care plan sections were updated monthly on a ruled sheet of paper, often stating 'no change'. However, where changes had been identified, they were not clearly indicated and staff would need to read through several pages to make sure appropriate care is given. One care plan noted as an update, 'Is confused, given time she can express her needs'. This did not give staff any guidance on how to work with the person.

People were not involved in planning their care. Where people were not able to have input, there were no records of best interests meetings or decisions. A best interests decision is when a person is unable to have input into their care and healthcare professionals and relatives are consulted on the best way to care for that person. Only three of the care plans we looked at were signed by the person or relative. There was no evidence of people's or the relatives input into the care plan. There were also no records, such as best interests meetings, that the person had given consent for their relative to be involved.

Care plans were task orientated rather than person centred and did not reflect people's preferences and individual needs. Staff told us, and we saw, that they had access to people's care plans and did use them to carry out care.

We saw that three people had pressure relieving mattresses. However, there was no recording of what the pressure setting was based on. We spoke to the manager who told us that the setting was based on the person's weight. This was not recorded anywhere in the care plan. Staff that we spoke to knew which people had pressure relieving mattresses but not how they were set.

Care plans did not document who people's keyworker was or show evidence of key working meetings. However, people were aware of who their keyworker was. Staff we able to tell us which people they were assigned to look after. A keyworker is someone who is responsible for an individual and makes sure their needs are met and reviewed.

We saw the complaints procedure and it was also displayed by the front door. It was written in small font and there were no alternative formats, such as large print or pictorial, to make it easy for people to read. A complaints book was available which had two entries from relatives raising concerns. There was no noted outcome or response to the complaints recorded. There was no evidence available of learning and improving care practices as a result of complaints. Most of the relatives that we spoke with told us that they knew how to complain if they needed to. However, two said that they did not know how to complain or who to speak to if they needed to. The manager told us that he always responded to complaints. We were not provided with recorded evidence of this when we asked for it.

Inadequate

Is the service well-led?

Our findings

The home currently does not have a registered manager. The registered manager had left several months previously and a new manager has been in post for three months. The new manager is planning to apply for registered manager status with the Care Quality Commission (CQC).

The manager told us that he had made several changes since he started and this has caused difficulties with the staff team. Staff told us that they felt that the manager did not listen to their opinions and that they no longer felt able to raise issues. Staff also told us that they were "told off" in front of people and other staff and said that they felt unsupported by management. There were issues between staff and management that staff felt were not being resolved or addressed. A relative told us, "There's a poor morale [amongst the staff] in the setting which has a knock on effect to care." Staff were aware of what whistleblowing was and said they would raise things if they were serious.

Relatives told us, "The manager is very helpful and understanding, he kept us in touch with what was happening [with their relative].", "He's [the manager] is very good." Another told us "he does not interact with people". We saw that the manager helped out serving morning drinks for people and people were aware of who he was. We observed that he was kind and respectful in his interactions with people who used the service.

We were informed that residents meetings happened. However, despite asking for the minutes throughout the inspection the manager was unable to find them. We received an email following the inspection with one scanned page for one meeting. It was not possible to see if meetings happened regularly. People told us that they had meetings "sometimes". We were unable to find evidence that people were consulted on their views about the home or that their views were taken into account.

On day one of the inspection, when walking around the home at 06:20am, we found the daily notes for the top floor. We checked the notes and found that they had already been written for all people on that floor. All of the entries were the same: 'This morning, given personal care. Sat in the lounge and had a cup of tea'. We saw that two people were still in bed. The notes had been written pre-emptively and did not accurately reflect the care that people received. We asked that manager if this was common practice and he told us that it should not be and that he would look into it. Daily notes were basic and task focused. The staff did not record information about people's mood or wellbeing. One entry in the daily notes stated that a person 'had a visitor today'. There was no further information or detail about the person's day. We observed that for several night shifts, the same statements had been written for one person.

There were records of staff meetings. The home has separate meetings for senior care staff and care staff. Staff told us that they were able to raise things at the staff meetings and found them useful.

We saw that the home had completed some quality assurance audit processes. There was a kitchen audit in July 2015 which showed no concern. We saw two medicines audits completed by the local pharmacist in February and May 2015. These were simplistic and did not pick up issues raised by our pharmacy inspector. We did not see evidence of any health and safety audits.

We saw a survey the home had carried out that had spoken with people and their relatives from autumn 2014. This talked about the quality of care, friendliness of staff, cleanliness, choice and social activities. The report was very positive about the home. There was no information on how many people had been consulted and how they were consulted.

Apart from the medicines policy there were no other policies and procedures available within the home. We requested, on several occasions, throughout the inspection to see specific policies. The manager had to contact head office and have them sent through. Staff did not have access to company guidance and best practice.

There was no evidence that management was reviewing when people needed to refresh training to ensure that best practice and current legislation was carried forward into care. Training records showed when training had been completed but not when it needed to be refreshed. The manager told us, and we saw, that he had organised some training for the following months. Staff told us that training was discussed at staff meetings. However, there was no evidence that training was understood by staff or that management used training to drive quality and improvement within the service.

Inadequate

Is the service well-led?

We observed that there was good joint working with healthcare professionals and saw that people's healthcare needs were dealt with promptly. However, details of appointments and visits were not always recorded in people's care files.

We found breaches of regulations 9, 11, 12, 16 and 17 the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This means that the home is not complying with all of the regulations we inspect against.

The homes systems to monitor and have oversight of the service were not effective. They were not reviewed regularly or not in place at all. The shortfalls we found in areas such as staff training, ensuring that people were involved in planning their care, the service they received and audits of care plans and risk assessments, had not been recognised by the provider or manager. This means that none of the risks we had identified had been recognised or mitigated against by the provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff were unable to demonstrate that they had the appropriate competence, skills and experience to provide care safely. **Regulation 12(2)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered provider failed to ensure that complaints received had been investigated and necessary and proportionate action taken. There was no complaints policy in place. There were ineffective systems in place to deal with complaints. **Regulation 16(1)(2)**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service user daily records were being written pre-emptively. Content of daily notes did not accurately reflect care received. There was no system in place to monitor and audit the quality and accuracy of daily notes. **Regulation 17(2)(c)**