Gastank Limited

Ailwyn Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2017, and was unannounced.

Ailwyn Hall provides accommodation and support to a maximum of 39 older people, some of whom were living with dementia. It is not registered to provide nursing care. At the time of our inspection there were 22 people living in the home.

At the time of our inspection visit a registered manager was not 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.

We last inspected this service on 10 and 14 November 2016 and found widespread and serious issues throughout the service. The provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. As a result of our November 2016 inspection the service had been placed into special measures. We carried out this inspection to check if the improvements had been made in order to achieve compliance with the regulations.

This May 2017 inspection found that improvements had been made. The provider had commissioned an independent consultant to provide support and carry out audits to monitor and identify where improvements were required. A new manager had been appointed to the home in January 2017 and a number of actions had been taken to drive improvements. We found these measures had achieved some success and progress had been made to improve the home which had benefited people living there. Whilst the provider acknowledged there was further work still to be done, they had stopped the decline in the service that our previous inspection had found and had begun to implement positive changes.

As a result of the improvements we found it was determined that the service is no longer in special measures. Given the recent history of the service we will inspect the home again within six months to ascertain whether the improvements made have been sustained and whether progress continues.

This inspection found that there continued to be some concerns with the management of risk to people's safety and wellbeing. This meant the provider remained in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found some incidents which had not been appropriately identified as adult safeguarding incidents and had consequently not been reported as required. This meant the provider was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had reviewed staffing levels and subsequently increased them. However, we found on some occasions the home was not being staffed to these levels which meant there was not always sufficient staff

to meet people's needs. This meant the provider remained in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements had been made to the governance in the home, we found further improvements to the quality of audits and monitoring of improvements in the home were needed. This meant that at this inspection the provider remained in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider had not always notified us of events in the home as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and report on what we find. Improvements had been made in this area. The provider had reviewed possible restrictions in place regarding people's care and made the appropriate applications. Further work was required on assessing people's ability to consent and make decisions on specific areas of their care.

People did not always receive responsive care as they were not always supported with their personal care needs. Care plans required further improvements as these did not provide sufficient guidance for staff and were not always accurate.

We found improvements had been made to the management of people's medicines and to staff training in the home. New staff received a formal induction and support to help ensure they understood their role and responsibilities. Staff worked together to support each other to provide effective care.

People received the support they required to eat at meal times. Staff consulted with people and offered them a range of options for their meals. Further work was required to sufficiently monitor people deemed to be at risk of dehydration. Staff contacted health and social care professionals appropriately and when required.

People were supported by kind and caring staff, who were respectful and promoted their independence. There were plenty of activities on offer. Activities were varied and took in to account people's differing needs and abilities so there was something for everyone.

People, relatives, and staff spoke positively of the changes in the home and the benefits this had brought to both people living and staff working in the home. Staff had confidence in the manager and of their ability to continue to make the improvements required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Further improvements were required regarding the management of risks to people's health and wellbeing.

Staffing levels had been increased. However there were occasions when shifts were not staffed to the identified required levels.

Some incidents in the home had not been identified as safeguarding incidents and had not been reported to the appropriate authorities.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Further improvements regarding the MCA were required.

Training in the home had improved, new staff received an induction, and staff worked together to provide effective care.

People were supported to eat and drink, although further improvements were required in the monitoring of people at risk of dehydration.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff, who treated them respectfully, and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported with their personal care needs.

Care plans required further improvements as they lacked

sufficient guidance for staff and were not always accurate.

A range of activities to meet people's individual needs and abilities were on offer.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Further improvements were needed to the governance systems in the home.

Incidents in the home had not always been reported to us as required.

Relatives and staff were positive about the changes in the home and the potential for future improvements.

Ailwyn Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 May 2017 and was unannounced. The inspection was carried out by two inspectors on 10 May and one inspector on 11 May.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us since the previous inspection carried out in November 2016. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority adult safeguarding team for their views on the service.

During our inspection we spoke with three people using the service and three relatives of people using the service. We spoke with ten members of staff. This included the registered manager, the operations director, three care staff, two senior members of care staff, the cook, the activities co-ordinator and the person responsible for maintenance. We also spoke with a visiting health professional.

Not everyone living at Ailwyn Hall was able to speak with us and tell us about their experiences of living in the home. We observed how care and support was provided to people and how people were supported to eat their lunch time meal.

We looked at seven people's care records, three staff recruitment files and staff training records. We checked the medicines records for eight people. We looked at quality monitoring documents, accident and incident records, and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 11 and 14 November 2016 we identified a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's welfare were not always identified and action was not always taken to keep them safe. At this inspection on 10 and 11 May 2017 we found that whilst some improvements had been made the provider continued to be in breach of this regulation.

Risks to people had not always been identified and managed appropriately. Two people living in the home required specialised diets because they were at risk of choking. Food records for one person showed that staff had failed to provide foods that were suitable for their needs and meant there was an increased risk of harm to the person. We saw there had been a serious incident two days prior to our inspection when another person had choked on a sandwich and required assistance. The person's doctor had been consulted and it had been agreed that whilst waiting for a specialist assessment they required food to be pureed to reduce the risk of this happening again. On the second day of our inspection we saw the person had been given a piece of cake which was not suitable and posed an increased risk to the person's safety. For a third person we saw they required pureed food and thickened fluids, we observed a member of staff assisting them to eat. The person was lying down in bed and had not been sufficiently sat up to reduce the risk of them choking.

We found actions were not always taken to sufficiently manage and mitigate the risks to people. For one person we saw they experienced periods where they refused to eat and had been losing weight consistently each month from November 2016 to January 2017. We saw no further weights had been recorded. There were no additional records, such as measurements, in relation to each person's weight loss to help assess the level of risk. This meant there was a risk that should the person continue to experience weight loss this would not be identified.

Staff we spoke with had varied knowledge of adult safeguarding including how to spot signs of abuse and report concerns. Three of the care staff we spoke with were unable to tell us who they could report concerns to outside of the home. One member of staff told us the numbers to report concerns to were displayed nearby. However when they went to show us these numbers we found they were not displayed. Whilst some safeguarding incidents were reported this was not consistent and we found two safeguarding incidents had not been reported as required. This meant the local authority had been unable to take action and provide support. This demonstrated that the systems in place were not effective enough to ensure safeguarding concerns were reported as required.

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

At our last inspection in November 2016 we found concerns with the deployment of sufficient and suitably trained staff which meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider remained in breach of this

regulation regarding the deployment of sufficient staff.

Relatives we spoke with told us they felt there were enough staff. One said, "Wherever [name] is there's always a member of staff." However, one of the people we spoke with told us at times shifts could sometimes run short. Staff we spoke with felt there were enough staff to meet people's needs although one said, "I think at the moment it is sufficient, at times we can be a little bit stretched."

The provider had reviewed staffing levels and people's needs in the home. They had increased staffing numbers in April 2017 in order to meet people's needs sufficiently. However, we reviewed the rosters for the two and a half week period after staffing levels had been increased and found there were three occasions on night shifts where there were only two staff available to support 22 people at night. A number of people living in the home required two staff to support them with their care at the same time which meant there was insufficient staff to assist other people. On a further seven occasions in the same period day shifts in the home were not staffed to the required numbers.

At our last inspection in November 2016 we found that the service was in breach of the regulations in respect to the management of medicines. At this inspection, we found the provider was no longer in breach regarding the management of medicines although further improvements were required.

At our last inspection in November 2016 we found a number of people were refusing their medicines. There had been no plan or guidance for staff regarding this and no records of conversations with medical professionals regarding what risks this posed to people. At this inspection we saw the provider had introduced a policy that staff were to consult a medical professional following three refusals of a person's medicines. We saw one person continued to experience periods where they refused their medicines. A record in the person's notes showed staff had discussed this with the GP; however this lacked any further detail regarding the advice given. There was no care plan or risk assessment for the person regarding how this risk should be managed.

We were concerned that the policy in place did not take account of the risk to people of declining specific medicines that could affect their welfare regardless of the amount of times they had declined them, such as anti-seizure or diabetes medicines. However, we discussed refusals of medicines with a member of staff responsible for their administration. They demonstrated they were aware of this policy and understood that certain types of medicines would pose a more significant risk if the person refused them less than three times and told us in which case they would contact a health care professional.

Guidance was in place for people who had been prescribed 'as required' medicines, although we saw for one person this guidance was not being followed consistently. This was because their care plan stated that staff should fill in a checklist to ascertain if the person's 'as required' medicine should be administered and we found this was not always being completed. Consequently, the provider could not be sure that these medicines were administered in appropriate circumstances.

We checked the topical medicine administration record (MAR) charts for three people and saw there were gaps in the records which meant we could not be certain medical creams were being administered as required. Handwritten entries on people's MAR charts were not counter-signed. Recommended guidance says that handwritten entries should be signed by another suitably qualified member of staff to ensure these were accurate and mitigate the risk of any errors.

Medicine administration records for oral medicines were completed accurately and with no gaps in people's records. We saw that where people required the dose of medicine to be adjusted staff liaised with medical

professionals, accurately recording this, and administered the medicine as required. We checked the stock of three people's medicines and found these corresponded accurately with the records kept. Medicines were stored securely and labelled accurately to ensure their effectiveness.

At our previous inspection in November 2016 we found the service had not taken in to consideration staff members experience and training to ensure there were a sufficient numbers of suitable staff on shift. At this inspection whilst we found improvements had been made we found that on occasions there was no trained member of staff in medicines administration on the night shifts. The manager told us that in the event staff needed support with medicines during the night a number of senior trained staff lived on site and could be contacted for support.

There was a system in place for the reporting of accidents and incidents that occurred in the service. We saw improvements had been made in the recording and analysing of these incidents which helped the manager to identify any themes or patterns so they could take effective action.

Requires Improvement

Is the service effective?

Our findings

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 can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met.

At our inspection on 11 and 14 November 2016 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not acting in accordance with the MCA. At this inspection we found although further improvements were required the service was no longer in breach of this regulation.

Potential restrictions on people living in the home had been reviewed by the manager in order to check whether they constituted a deprivation of the person's liberty and would require an application for an authorisation under DoLS. We saw where restrictions had been identified a best interests decisions had been made on behalf of the person following consultation with other appropriate parties. In some cases there was no documented mental capacity assessment in relation to these decisions. When we reviewed one person's DoLS application we found not all the restrictions in place for the person were included in the application for authorisation. This meant there was a risk the local authority would not be able to identify appropriately if a DoLS authorisation was required.

We found that some decisions, such as moving people in to a different wing of the home, had been made in people's best interests before formal mental capacity assessments and best interests decisions were completed.

We found there was a lack of recording of people's ability to consent to specific aspects of their care. For example, one person had bed rails in place and limited capacity to consent to their use. However there was no MCA or best interest's decision in place for their use. We saw two people had assessments of capacity in place regarding the self-administration of medicines. However, there was no best interest's documentation in place to demonstrate that relevant people had been consulted or the outcome of the best interest's decision. We saw the provider had identified this as an area that required further development.

The provider had taken action to provide training for staff on MCA and DoLS. Whilst some staff showed an understanding of MCA we found this was not the case with all staff we spoke with.

At our last inspection in November 2016 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken steps to ensure staff had the knowledge and skills to meet people's needs. At this May 2017 inspection we found whilst some additional improvements were required the provider was no longer in breach of this regulation in so far as it related to the training and support of staff.

At our November 2016 inspection we found concerns that new staff were working in the home without an induction or training. During this May 2017 inspection we spoke with two staff who had recently started to work in the home. They told us they had received an induction prior to working in the home which included shadowing staff. We saw an induction checklist was completed with staff to check they had been introduced to the home and working arrangements. When we reviewed training records and staff rosters we saw some new staff had started working on shifts without receiving training in key areas such as practical moving and handling, fire safety, and first aid. Rosters showed however that they were working alongside other more experienced and trained staff who could support them in these areas. Staff we spoke with also confirmed that they supported each other to provide effective care. One said, "The whole team are supportive." Whilst a second staff member said, "We can work together, everyone is so helpful."

The provider had implemented additional training for staff to help ensure they could provide effective care. Records showed staff training had improved and there were few gaps or expired training dates for staff.

On our last inspection in November 2016 we found a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured people's nutritional intake was adequate. At this inspection in May 2017 we found whilst improvements were still required in some areas the provider was no longer in breach of this regulation.

During this May 2017 inspection we found there was insufficient monitoring of people who were at risk of dehydration. Fluid charts were in place for people deemed at risk, however we found there was no optimum total that staff should be aiming for. We looked at three people's fluid charts and found totals had not been added up, which meant there was no oversight of whether people had received sufficient hydration. However people told us, and our observations confirmed, that they received enough to drink. One person said, "We're always offered plenty to drink, no reason why anyone should be dehydrated."

People told us they enjoyed the food and had a choice of options. One person said, "The food is excellent." A relative told us, "The cook is fantastic, the food they produce is lovely." We saw menus with pictures had been devised and staff used these in the mornings to assist people in choosing what they wanted for their lunch time meal. A number of people living in the home had memory problems and were not fully able to use the menus provided. We saw some staff showed people the actual options at the time of the meal to help them choose, however this was not consistent practice with all staff. We observed the support provided over lunchtime and saw where required people were given the assistance they needed to eat.

Records we reviewed showed that health and social care professionals were consulted when required in order to ensure people's health care needs were met. During our inspection we observed two people were unwell and needed to be seen by a medical professional. We observed staff had identified this and liaised with the home's medical practice to ensure they could be seen that day.

Good

Is the service caring?

Our findings

People we spoke with talked positively about the staff. One person told us, "The staff are good, they really are." Another person said staff were, "Good, they look after me." A relative told us, "[Staff] are just so kind, the way they talk to [name] and they're interested when [name] comes in to the room." A second relative said, "I don't think there's anybody there that shouldn't do the job." A third relative told us that positive changes in the home had meant people and staff were, "More like family, like it used to be." They went on to say staff had, "More time to talk to you, residents are looked after better, and a lot better atmosphere."

Staff we spoke with talked about people in caring way and showed they were committed to providing kind and caring support. One staff member told us that they wanted to ensure the home was somewhere they would want to live themselves. They said, "If I don't want to live here then I know we're doing something wrong." A second staff member told us how they cared and treated the people living in the home as if they were their own parents.

During our visit we observed staff interacting with people in a kind and caring way. We saw staff laughing, joking, and interacting with people on a one to one basis. For example, we saw several staff members sharing jokes with people or dancing with them. We also saw staff made an effort to engage and involve people who were more reluctant to join activities and events in the home. On one occasion we saw a member of staff sit down with a person, who hadn't wanted to engage with activities in the home, and show them some photos of their pet on their phone. It was clear the staff member knew the person enjoyed this topic of conversation and they happily started to engage with the staff member.

Throughout our visit we found there was a happy, calm atmosphere. Several staff, a health care professional, and relatives we spoke with also remarked on this change and the positive impact this had had for people living in the home. One staff member said, "It does feel calm, under control, and everyone is happy." A person told us, "It just feels comfortable as a home." A relative we spoke with also told us that recent changes in the home had helped make their relative feel, "More comfortable."

The people and relatives we spoke with felt they were involved and consulted on the care provided. One person said, "We always have an option." A relative told us how the provider had rearranged and redecorated one of the lounges in the home. They said when they did this they consulted with their relative so they could choose where they wanted to sit.

People were treated respectfully and their dignity was considered. We observed staff interacting with people in a respectful manner. A relative told us, "Absolutely they do, I haven't seen anybody there spoken to badly or overlooked." Whilst another relative told us they observed staff knocking on people's doors before entering. On the first day of our visit we saw people's daily records were out and accessible in the home. We discussed this with the manager who acknowledged that this did not fully ensure people's private details were secure. On the second day of our visit we saw that these records had been tidied up and put away in a filing cabinet.

Relatives told us they felt people's independence was promoted where possible. Staff we spoke with confirmed they tried to promote independence. One staff member said. "We always encourage [people] to do what they can do themselves." We observed staff doing this in practice during our visit. For example, we saw staff respecting one's person's desire to help themselves and manage their meal independently. We saw for another person they were assisting staff to tidy up after lunch and later in the afternoon were assisting staff with offering cups of tea. We saw the home had purchased some fish and a budgie for the home. A staff member we spoke with told us how certain people in the home liked these animals and helped staff to care for them. A relative we spoke with confirmed this.

Requires Improvement

Is the service responsive?

Our findings

Staff did not always provide responsive care as they did not ensure people received the appropriate support with personal care and assistance with accessing the bathroom. We noticed at points during the day there were strong odours. We observed one person had requested assistance to go to the bathroom, staff had assisted the person towards the toilet but the person had become confused regarding where to go and what support they needed. Staff then directed the person in to a seat in the lounge and made no further attempts following this to provide the person with the support they required. For another person we saw they had not been assisted to use the facilities in time and following this staff did not respond to offer the person assistance in a timely manner.

The care plans we looked at did not always contain people's personal preferences regarding their care and life history. Providing this information to staff can help them understand the people they are caring for in greater depth and helps to ensure people have care provided in a way that takes into account their individual needs.

Not all the care plans we looked at had been reviewed on a monthly basis or when people's needs changed. This meant that we found instances where care plans did not reflect people's current level of need or the actual support required. For example, we saw one person's care plan said they required bed rest and equipment to be in place to manage the risks to the skin. We saw this person was not in bed during our inspection. When we queried this with the manager they told us the person's skin and the support required had improved and the care plan was no longer accurate.

The care plans we looked at did not always contain sufficient information or guidance. For example, we saw one person often refused support with their care. There was no care plan or guidance for staff on how to manage this. For a second person who was requiring end of life care there was no specific end of life care plan in place. For other people with behaviour that staff may find challenging there was a lack of specific detail for staff on how to manage this and what might work well for each person. This meant staff did not have sufficient written guidance to meet people's needs. It also meant that new or agency staff did not have sufficient guidance to meet people's needs in the event that permanent staff were not available.

Some of the care plans we looked at showed people, or their relatives where appropriate, had been involved in reviewing the care plan and signing these. However, we found this was variable and not all care plans evidenced this. People and relatives we spoke with confirmed that they were consulted regarding their care plans. However it was not clear from speaking to people and relatives that formal opportunities to do so were in place.

People and relatives we spoke with told us they felt staff were responsive to people's needs. One relative told us, "There's some people that need a lot of attention and they get a lot of attention." A person told us, "We have what we want, if we want something done there's always someone there to do it." They provided us with an example of needing support with some equipment and told us staff had responded and arranged this straight away. Another person gave us an example of how staff were aware of their spiritual needs and

had offered to support them with this. They said, "Staff are very accommodating."

There was a range of activities in place; some formal outings for people had been planned as well as planned entertainment in the home such as visiting musical entertainers. People we spoke with told us they enjoyed the activities on offer. One person said, "We have fun."

There was an activities co-ordinator in place who worked during the week. The manager told us they planned to extend this to include outings at the weekend as well. The activities co-ordinator told us that the separation of the home in to two units had meant they were better able to organise their time as well as specific activities aimed at people's differing levels of needs. We saw during the day they split their time between the two units, engaging people in activities and moving between the two units to ensure there were opportunities for everyone. We saw they selected and engaged people in activities that matched people's individual needs and preferences. A relative told us that previously their relative had been left in their room often. However this had changed and they were spending much more time in the communal lounge. They said although their relative wasn't always able to take part directly in activities they enjoyed watching what was going on and felt this was a positive improvement.

The activities co-ordinator told us they left plenty of activities, such as games and puzzle books, in both communal lounges so staff could engage people in them when they were not available. We saw this was the case however we noticed care staff were not always proactive in engaging with these when time to do so was available to them.

The relatives we spoke with told us they felt able and comfortable to raise concerns or complaints if they needed to. We saw there was a suggestions box in the hall way and the complaints procedure was on display. A residents and relatives meeting had been held, the manager said they planned to hold further meetings. This provided people and relatives with an opportunity to discuss any concerns and complaints. A relative who attended the meeting told us, "They let us have our opinions and asked if we thought anything was wrong or could be done better."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 11 and 14 November 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. At this inspection although we found some improvements had been made, further improvements were required. The provider remained in breach of this regulation.

Since our last inspection the provider had contracted an external consultant who had carried out two audits of the home. We saw these audits covered key areas such as staffing, medicines, care plans, training, and the premises. We reviewed the action plan the provider was using to make improvements in the home. The action plans lacked detail regarding when actions were required to be completed by and by whom. We found recommended actions from the external consultant had not been incorporated in to the provider's action plan and actions had not been taken to address some of their recommendations. This meant we found the current system to drive improvements to be ineffective.

Since our last inspection there had been no change to the audits the manager had been carrying out. These audits were not detailed and did not cover a number of areas where improvements needed to be made. For example, in care planning and nutrition. This meant that issues in these areas had not been identified and that subsequent action to make improvements had not been taken. We saw the monthly audits that were in place had been ineffective and had not identified a number of issues that we had identified during our inspection.

We were concerned that feedback had been provided to the manager regarding concerns but there had been a lack of timely or sufficient action to make the improvements necessary. An external audit carried out on 28 February 2017 by a consultant employed by the home had identified staffing numbers in the home were not sufficient. They had advised additional staff were required in order to meet people's needs sufficiently. We saw this had not been implemented until two months later. This meant the provider had not taken action to ensure there was sufficient staff required to meet people's needs during this time. Additionally the local authority safeguarding team told us they had raised concerns regarding staff placing people at risk of choking due to not following specific requirements in place. We found this concern had not been addressed effectively as we found further examples of this at this inspection.

At our last inspection in November 2016 we found systems in place were not robust enough to protect people from the risk of harm in relation to the management of the premises. At this inspection we found improvements were still required. For example, a legionella risk assessment had identified a number of risks and actions required in relation to the management of legionella in the home. We discussed this with the person responsible for the maintenance of the premises; they told us these actions had been taken. However, there was no clear action plan or documentation to confirm this was the case.

Care records and risk assessments we looked at contained information about people's care needs but these were not always detailed enough and did not always contain key information. The care records we looked at this inspection showed this continued to be a concern and action had not been taken to make sufficient improvements. Care plans and risk assessments for one person whose health was deteriorating and who was receiving end of life care had not been reviewed in the last two months. For two other people we saw there had been recent changes to the level of support they needed however their risk assessments and care plans had not been subsequently reviewed to ensure they were still accurate. This meant the home did not have in place accurate, complete, and contemporaneous records of people's care. It also meant systems in place to make improvements in this area were not effective.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. At our last inspection on 11 and 14 November 2016 we found the provider had not submitted required notifications. At this inspection we found three further incidents that had not been reported to us as required. This meant the provider continued to be in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the provider remained in breach of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We also identified a further breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This meant the systems in place had not been effective at driving improvement or sustaining areas of no concern previously identified at the last inspection.

The provider had arranged a meeting with people living in the home and their relatives to discuss the previous inspection, the improvements required, and to listen to their comments. The manager told us they planned to arrange further meetings to ensure people and their relatives had an opportunity to discuss issues and to share information about the home. We saw the manager had analysed a quality assurance survey sent to relatives of people using the home to order to identify any issues or themes. They told us they planned to send out a further survey in July 2017 to assist them to collect feedback about the home and monitor the quality of the service.

We saw the provider had started to implement their own audits, although only one audit had been carried out at the time of the inspection, we saw these covered a number of areas such as staffing, care plans, and mealtime. The audits included speaking to people and staff to gain their views.

Staff we spoke with, and minutes of meetings confirmed, that the provider had also held staff meetings with them. The minutes showed there had been open and honest communication with staff regarding the improvements required. Staff told us both the provider and manager listened to them and took action to address any concerns they raised. They gave us positive examples of this. One member of staff we spoke with told us the operations manager for the provider was visible in the home. They said this meant the provider was approachable and they felt comfortable raising any issues they had in the event they were unable to speak to the manager.

People, relatives, and staff spoke positively about the new manager. A staff member and relative told us they felt more confident in the manager. A member of staff said, "[Manager] is on the ball." A second staff member said, "Best manager since I've been here" whilst a third said, "I think [manager] has made such an impact already I think they can do it."

We saw, and people and staff told us, that the provider and manager had implemented some changes in the home that had a positive impact on the running of the home and people's care. One person said, "I think the

general care is better, things are getting done when perhaps when I first came here they weren't." A member of staff told us they felt there had been a reduction in the number of falls and injuries people had sustained.

The manager and provider had separated the service in to two separate units which accommodated people depending on their level of need. Staff told us that this had helped with the division of tasks and roles in the home. One staff member said, "I know what I must do." Two people and a relative told us that the separation in to two units meant that people with lower less complex needs did not get overlooked. A staff member said this meant people with less complex needs, "Get quality time now." A relative told us their relative was less upset now the home had two separate units.

Staff we spoke with told us there was a positive relationship between each other and the manager. One staff member said, "[Manager] listens and wants to help you." Whilst another staff member said, "I think we've got the right staff, it's more of a team, before it was them and us."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Commission where required of incidents that had occurred in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way because risks were not always identified and mitigated. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes in place were not operating effectively to ensure safeguarding concerns could be investigated. Regulation 13 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. The service did

not maintain an accurate and complete record in respect of each person who used the service.

Regulation 17(1)(2)(a)(b)(c)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always deployed to ensure people's needs were met. Regulation 18(1)