Durham Care Line Limited

St Aiden's Cottage

Inspection report

St Aiden's Cottage, Auton Style
Bearpark
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Date of inspection visit:
15 November 2016
16 November 2016
01 December 2016

Date of publication:
16 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15, 16 November and 1 December 2016. The inspection was unannounced which meant the provider did not know we would be inspecting.

St Aiden's Cottage is a care home that provides accommodation for people who require personal or nursing care. The home is based in Bear Park, County Durham and provides care for older people with learning disabilities, people living with acquired brain injury or dementia. The home is registered to provide accommodation for up to 41 people. On the day of our inspection there were 30 people using the service.

The home did not have a registered manager in place managing the service. 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.

At the time of our inspection visit there was a care manager acting as a deputy manager and a covering manager from another service but no registered manager in place at the service.

We spoke with a range of different team members; the care manager, the covering manager, care staff, kitchen staff, domestics and maintenance staff who gave us mixed reviews about the management of the service.

From looking at people's care plans we saw they held some personal history and described individuals' care, treatment, wellbeing and support needs. They detailed the care required and were written in plain English but not always in a 'person-centred way'. Person centred care is an approach that aims to see the person as an individual, rather than focusing on their illness or disability.

Individual care plans contained personalised risk assessments. These risk assessments identified risks and were in place to enable people to take risks safely.

On the day of our inspection people who used the service were not supported by sufficient numbers of staff to meet their needs. We could see in the staffing rotas that there had been recent staffing issues and people who used the service were not supported by enough people to enable them to take part in leisure activities.

When we looked at the staff training records they showed us that staff were not always supported to maintain and develop their skills through training and development opportunities. We found that some training had expired and staff needed to attend refresher training imminently.

When we looked at supervision and appraisal records we saw that these had not been carried out with all staff.

Staff recruitment records that we looked at showed us that staff were recruited safely.

We observed how the service stored and administered medicines. We looked at how records were kept and spoke with the management team about how staff were trained to administer medication and we found that medicines were administered safely.

During the inspection we witnessed the staff rapport with the people who used the service and saw some positive, caring and warm interactions took place.

We observed some practices that at times didn't respect people's dignity or maintain their privacy. Activities for people to take part in were not provided. We saw some evidence that plans were made for people to be supported to go out but this was not regular or consistent.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. We saw people enjoying their meals. The daily menu was not developed with the people who used the service to incorporate their likes and preferences but was adapted to suit the people who used the service.

We saw a complaints and compliments procedure was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. We saw evidence that the complaints procedure was adhered to. People who used the service were aware of how to complain and were supported to do so.

We found a quality assurance survey had taken place previously with the people who used the service and we looked at the results. There were actions identified to make improvements to the service as a result of people's suggestions however these were not all implemented.

A programme of audits was carried out by the care manager and some were ineffective and some were not carried out recently.

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 is in their best interests and legally authorised under the MCA. We found the service had a policy in place that was working within the principles of the MCA.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

This service was not always safe.

Staffing levels did not always enable people to be supported with leisure activities..

People were not always supported to maintain their healthcare needs.
Medicines were stored and administered safely.

Staff were recruited safely.

Is the service effective?

Requires Improvement

This service was at times not effective.

Not all staff training was up to date.

Staff appraisals and supervisions were not adequate.

The service met the requirements and principles of the Mental Capacity Act 2005.

People's nutritional and hydration needs were met.

Is the service caring?

Requires Improvement

This service was not always caring.

Peoples privacy was not always respected.

Peoples dignity was not always maintained.

People had access to advocacy services when required.

Peoples independence was supported.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Care plans were not person-centred to reflect people's preferences and interests.

Activities were not planned and organised to ensure they took place regularly.

The service responded to complaints appropriately.

Is the service well-led?

Inadequate

This service was not well led.

The service had no registered manager in place.

Staffing levels were not managed appropriately.

Audits of accidents and incidents were not always carried out.

Quality audits were ineffective.

Quality assurance surveys took place but no actions were carried out as a result.

St Aiden's Cottage

Detailed findings

Background to this inspection

The inspection was carried out 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.

We visited the service in response to concerns raised about the registered provider. We carried out this inspection to assure ourselves that none of the concerns raised were impacting on the people who used the service.

This inspection took place on 15, 16 November and 1 December 2016 and was unannounced. This meant that the service was not expecting us. The inspection team consisted of one Adult Social Care inspector, an expert by experience and a specialist advisor who both had experience of nursing care and caring for people with learning disabilities and older people. At the inspection we spoke with 12 people who used the service, the covering manager, the care manager, domestic staff, maintenance worker, kitchen staff, eight care staff, Nursing staff and a visiting professional from the community nursing team.

We looked at seven people's care plans from the service, five staff records that included recruitment, supervisions and appraisals and five staff training records.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including the local authority contracts team.
Prior to the inspection we contacted the local Healthwatch and no comments had been collected by them about the service. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, comments, concerns and compliments through their engagement work.

During our inspection we observed how staff interacted with people who used the service and with each other. We spent time watching daily routines to see whether people had positive experiences. This included

looking at the support that was given by the staff, by observing practices and interactions between staff and people who used the service.

We also reviewed records including medication administration records (MARs), safety certificates, care plans and records relating to the management of the service such as audits, rotas, complaints, action plans, surveys and policies.

Requires Improvement

Is the service safe?

Our findings

At our inspection we spoke with people who used the service and asked them about the staff at the service and if they felt there were enough to support them safely. One person told us; "Yes I am safe, the staff make sure I'm safe when I go out to visit my family."

We also spoke with people who used the service about staffing levels and we received mixed comments. One person told us; "The staff are brilliant." Another told us; "I see the staff at meal times, I stay in my room." During our inspection we reviewed the staff rotas covering October and November 2016 we found that the service was running understaffed regularly on an evening. Numbers of staff were falling low on the night shift and we found evidence of this on 19 occasions. We could see from the rotas that the recommended number of staff on night shift should be six and the covering manager confirmed this. However staff numbers were regularly down to five staff. We raised this with the covering manager and asked if there was any risk assessments in place for when staffing was short and they told us; "There should be, but there isn't one in place."

Staff members raised concerns with us regarding the impact of the staffing levels and how it was affecting their role and the people they support. Staff members told us; "There is no time to spend with people. I would rather spend my time with people than in the laundry." Another told us; "We get the basic things done; People's care, cleaning up and the laundry, there is no time to spend with people. People who like to go out, don't get out." Another told us; "Even when we are short staffed if someone has an appointment, no one extra comes in to help, you are left short and left to manage."

During our inspection staff highlighted that they had been advised by management not to take two people who used the service out to attend medical appointments on the same day to save on staffing. One staff member told us; "If there are two appointments we were told to cancel one as only one allowed. It is really hard to get people these appointments and how do you choose which one to cancel." Another staff member told us; "When people do go for appointments then it's really hard for the staff who are left." We found that staff had been advised to cancel appointments within a team meeting and we found evidence within the team meeting minutes. When we asked the care manager they told us they were un-aware of this practice.

During our inspection we looked in people's care files and within one we found incomplete health records. We saw documentation stating that the person required their pulse monitoring at regular intervals as requested by their outpatient clinic. We found that this had not been carried out. When we asked the nurse-in-charge why the record was in place and why it was incomplete. The nurse was unable to explain why this was in place or why it was incomplete. This meant that people were not supported to maintain their healthcare needs.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a main kitchen and a smaller kitchen that was accessible for people who used the service to

access when they wished. When we looked in the smaller kitchen we found that recording of fridge and food temperatures were not taken regularly.

When we looked in the larger kitchen we found that the temperatures were being kept regularly, however we found the larger kitchen to be untidy and in areas unclean, for example, the dry food storage and extractor fan, even though a kitchen cleaning schedule had been completed. We also found that one member of kitchen staff was not wearing protective clothing. When we brought this to the care manager's attention they were unaware of this practice and assured us that they would address this with the staff member immediately.

We found that all accidents and incidents were entered into an accident book and the information from here was transferred on to an audit but we found these audits were not completed recently therefore there was no evidence of analysis of this information or any actions that were in place to reduce risks.

We looked at the arrangements that were in place to manage risk, so that people were protected and their freedom supported and respected. We saw that risk assessments were in place in relation to the people's needs such as nutrition and falls and these were reviewed however we found some were not identifying changes, for example, an increase in falls.

During the inspection we discussed all aspects of medicines with the nursing staff and senior care staff. We observed the medicines administration process and looked at the medicines administration record sheets (MARs) and found no omissions. We found that the medicines were administered safely.

When we looked at people's MAR charts we saw that they held information regarding side effects or allergies. Also we found descriptions to describe how people liked to take their medicines and how to support them. We found that where people needed to take medicines covertly this was done appropriately and the correct guidelines and best interest decisions were in place where needed. Where people needed medicines 'as and when required' we saw that there were clear procedures in place that were individualised.

We spoke with a visiting professional on the day of our inspection from the community nursing team who told us; "I have been visiting today to give people their flu jabs and I find that the medicines are always locked away and always handed to us. I have no concerns."

We found that room temperatures in the medicine room were regularly recorded and were within the recommended temperature for storing medicines, which is below 25 degrees Celsius, as above that temperature medicines may become ineffective. Fridge temperatures were also regularly recorded within the recommended temperatures.

We discussed controlled drugs with the senior staff member and carried out a random stock count and these were correct and these drugs were stored and monitored safely. Controlled drugs are medicines which may be at risk of misuse and are subject to additional legal requirements in relation to their safe management.

Topical medicines such as prescribed creams were administered and recorded on separate MARs that included clear instructions for administration.

We found that the medicine trolleys in the ground floor treatment room were not secured to the wall as advised in a previous audit. We brought this to the care manager and the covering manager's attention who advised us that this would be rectified immediately.

The home was secured at the front door and between floors there were keypads to ensure people's safety. Staff and visitors to the home were asked to sign in and out.

We also saw that personal emergency evacuation plans (PEEP) were in place for each individual who used the service. These plans provide staff and other professionals with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency.

Staff members we spoke with were aware of who to contact to make referrals to or to obtain advice from if they had concerns regarding people's safety. Staff said they felt confident in whistleblowing (telling someone) if they had any worries. We saw that where there had been safeguarding concerns these were investigated through the local authority safeguarding procedures. One staff member told us; "I would report anything I thought was a safeguarding issue."

We looked at five staff files and saw the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, and two previous employer references and a Disclosure and Barring Service (DBS) check, which was carried out before staff commenced employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. We also saw proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates.

We saw that care staff had access to protective clothing for carrying out care tasks and these were in plentiful supply. We observed care staff accessing these throughout the inspection.

Requires Improvement

Is the service effective?

Our findings

During our inspection we asked people who used the service about the staff and they told us; "The staff are great," and "The staff do what I need them to do."

We looked at staff training records and a training matrix and found that several training courses were out of date or not completed in the following areas; safeguarding, moving and assisting and fire safety. When we highlighted the training to the covering manager they told us that staff were being booked on to training courses and that it was on going. However this meant that at the time of our inspection staff training was incomplete or out of date.

Within one of the staff files, a member of staff stated at their interview that they had no experience of working with people with complex needs or challenging behaviour and would need training in managing behaviour. At the time of our inspection the staff member hadn't received any training in this area. The staff member had received supervision but their training needs had not been identified. When we raised this with the care manager and covering manager they were not aware of the training shortfall and that they would address this with the staff member immediately. This meant that the supervision process was not highlighting staff training requirements to enable them to carry out their role.

We looked at the staff Supervision and appraisal records during our inspection and we found that out of 39 staff six had received an annual appraisal during 2016. Within the staff supervision records we established that in the last 12 months 12 staff had no supervision, 15 staff had only received one, five staff had received two and four staff had received three. Out of staff 39 staff, 36 staff had received little or no supervision.

The staff supervision policy that was in use by the service required the staff to receive formal supervision at least six times a year. This meant that staff were not always supported to carry out their role effectively.

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

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. Throughout the inspection we observed people being offered drinks. The menu that we looked at offered one main course. When we spoke with kitchen staff they told us that the current menu wasn't developed with the people who used the service and didn't incorporate people's choices. However if people didn't like something they could have something else or the menu could be adapted. We saw kitchen staff making sandwiches for someone just as they had requested them. We also saw that food was presented in different ways for people who had specific preferences to meet their needs.

We could see that people with special dietary requirements were catered for. When we looked in the kitchen we could see that people who had guidance from the speech and language therapy team had their food prepared as required. People's guidance was in the kitchen for staff to see.

We observed the people who used the service having their lunch in the dining room. We could see that staff were encouraging and supporting people who needed assistance. The atmosphere in the dining area was relaxed and the people who used the service were enjoying their lunch. People who used the service told us; "The food is tasty", "I enjoy the food I eat it all," and "I like the food, I like sausages."

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 is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We spoke with staff who were able to demonstrate that they knew which people who used the service were affected by DoLS.

We also discussed DoLS with the care manager who was aware of their responsibilities with regard to DoLS. The service had an effective MCA/DoLS policy in place. All the active DoLS and applications were current and the care manager was able to demonstrate clearly how these authorisations were managed.

We saw records that showed us that some community professionals were involved in the care and treatment of the people who used the service, such as social work team, occupational therapy and the speech and language therapy team.

Requires Improvement

Is the service caring?

Our findings

During our inspection we spent time speaking with people who used the service about the care they received, people told us; "The staff are kind," and "The staff are good." Another told us; "I have memory loss and the staff are good here they help me a lot, I am doing really well here."

We spent time observing interactions between people who used the service and the staff and we found there was a genuine rapport with people and we saw some staff interacting with people in a positive and caring way. However when we spent time observing the support taking place in the home we saw that people's dignity and privacy was at times compromised by the behaviour of some staff and some staff attitudes.

We observed some staff entering people's bedrooms without knocking on their doors first. We also witnessed some staff talk about the people who used the service to the inspection team in their bedroom door way within earshot of the individual. For example one staff member opened a person's bedroom door and made introductions and told us; "[Name] has advanced MS and will be a good one for you to speak with."

Throughout our inspection when staff were talking about the different parts of the home they regularly referred to them as 'units' and referred to one part of the home as the 'LD unit', this was done openly in front of people who used the service. This language was also used by members of the management team.

When we spoke with staff and asked them how they would maintain people's dignity and privacy they were able to demonstrate how they would do this and told us; "I always knock on people's doors first." However we witnessed practice that this didn't take place. We also observed staff speaking about people who used the service and their personal health information in a communal area and with members of the inspection team. This meant that some staff were unable to maintain people's confidentiality or respect their dignity.

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

We asked people if they were supported to make choices and we found that people who used the service were encouraged to make choices and we saw that some people had individualised bedrooms that reflected their preferences. We saw that people who used the service had their own preferences met for example where they liked to sit, how they liked their food and what they wanted to wear.

At the time of our inspection some people who used the service had an advocate in place to support them with important decisions and for exercising their rights. When we asked the care manager about advocacy they advised us that people used a local independent organisation and this was available to anyone if needed. When we asked staff members about advocacy they were also knowledgeable and knew who to make contact with to organise if needed. At the time of our inspection there was no information on display regarding advocacy but the care manager informed us that they would make this available for people and

their relatives.

We asked members of the staff team how they encouraged people who used the service to maintain their independence. They told us; "Where people can do things for themselves we always encourage it." and "[Name] can make their own bed and they sometimes want us to do it but we help and encourage them to still do it." One person we spoke with who could go out independently told us; "I like to go out for a walk to the shops and my doctor told me to keep fit and walk as much as I can." We saw that this was supported and encouraged.

We saw that people who used the service who were able to were supported to access kitchen facilities independently to prepare their own drinks and snacks. We observed this and saw that this was supported throughout the inspection. This meant that people were supported to maintain their independence where it was possible.

At the time of our inspection there was no one in receipt of end of life care.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we spoke with the people who used the service about the support that was provided to meet their needs in a person-centred way, to meet their needs socially and to support their wellbeing. We received mixed comments from people including; "That's all I do (watch TV) I get bored." Another told us; "It's alright here." Another told us; "I go out on my own, but there have been no outings arranged."

During our inspection we were informed that the service employed an art therapist who provided art activities at the service. At the time of our inspection they were on annual leave and we established they had had been for six weeks. A staff member told us there were no activities planned for people and said; "Nothing has been put in place for people while the art therapist has been off. Activities should be on the rota, things have started to improve a little since you came last week." When we asked the care manager what else was planned they told us; "Anyone can access the art facility whenever they want." However during our inspection visit the art therapy room was locked at all times and the care manager was unable to open the room. When we asked if anything was on offer the managers were unable to demonstrate what else was in place for people who used the service. The covering manager told us; "At the moment we are under constraints and for me it's about putting more processes in place and more structure for the staff and activities for the service users. Again we are looking at reviewing people for more hours as I would like more staff in for activities."

When we spoke with staff they told us how they were frustrated with the lack of staffing and the impact it was having on the people who used the service. One staff member told us; "People who used to go out don't get out. Some people want to go but can't because there is not enough staff to take them out." Another member of staff told us; "The best thing about working here is the people but the worst thing is the activities, I wouldn't want to be cooked up in here all day every day, so what's it like for them?" Another told us; "There is just no time to spend with people just chatting." Another told us; "There is one thing lacking here and that is activities for people."

During our inspection we identified that people who used the service had limited access to the community, some were socially isolated. People also had interests and hobbies that they were not being encouraged to develop to enable them to be socially active and stimulated. Staff raised concerns with us that people who used the service don't always go out and one person who used the service told us; "I can't remember that last time I was outside the building. I am a friendly person but I don't see anyone. I see staff at meal times." Staff told us that activities had been discussed at team meetings previously. We found evidence of this within the team meeting minutes. This meant that staffing levels had a direct impact on activities offered to people who used the service.

We found that one person had a communication plan in place that required staff to interact with them and use sensory activities to encourage them to engage. During the inspection it was observed that the person never left their room and no observations were made of staff engaging them in any communication activities besides personal care and meal times. This meant that where people had plans in place that included activities they were not always followed.

When we looked at the care plans we could see that they were not person-centred. The care plans gave in depth details of the person's care needs and risk assessments. They were presented in a format that was sometimes task oriented. Some of the care plans didn't give an insight into the individual's personality, preferences, choices and dislikes.

Some care plans we looked at contained very detailed communication plans that were person-centred however this did not reflect throughout the service. People didn't have person-centred plans in place that focussed on goal planning.

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

The care plans contained lots of details about people but no profile information that could be used to learn about the person at a glance. When we spoke with the care manager and covering manager they explained that they were in a process of putting one page profiles in place for people. A one page profile is a one page sheet that gives an overview of the person, their likes, dislikes, needs and wishes.

The complaints procedure that we looked at provided clear protocols for staff, people and their relatives to follow should a concern or complaint be raised. We saw there had been no recent complaints made. We were shown complaints records that provided evidence that the care manager had responded timely and investigated previous complaints. This meant that complaints were managed and responded to appropriately.

We asked people who used the service if they knew what to do if they wanted to raise an issue or a complaint and they told us; "Yes I would tell the main bloke." When we asked the staff if they knew how to make a complaint they told us, "I would go straight to the manager or whoever was in charge." We found that the service had a complaints procedure in place and from speaking with staff and people who used the service we could see that the procedure was embedded within the service.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection visit there was a care manager acting as a deputy manager and a covering manager from another service but no registered manager in place at the service.

During our inspection we looked at processes in place for responding to incidents, and accidents. We looked at accidents and incidents audits and we found they had not been carried out since August 2016 covering the July 2016 period. Within the two audits carried out in July and August we noted incidents of un-witnessed falls that were recorded. We found that incidents of un-witnessed falls were also recorded within the accident book for September and October 2016 relating to the same person and these were not picked up as there had been no audit covering that period. When this was brought to the attention of the covering manager and the care manager they told us that the audits hadn't been completed and they the covering manager assured us that they would look into this immediately. This meant that audits were not always completed in a timely manner or trends identified and actioned.

We looked at audits relating to people's care plans. We found that within one person's care plan they were at risk of falls and they had a risk assessment in place. However, this person had fallen several times and within their care plan audit and review it stated 'no changes needed.' When this was raised with the covering manager and the care manager the covering manager told us; "[Name] should have been referred to the Occupational Therapist for a review of their equipment" but they were unable to provide any evidence that this had occurred. They assured us that this would be made a priority. This meant that some audits that were carried out were not effective in ensuring improvements were made.

During our inspection we looked at quality audits that had been carried out during July, September and October 2016. The following actions were highlighted; in the July audit it stated that following advice from the environmental health visit on the 20 July 2016 the 'extractor fan in the kitchen storage cupboard needed cleaning'. This action was then carried forward in subsequent audits in September and October 2016. At the time of our inspection the extractor fan had not been cleaned and was full of dirt and dust. This was brought to the attention of the care manager and the covering manager's attention who were aware that this action was still outstanding and could not provide us with any evidence that the action was to be completed.

Within the same quality audits mentioned in the paragraph above, the following actions were highlighted; The July 2016 audit stated that the medicines trolleys were not secured to the wall in the ground floor treatment room. Within the audit carried out in September and October 2016 this action was highlighted again and still not completed. At the time of our inspection the medicines trolleys were still not secured to the wall. This was highlighted to the care manager and the covering manager who were unaware that this action was still outstanding and could not provide us with any evidence that the action was to be completed. The covering manager told us; "I know there are gaps it's something we really need to work on. I want to bring in new systems where the action plan is on the wall and can be seen so you know where you are." This meant that quality audits carried out at the service were ineffective.

We saw a quality assurance survey had been carried out with the people who used the service in July 2016.

The feedback from people included comments regarding the lack of opportunities to develop their hobbies and interests and the lack of activities on offer for them. From this survey an action plan was created. Within the action plan a list of completed actions stated; 'Art therapist works 8.30am till 5pm Monday, Tuesday and Fridays with a dedicated art room.' And 'Needs analysis is being completed to review staffing levels in order to provide staffing for extra activities.' At the time of our inspection the needs analysis stated in the action plan had not been completed and no additional staffing was in place. The Art therapist stated in the action plan was on annual leave for six weeks with no replacement activities in place. This meant that the actions stated as completed within the action plan had not been carried out and issues raised by the people who used the service in July 2016 hadn't been resolved.

During our inspection we looked at staffing levels and how these were being managed to meet the needs of the people who used the service. When we asked the covering manager how the staffing levels were calculated and how the evaluation of people's needs were taken into account when managing staff and producing rotas. The covering manager told us that these calculations had not been completed and explained that this needed to be carried out as the previous manager hadn't completed them. The covering manager told us; "These needs analysis need re doing, I know people's needs have changed and I want more staff, I need to assess everyone individually and the process needs reviewing." At the time of the inspection the covering manager and care manager were unable to provide us with any evidence to show this needs analysis was taking place.

We looked at rotas for the service and between the 17 October 2016 and Sunday 13th November 2016 night staff numbers fell below six which was the minimum identified by the service, on 19 occasions. When we asked the covering manager if there was a risk assessment in place to manage any potential risks with running at low staffing levels they told us, "There should be, but there isn't one in place." This meant that the service's staffing levels were not being managed appropriately.

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

We discussed partnership working to tackle social isolation with the covering manager and they explained to us that they had made some initial contacts in the community at the local church and community centre and that this had not always been maintained but this was something they were planning to build on in the future.
We saw records were not always reviewed however they were well presented, kept secure, and used in accordance with the Data Protection Act.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Peoples care plans were not always person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always respect peoples dignity or maintain their privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not supported to maintain their healthcare needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not always ensure that people could engage in social activities. Not all staff training was up to date and staff supervision and appraisals were not always carried out.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality auditing and monitoring was not always completed or effective.

The enforcement action we took:

Warning notice.