Aryaa Care Limited

Ambleside Residential Home

Inspection report

60 Hart Hill Drive
Luton
Bedfordshire
LU2 0AY

Tel: 01582454402

Date of inspection visit:
28 March 2017
06 April 2017

Date of publication:
02 October 2017

Ratings

Overall rating for this service	Inadequate

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

This unannounced inspection took place between 28 March 2017 and 6 April 2017.

When we inspected the service in August 2016, the provider was not meeting some of the fundamental standards of care. We found people were put at risk of acquired infections because the service and equipment were not sufficiently cleaned. There were not sufficient numbers of skilled staff to support people safely and staff had not received regular supervision. People had not been adequately supported to pursue their hobbies and interests. Also, the provider did not have effective systems in place to assess and monitor the quality of the service. We found these were breaches of regulations.

At this inspection, we found the provider was still not meeting these standards. In addition to this, the provider did not follow safe staff recruitment processes and was not adequately meeting people's nutritional needs.

Ambleside Residential Home provides care and support for up to 17 people with a range of care needs including those living with chronic health conditions, physical disabilities, and dementia. At the time of this inspection, 11 people were being supported by the service.

There was a registered manager in post, who is also the provider of 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.

The service was still not always adequately cleaned and this put people at risk of acquired infections. The provider did not have safe staff recruitment processes in place, and there were not always sufficient numbers of staff to support people safely. However, there were systems in place to safeguard people from risk of possible harm, including individual risk assessments that gave guidance to staff on how risks to people could be minimised.

Staff had received training, but this had not always been appropriately applied to ensure that people were not at risk of acquired infections. However, staff now received regular supervision and were supported when they required it. Staff also understood their roles and responsibilities to seek people's consent prior to care being provided and they worked in accordance with the requirements of the Mental Capacity Act 2005 (MCA).

Although people were supported by caring, friendly and respectful staff, inadequate staffing numbers meant that they did not always have opportunities to chat with staff. People were not always sufficiently supported to make choices. Although people had enough food and drinks, the food provided did not appropriately provide the nutrition they required to maintain their health and wellbeing. However, people had been

supported to access other health services when required.

People's needs had been assessed, and care plans took account of their individual needs, preferences, and choices about how they wanted to be supported. However, people told us they were bored at the service and had not been adequately supported to pursue their hobbies and interests. The provider had a formal process for handling complaints and concerns, and people were mainly happy with how their care was managed.

The provider did not have effective processes to assess and monitor the quality of the service. They had failed to make sustained improvements to areas where shortfalls had been previously identified. Where improvements had been made, the provider had failed to show that they had put systems in place to enable them to sustain the improvements they had previously made. Although the provider encouraged feedback from people who used the service, relatives, staff and external professionals, they did not always act on the feedback received to improve the quality of the service.

During this inspection we identified that there were breaches of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Furthermore, the service has been rated Inadequate in Well-led for two consecutive inspections because the provider had not taken appropriate steps to ensure that they provided safe, effective and compassionate care that met people's needs and expectations. They had failed to sustain improvements they had previously made and they did not have effective systems to continually improve the quality of the service. This meant that at this inspection, the overall rating became Inadequate. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

As the overall rating for this service is 'Inadequate', the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not always ensure that the service was adequately cleaned and this put people at risk of acquired infections.

The provider did not always follow safe staff recruitment processes and there were not always sufficient numbers of staff to support people safely.

Staff had been trained to safeguard people and people felt safe at the service.

People had individual risk assessments in place and their medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always apply their training to ensure that they protected people from risks of acquired infections. Staff now received regular supervision and support

People's consent was sought before any care or support was provided. The requirements of the Mental Capacity Act 2005 (MCA) were being met.

People had enough to eat and drink, but the food provided did appropriately provide the nutrition they required to maintain their health and well-being. People were supported to access other health services when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Although people were supported by kind, friendly and caring staff, they did not always get opportunities to chat with staff.

Staff understood people's individual needs, but they did not

always support them to make choices.

Staff did not always promote people's privacy and dignity, but they supported people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were being met in a timely manner, but they had not been adequately supported to pursue their hobbies and interests.

The provider had a system in place to handle complaints and concerns.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have effective processes to assess and monitor the quality of the service. They had failed to make sustained improvements to areas where shortfalls had been previously identified.

Although people who used the service, relatives, staff and external professionals had been enabled to routinely share their experiences of the service, their feedback had not always been acted on.

Ambleside Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 28 March 2017 and it was unannounced. It was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was completed on 6 April 2017 when we had received information we requested from the provider and reports from the rest of the inspection team. We asked the provider to send us the following information: evidence of how they supported people to pursue their hobbies and interests; a missing reference for one member of staff; duty rotas for March and April 2017; food receipts; results from the most recent survey.

Before the inspection, we reviewed information we held about the service including our previous inspection report, the report of the inspection carried out by the local authority in February 2017, and notifications the provider had sent to us. A notification is information about important events which the provider is required to send us. We attended meetings arranged by the local authority on 26 January 2017 and 14 March 2017 to discuss with the provider concerns the local authority had about the service.

During the inspection, we spoke with five people who used the service, three care staff, the deputy manager and the registered manager, who is also the provider of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for six people who used the service to ensure they were reflective of people's current needs. We also looked at three staff files for members of staff who had been employed since our

previous inspection in August 2016 to review the provider's recruitment processes. We reviewed training and supervision for all staff employed by the service to determine how robust this was. We also reviewed information on how medicines and complaints were being managed, and how the provider assessed and monitored the quality of the service so that we could identify how they used this information to drive future improvement.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in August 2016, we found the provider was putting people at risk of acquired infections because the service was not sufficiently cleaned. There was no dedicated member of staff to do the cleaning. Some of the equipment was dirty and there was not always evidence that it had been serviced. Also, there was not sufficient numbers of skilled staff to support people safely.

Prior to this inspection, we received information of concern about insufficient staffing levels and that there was an infestation of bedbugs. We shared this information with the commissioning local authority and attended a meeting on 26 January 2017 to discuss these concerns with the provider.

During this inspection, we found some improvements had been made to the cleanliness of the service. For example, the dirty and foul-smelling carpet that we found in the conservatory during our previous inspection had been replaced with vinyl flooring, the lounge carpet had been cleaned and the dirty armchairs had been replaced with new ones that could be easily cleaned. An external contractor had treated the bedbugs and daily checks by staff did not show any new evidence of infestation.

Although there was now a dedicated member of staff to clean the service during weekdays, we found they did not always clean some areas of the service thoroughly. For example, when we checked on the morning of the inspection, a toilet bowl on the third floor was stained with faecal matter. Although this had been cleaned in the afternoon, there was still a stain left at the base of the bowl. The provider told us that they treated all toilet bowls with bleach once a week to get rid of any stains, but this had not been effective in this case. We noted that the member of staff who carried out cleaning duties had been initially employed as a care worker and we were concerned that they neither had the experience nor training to carry out their cleaning role at an acceptable standard. However, we were unable to talk with them about the training and support they received because they had left by lunchtime. We also found the member of staff was unclear about their role as they told us that they were a care worker when we initially spoke with them.

People did not have any concerns about the cleanliness of the service following the refurbishment of the lounge. Staff told us that their work demands were better now that there was someone to do the cleaning, although one member of staff said that the service was still not as clean as it should be. Another member of staff said, "It was not practical doing cleaning and care. It is better now there is a cleaner because we are now focusing on one thing." However, we noted that the conservatory floor had some debris on it and of concern, neither the members of staff nor the provider who had at some point during the day entered this area seemed to notice this or sweep the floor. During the morning, this area had been used by community nurses to change a person's leg dressings and had not been cleaned following this to reduce the risk of cross infection. It was clear staff had not considered that a communal area was not the most appropriate place to carry out this task because it was more convenient to use this area than to take the person to their bedroom.

This was a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some areas of the service were cold in the morning including the bathrooms and the conservatory where the community nurses were attending to a person. The lounge became cold at some point during the late morning. We brought this to the attention of the provider who told us that the heating was on throughout the day and they said that they did not understand why it sometimes got cold. We observed a member of staff offering blankets to two people sitting in the lounge to cover their legs. One person told us that they did not have a bath very often because the bathroom was usually cold." One member of staff told us, "It does get cold sometimes." We had previously brought issues about the temperature to the attention of the provider as we were concerned that this put people at risk of cold related health conditions.

Although people told us that there were enough members of staff to meet their needs, they said that staff did not always have time to sit and talk with them because they were busy. One person said, "I get the care I need, but they seem busy all the time." Another person said, "They are always busy." This was particularly important so that people who did not have regular visitors did not feel lonely and isolated. During our inspection in August 2016, we found the provider had put people at risk of unsafe care because there were not sufficient numbers of staff to support people safely. During a meeting arranged by the local authority in January 2017, it had been agreed with the provider that three members of staff were required to support people safely, particularly in the evenings when the provider was not available to provide additional support. We had previously also found that the provider and the deputy manager were routinely counted in the numbers of care staff which meant that they were not able to carry out their leadership and managerial roles and we found this to be the case at this inspection too. For example, on the day of the inspection there were three members of staff when we arrived and this was made up of the provider, the deputy manager and one care worker. Another care worker arrived just before 11am to cook lunch as the cook was unwell that day.

Staff we spoke with told us that the duty rotas did not always reflect what happened in practice. They said that they basically had two members of staff supporting people on the days when the provider was on the rotas as the third of member of staff. We observed this during our inspection. For example, the provider spent most of their time in a downstairs office which meant that they did not provide much practical support to people who used the service. One member of staff told us, "The manager is on the rota as one of the three care staff, but she doesn't help with personal care or medication. She puts herself on the rota to make the staffing look better." Another member of staff said, "The deputy manager is just a care worker really. I don't know how she can do other work when she always works on shift with us." A third member of staff said, "Helping residents to wash and get dressed can be a bit challenging when there is only two of us in the mornings. It is much better with three staff." We looked at the planned staff rotas for March and April 2017 and found there were now mainly three members of staff planned to support people including the deputy manager, and at times, the provider. However, it was clear that any improvements in staffing numbers were not a reflection of what happened on a day to day basis and we found this continued to put people at risk of unsafe care.

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

We found the provider did not always have effective recruitment processes in place to carry out thorough pre-employment checks. We reviewed the recruitment records for three members of staff who had been employed following our previous inspection. We found there was missing information on the application forms which meant that the provider was unable to check the applicants' full employment history to ensure that they were safe to work at the service. One member of staff had applied for a position as a care worker, but had been employed as a cleaner. However, there was nothing in their file which demonstrated their change in role.

Although Disclosure and Barring Service (DBS) checks had been completed for all members of staff, the provider did not always demonstrate that they requested references from the right people to ensure that staff were safe to work at the service. We noted that for two members of staff, references had not been requested from their previous employers, with some of the references having been provided by former colleagues or friends. Also, no risk assessment had been undertaken in relation to a member of staff whose references had indicated that two previous employers would not re-employ them. Although the provider told us that they spoke with the member of staff about this, they had neither documented the content of the conversation nor sought further information from the referees. Allowing the member of staff to support people without knowing what the concerns of the previous employers were put people at risk of harm. The provider had also failed to follow their own recruitment policy which stated that if unsatisfactory references were received, the manager should decide whether to request an additional reference, whether to re-interview the applicant, whether to advise the applicant that the service no longer wished to proceed with the appointment, and whether another option was available to them.

We noted that the provider had not taken reasonable steps to ensure that two members of staff had the right to work in the United Kingdom (UK). The provider had not seen the passport for one member of staff and there was only a letter from a solicitor on file which had not been verified by the provider. For another member of staff, copies of their passport did not show whether they had a valid visa to work in the UK. The provider's policy stated that if the applicant was unable to provide proof that they were legally entitled to work in the UK, the manager should inform the applicant that the service was not able to proceed with the appointment. However, this had not been followed in these cases.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at the service and they were supported well by staff. One person said, "I'm safe. The girls (staff) make me feel safe." Another person said, "I feel safe with people around me, I don't like to be on my own." A third person who said they would rather be living in their own home told us that they were safe at the service. They further told us, "I have no choice, but be here because everyone says I can't look after myself anymore." Although another person told us that one person exhibited behaviours that put others at risk, they said that they felt safe because staff dealt with the situation quite well. They said, "They walk over to [person] and talk nicely to calm [person] down."

Staff had received training on how to safeguard people and they showed good understanding of procedures to follow to keep people safe. The provider had processes in place to safeguard people from the risk of harm or abuse including safeguarding guidance for staff and a whistleblowing policy. There was evidence that the provider had appropriately reported incidents of concern to the local authority and the Care Quality Commission. Staff had previously used the whistleblowing policy to report concerns and staff we spoke with told us that they would do so if they had concerns about a person's safety. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so.

Potential risks to people's health and wellbeing had been reduced because there were personalised risk assessments in place. These identified a variety of risks including those associated with people's mobility and increased risk of falling, eating and drinking, behaviours that may challenge others, specific health conditions, and pressure damage to the skin. We noted that the risk assessments had detailed information to enable staff to support people to minimise the risks, and they had been reviewed regularly or when people's needs changed. For example, a person's care plan and risk assessment had been amended following a recent fall. This meant that staff could monitor the person more closely when they walked using

their frame and we observed staff doing so during the inspection. People had no concerns about how their care was managed. We noted that people's care needs were met safely and that very few incidents occurred at the service.

People told us that they had no concerns with how their medicines were given to them. One person said, "I'm okay and I get my medication." We noted that people were supported to take their medicines by staff who had been trained to do so safely. The medicine administration records (MAR) we looked at had been completed correctly, with no unexplained gaps. Staff we spoke with said that people's medicines were managed safely and their competence to manage medicines safely had been assessed. The deputy manager had started completing regular audits of medicine records and they also checked stock levels to ensure that medicines were being managed safely.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in August 2016, we found records had not always been kept up to date to show that staff had received regular supervision and appraisals. During this inspection, the provider had a schedule of supervisions which gave them information on when each member of staff was due to have their supervision meeting. We saw that staff were involved in their supervision and records had been kept of supervisions that had taken place in last few months. Staff told us that they now had regular supervisions and they found these beneficial. One member staff said, "I get supervisions and I can express what I really want. I can make suggestions on how to improve the home." Another member of staff said, "Supervisions are much regular now and I can get support if I need it."

Although people were not able to tell us about the quality of staff training and whether they had the right skills to support them effectively, they said that staff supported them well. One person said, "I think some off the staff are skilled." Another person said, "The staff appear to be skilled." They further told us that they could not really comment more about this because they did not need that much support from staff. Additionally, they did not spend much time in communal areas to observe how staff supported other people, apart from during mealtimes.

Staff told us that they supported people appropriately to meet their needs because they understood people's individual needs and they had received adequate training. We noted that the provider's mandatory training covered areas such as health and safety, safeguarding, moving and handling, medicines, first aid, and infection control. Although staff told us that they applied what they had learned in their practice, we found this was not always the case as infection control and prevention measures were not always followed to ensure that people were supported in a clean environment. One member of staff said, "Training is okay and I'm sure we would get more training if we needed it to care for a resident with specific needs." Although most of the training was done through e-learning, staff told us that they had attended training facilitated by external training providers. This was confirmed by one member of staff who told us of training they had recently undertaken.

People told us that they had enough to eat and drink, although there were mixed views about the quality of the food. People also said that there was not enough variety and choice of food, and they felt that they ate the same types of food all the time. One person said, "The food is okay, but there's not much choice. If we're lucky, we might get fish and chips now and again on Fridays." Another person told us, "There is not much choice really and the vegetables are always the same. I suppose it's not what I would cook at home." A third person said, "The food I would say is moderate, with a lot of tinned stuff and very repetitive."

Staff were also not complimentary about the quality of the food. One member of staff said, "Food could be better. There are limited options and it could be prepared more from fresh ingredients rather than frozen ones. Fresh fruit is available sometimes, but not all the time." Another member of staff said, "Food seems to be mainly frozen or tinned. I have seen some fresh fruits and vegetables sometimes." Although there was a planned menu, staff we spoke with told us that it needed reviewing to ensure that there was a variety of food offered to people. They also said that it was not always followed, particularly on the days the cook was not

there. We saw that a pictorial cooked breakfast menu included bacon, but people we spoke with said that they had never had this. One member of staff told us that they had never served bacon to people and that breakfast was mainly in the form of cereals and toast. The provider told us that one person regularly had bacon for their breakfast and others were offered, but preferred to have porridge. However, we could not find evidence for this.

When we checked the food cupboards, fridges and the freezer, we noted that there was not much food available. We discussed our concerns with the provider and they told us that it was because they were due their two-weekly food delivery the following day. We asked them to send us receipts of food ordered from January 2017 so that we could check the quality and quantity of the food provided to people. Also, we noted that there were mainly tinned fruits and vegetables, tinned and packet puddings, and bottles of diluting drinks kept in the cupboards. There were no fresh fruits, vegetables or meat apart from cooked chicken slices to make sandwiches with. The rest of the vegetables and meat were in the freezer. On reviewing the receipts we received from the provider, we noted that the amount of fresh fruits and vegetables ordered were not enough to last until the next order.

When a person asked if there were no biscuits with their mid-morning hot drinks, a member of staff told us that they had had run out of these. The provider went out to buy a selection of biscuits which were then offered to people. During lunch, people were offered ice cream and tinned fruit for their pudding and a person commented that this was a 'one off' because we were there. They added, "We usually have the same cake baked by the cook with custard."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they always asked for people's consent prior to providing care and support and we observed this during the inspection. Most people were able to give verbal consent to their care and where possible, they had signed forms to show that they consented to being supported with personal care, medicines, and having their photographs taken for identification and during activities. We saw that the requirements of the Mental Capacity Act 2005 (MCA) were met for those people whose needs meant that they did not have capacity to make decisions about some aspects of their care, and they were not able to give verbal or written consent. The 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.

We also saw that when required to safeguard people, referrals had been made to the relevant local authorities so that any restrictive care met the legal requirements of the MCA, and appropriate authorisations had been received. People can only be deprived of their liberty so that they can 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).

People told us that they were supported to access healthcare services, such as GPs, dentists, opticians, chiropodists and community nurses when required to maintain their health and well-being. Two community nurses and a chiropodist visited the service on the day of the inspection. One person said, "I mentioned to the manager about my foot and she got the nurses to look at it for me." Another person said, "I can see a GP when I want and I have had the chiropodist today." A third person said, "Yes we get to see people from outside and they come here often."

Requires Improvement

Is the service caring?

Our findings

When we inspected the service in August 2016, people told us that staff did not always have enough time to sit and chat with them because they were always busy. During this inspection, people told us that this had not improved, although they all said that staff were kind, friendly and caring. One person said, "They are friendly and always have a chat whilst getting me ready in the morning, but that is about the only time they have to chat." Another person said, "I think they're kind and considerate." A third person said, "The girls (staff) are very caring. They know me very well and they sit and chat when they can." Staff told us that they really cared about supporting people in a way that made them happy and content. One member of staff described how they showed people they cared. They said, "I make residents happy and I am close to them. I want to look after them the way I would want someone to look after my mum or my gran. I get on well with all of them."

When staff could sit in the lounge and talk with people, we observed that they interacted with people in a positive and respectful manner. People knew who the members of staff were and they appeared to have developed positive relationships with them. For example, a person pointed at a member of staff and said, "That girl's manner is very nice. They all are, I suppose." Another person was delighted when they saw another member of staff and they said, "Where have you been, I have missed you." We then observed the member of staff give the person a hug and sat on the arm of the chair to chat with the person.

People told us that staff respected their views about how they wanted to be supported. They were also able to make choices about when they went to bed and got up in the morning. Although people could not recall whether they had seen their care plans or had been involved in developing and reviewing them, most said that it was their choice to come to the service and were therefore happy with the support provided by staff. They also told us that they liked that staff supported them to remain as independent as possible. One person said, "Staff communicate very respectfully with me and I'm encouraged to be independent. They know I like to wash myself." Another person said, "I have a frame and that helps me stay mobile. I'm happy with that." A third person told us, "I have a walking frame and I am encouraged to use it, but if I'm finding things a bit too much they will always put me in a wheelchair." Staff told us that they always supported people to live their lives the way they wanted to. One member of staff said, "We always make sure that people have a say in how we care for them."

However, we observed that people had not always been able to make choices. For example, we noted that during mid-morning and the afternoon, cups of tea were brought on a tray already with milk and sugar in it. This meant that people were unable to decide whether they wanted tea or coffee or whether they wanted to take their choice of drink with or without milk or sugar. When we asked why the hot drinks could not be brought in tea or coffee pots so that people could choose what they wanted, a member of staff told us that they brought ready prepared drinks because they knew what people preferred. However, they said that they would consider our suggestion for the future. Also at lunchtime, people were only offered blackcurrant diluted drink and water despite there being other flavoured drinks in the food cupboards. It was evident that people did not ask for other flavours because they did not know that these were available. We found this did not promote person-centred care and choice.

People told us that they were treated with dignity and respect, and that their privacy was protected. However, we were concerned that an external hairdresser was using a person's bedroom to do other people's hair. This was despite the service having a few unoccupied bedrooms. Although the person told us that they did not mind this, we found it was inappropriate for other people to use the person's bedroom in that way. Staff could not give us a valid explanation as to why they could not use the unoccupied bedrooms. In addition, staff did not protect the dignity of a person whose dressings were being changed in the conservatory because everyone sitting in the lounge could see what was happening.

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

When they moved to the service, people had been given information about the service so that they could make informed choices and decisions about whether they wanted to live there. A file with a variety of information about the service was available for people and relatives to look at. Some of the people's relatives or social workers acted as their advocates to ensure that they understood the information given to them and that they received the care they needed. There was also information about an independent advocacy service that people could contact if they required additional support to understand their care options.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in August 2016, people told us they were bored and had not been adequately supported to pursue their hobbies and interests. During this inspection, we found not much improvement had been made. People told us that they were mainly bored as there was not much of interest to do within the service, apart from occasional themed activities. The display board showed photographs of activities that took place prior to our previous inspection. It was on speaking with the provider that we were informed of themed activities that took place after the previous inspection. We requested evidence of this and the provider sent us photographs showing some of the people decorating cupcakes, having a Christmas meal at a local restaurant, and others either playing a card game or completing a jigsaw puzzle. Most people said that they did not particularly enjoy board and card games, with two people telling us that they preferred reading on their own. One of them said, "If I didn't occupy myself with books, I would imagine it to be very boring. I have not been out on any trips." Another person said, "It gets very boring. My hobby was gardening, but there's not much of a garden out there."

Staff told us that there was not a good and stimulating variety of activities offered within the service. One member of staff said, "Choices of activities are boring. Most residents are bored and do not want to do them. The manager asked our opinion on this, but no improvements have been made. I have seen the residents engage more when there is something interesting to do." Another member of staff said, "There is really not much for residents to do here." Staff also told us that people did not go out much. One member of staff said, "Residents sometimes go out with their relatives. The only time we normally go out with them is when they have a hospital appointment." The provider told us that they tried to take people out once a month, particularly to coincide with their birthdays, but there was no evidence of this. The provider also told us that they had a planned trip to take one person shopping to buy some clothes.

During the inspection, we observed a member of staff trying to encourage a couple of people to do a jigsaw puzzle, but only one person agreed to do this. Two other people played a game where they threw rings. A music CD was playing throughout the morning and early afternoon, but this was changed at the request of a person who said that they were fed up of listening to it repeatedly. When the television was put on in the afternoon, there was nothing of interest for people to watch and some of them fell asleep. When we asked a member of staff if they had any DVDs that people might enjoy watching, they went away and brought back a selection of DVDs. They then asked everyone what film they would like to see and people selected 'The sound of music'. It was evident that people really enjoyed this because we observed them singing along to the songs. Some people even recalled the names of the actors who were in the film and this prompted people to chat amongst themselves.

We found staff were not always creative in planning activities that people would enjoy and this was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that their individual care and support needs were met by the service and they were happy with how their care was being managed. Assessments of people's needs had been completed prior to them

moving to the service. Appropriate care plans were in place and these gave staff detailed information about each person to enable them to provide care that met people's needs, preferences and wishes. The care plans were being reviewed and updated regularly and where possible, people and their relatives had been involved in planning and reviewing these.

There was a complaints policy in place and a system to manage any complaints raised by people or their relatives. People told us that they were happy with their care and therefore, they had not complained about anything. One person said, "I would complain if it was anything major. On the whole, the girls (staff) are good." Another person told us, "I have never complained because I don't like to make a fuss, but they are very approachable if I had to." A third person said, "If I needed to complain I would tell a member of staff, but I never had to." The only person who told us that they had complained said that the provider had taken appropriate action to resolve the issue. The complaints records we looked at showed that the provider dealt appropriately with any complaints raised.

Inadequate

Is the service well-led?

Our findings

The director of the limited company that owns the service is also the responsible person and the registered manager. They had previously owned the service which was known as Ambleside-Luton as an individual until it was re-registered in January 2016.

When we inspected the service in August 2016, the provider did not have effective systems in place to assess and monitor the quality of the service. This was because they did not have sufficient time to carry out their leadership and managerial roles as they routinely took on other roles within the service. For example, they were normally counted in the numbers of care staff and occasionally cooked meals for people who used the service.

During this inspection, we found no improvements had been made to the provider's quality monitoring and audit systems, although they had made some improvements to the areas we had previously identified as not meeting the fundamental standards of care. For example, they had been improvements to the cleanliness of some areas of the service and equipment, although it was evident that the provider had not put systems in place to enable them to sustain the improvements made. Overall, we found there were continuing breaches of regulations in relation to the cleanliness of the service, numbers and effectiveness of staff, and people not being appropriately supported to pursue their hobbies and interests. We also identified new breaches of regulations because the provider had failed to follow safe recruitment procedures, people's dignity was not always promoted, and people's nutritional needs were not being appropriately met.

Although the deputy manager had started undertaking audits of medicines and medicines administration records, updated the list of tasks to be completed by night staff, and developed the 'resident of the day' schedule, no other regular audits had been completed since our previous inspection. For example, the provider did not routinely carry out regular health and safety checks to ensure that the environment where people lived was safe. Despite the continued concerns with the cleanliness of the service, the provider did not have robust systems to monitor the cleanliness of the service so that appropriate actions could be taken to safeguard people from the risk of acquired infections. This included toilets not being cleaned often enough to ensure that they were always clean when people wanted to use them. Additionally, the temperature of the service was not routinely monitored to ensure that it was always within safe levels. This meant that the provider was unable to assure themselves that they provided safe care that met people's needs and expectations. Neither could they demonstrate to us that they had put robust systems in place to fully embed the improvements they had previously made.

The lack of pro-activeness by the provider to continuously review the quality of the service and their failure to employ effective senior staff to support them in developing the service, had resulted in continuing breaches of regulations. When we shared our concerns about the unacceptably low improvements since our previous inspection, the provider told us that it was because they did not have a deputy manager. We noted that there had been two changes of deputy managers since our inspection in August 2016 and the current deputy manager had only been at the service for just over a month. The provider has had a lot of support from the local authority to help them improve the quality of the service, but this support had not been

effectively used. It was clear that the provider did not act on the advice and guidance given to them as the service has a history of not embedding and sustaining good quality care.

Staff we spoke with were also concerned that not much improvements had been made by the provider in relation to the issues we identified during our previous inspection. One member of staff said, "Food, activities and staffing needs to be really improved. More money needs to be spent to make this place better for the residents." This reflected what we found during this inspection. We further discussed other areas they thought needed improving and they said, "Furniture". They told us that the provider did not normally buy new furniture and would replace any broken pieces of furniture with second hand ones. We noted that some wooden side tables had been covered with wood coloured 'Teflon sheets' rather than them being re-vanished. This made them look cheap and unattractive. Additionally, the sheets were not firmly stuck around the wood and had the potential to harbour bacteria that could put people at risk of acquiring infections. We had also been made aware by the local authority that they had found a broken chest of drawers in a person's bedroom and a member of staff told us that this had now been replaced with 'another old one'. Another member of staff told us, "There are a lot of improvements needed. We have made some suggestions for improvements, but the manager never takes these or acts on them." We found these failings continued to put people at risk of unsafe care and we were not confident that the provider's systems were robust enough to effectively address the issues we found.

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

Although there was evidence that the provider sought feedback from people who used the service, relatives, staff, and external professionals by way of occasional meetings and annual surveys, some people were despondent about whether their views made a difference. We noted that some people could not recall if they had ever been asked for their opinion or suggestions for improvement, but some said that some improvements had been made following discussions at meetings. One person said, "They have never asked me if I would like to change anything. If they did, I will tell them it would be nice to get a cup of tea when I want it." Another person said, "I have been to a meeting and things were said, but I don't remember what they were. They know I like to read and they arranged for the library van to come and give me some books." A third person said, "I haven't been to any meetings." One meeting had been facilitated this year and we noted that the one prior to this had been in May 2016. We found this did not provide enough opportunities for people to share their experiences of the service.

We asked the provider how often they held meetings and they told us occasionally to plan activities. However, they also said that they had plans to hold these at quarterly intervals in the future. We noted that the lounge had now been re-painted following people asking for this to be done at a meeting in 2016. In line with our findings during the previous inspection, people still had mixed views about whether the service was good. Some people said that they were happy with their care, but others said that more staff, more regular activities and better food could improve their quality of life. During this year's meeting, one person said that they would like to be involved in menu planning, walks and to go out shopping, but this had not yet been facilitated at the time of the inspection. This showed that the provider did not always act on feedback in order to continuously improve the quality of the service.

There had not been a full survey since our previous, but the provider had sent questionnaires to people, relatives, staff and external professionals in November 2016 in relation to the key question 'Is the service well-led'. There had been no responses from external professionals, but we saw that the provider had analysed the other responses they received and had developed an action plan. However, it was not clear whether their planned outcomes had been met because there were no dates to show when they should be

completed by. This meant that the provider could not easily monitor whether they had made any progress.

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 9 HSCA RA Regulations 2014 Person-centred care People had not been adequately supported to pursue their hobbies and interests.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity had not been always promoted.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was not always a variety of food provided to maintain people's health and well-being.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home was not adequately cleaned and this put people at risk of acquired infections.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effect systems in place to assess and monitor the quality of the service. They had failed to make sustained improvements to areas where shortfalls had been previously identified.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always follow safe staff recruitment processes and this put people at risk of harm.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff to support people safely.

The enforcement action we took:

The service has been placed on 'Special Measures' while we consider other appropriate enforcement options.