Ashill Lodge Care Limited

Ashill Lodge Care Home

Inspection report

Watton Road
Ashill
Thetford
Norfolk
IP25 7AQ

Tel: 01760440433
Website: www.ashill-lodge.co.uk

Date of inspection visit:
12 December 2017
14 December 2017

Date of publication:
08 March 2018

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?	Requires Improvement

Summary of findings

Overall summary

Ashill Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashill Lodge provides accommodation and personal care to a maximum of 20 older people, some of whom may be living with dementia. Bedrooms are arranged over two floors with a stair-lift between them. This makes parts of the home unsuitable for, and inaccessible to, people with significant difficulties with their mobility.

There were 14 people using the service when we inspected with one additional person accommodated each weekend. We inspected on 12 and 14 December 2017 and the first day of our inspection was unannounced.

There was no registered manager in post, the previous registered manager having left the home before our inspection. They were in the process of cancelling their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 (HSCA) 2008 and associated Regulations about how the service is run.

The provider of the service had appointed a new manager who had submitted a successful application to register with CQC. However, shortly after our inspection visits and while this report was being drafted, the new manager left the service. This meant that the director, who was the provider's Nominated Individual with CQC, was responsible as a registered person, for ensuring the satisfactory operation of the service.

The new provider registered with us on 6 February 2017 when they took over the service. This was their first inspection. We acknowledged the very poor standards the new provider found when they started to run the home and that they had made some progress. However, we found that improvements were still needed in all areas.

There were concerns about how people's safety was promoted. Risks to people's safety were not always properly and fully assessed. This included arrangements in an emergency such as a fire. Although staff understood how to administer medicines safely and completed records showing they had done so, people's medicines were not always managed safely. Sometimes people were left without the medicines they had been prescribed.

The director of the service had plans to develop and improve the premises and had already improved some of the décor. Major works to control infection were needed and scheduled. However, there were some areas needing addressing as part of routine day-to-day management.

These concerns represented a breach of Regulation 12 of the HSCA 2008 (Regulated activities) Regulations

2014 for safe care and treatment.

Staff recruitment measures were not robust enough to properly contribute to protecting people from the appointment of staff unsuitable for care work. Appropriate checks were not completed to promote safe recruitment decisions and contribute to safeguarding people from the employment of unsuitable staff. This was a breach of Regulation 19 of the HSCA 2008 (Regulated activities) Regulations 2014 for fit and proper persons employed.

There were systems for monitoring when staff needed to complete training so shortfalls could be addressed. However, staff were not always properly supported, including through supervision and when they were new to the home, to ensure they could support people effectively. This was a breach of Regulation 18 of the HSCA 2008 (Regulated activities) Regulations 2014 for staffing.

People's needs were not always properly and fully assessed and planned for. They were not always involved in planning their own care and their preferences were not always taken into account. People's social and recreational needs were not met. They described themselves as bored and staff were concerned some people were becoming isolated. This was a breach of Regulation 9 of the HSCA 2008 (Regulated activities) Regulations 2014 for person centred care.

There had been a period of stable leadership but this had changed. This compromised the way that the necessary improvements were identified, embedded in practice and sustained. Systems for monitoring the quality and safety of the service and for identifying and addressing risks were not always operating effectively. Action was not always taken promptly and robustly to identify shortfalls and address the failure to meet regulations. This was a breach of Regulation 17 of the HSCA 2008 (Regulated activities) Regulations 2014 for good governance.

The statement of purpose for the service had not been kept up to date and accurate. This was a breach of Regulation 12 of CQC (Registration) Regulations 2009.

You can see what action we have told the provider to take at the back of the full report.

Although not always well documented in care records, staff understood the need to seek people's consent to deliver care in line with the Mental Capacity Act 2005. They recognised the importance of acting in people's best interests. The manager understood the Deprivation of Liberty Safeguards and when applications were needed to protect people's rights.

People had enough to eat and drink. Although choices were not always made clear to people, staff ensured they had access to something to eat that they would enjoy. Staff also promoted other aspects of people's health to ensure they received advice from relevant professionals about their wellbeing.

Staff treated people in a kind and compassionate way. However, they recognised they were not always able to attend to details and "niceties" about people's care that would contribute to promoting their self-esteem. They treated people with respect for their privacy and independence and also understood their obligations to report any suspicions of harm or abuse.

There was a system for managing people's complaints. However, the changes in management arrangements may influence people's awareness of who they should raise their concerns with.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety and welfare were not always properly assessed. This included measures to promote their safety in an emergency such as a fire.

People's medicines were not always managed safely and they were sometimes left without the medicines they required.

There were some risks that any outbreak of infection could not be properly controlled.

Staff recruitment measures were not robust enough to properly contribute to protecting people from the appointment of staff unsuitable for care work.

Staff understood their obligations to report any suspicions people are at risk of harm or abuse and people felt safe with them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive appropriate support to ensure they were competent to care for people properly.

People's needs were not always properly assessed, although staff knew what help people needed.

Although not always well documented in care records, staff understood the need to seek people's consent to deliver care. The manager understood the Deprivation of Liberty Safeguards and when applications were needed to protect people's rights.

People had enough to eat and drink although choices were not always made clear to them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported to express their views and make decisions about their day-to-day care.

Staff were kind and compassionate to people but were not always able to attend to details about people's care that would contribute to promoting their self-esteem.

Staff treated people with respect for their privacy and independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not always properly assessed, planned and delivered in a way that took into account their individual needs and preferences.

People lacked opportunities to join in meaningful activities that reflected their hobbies and interests.

There was a system in place for managing people's complaints although, with a lot of management changes, they were not always clear who they should speak to.

There was a lack of guidance for staff about how they should support some people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Changes in the leadership of the service compromised consistency and a clear vision for developing the service that staff felt a part of.

Systems for monitoring the quality and safety of the service were not robust enough to ensure regulatory requirements were met.

Some improvements had been made and were ongoing. These were not yet fully implemented and embedded to show sustainable progress in improving the quality of care people experienced.

Ashill Lodge Care 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 was the first inspection of the service.

The inspection visits took place on 12 and 14 December 2017 and the first day was unannounced. It was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the service, we reviewed all the information we held about it. This included concerns raised with us and information from the local authority safeguarding and quality assurance teams. We also reviewed statutory notifications made to us. These relate to information about specific events taking place in the service and which they have to tell us about by law.

During our inspection, we spoke with six people using the service and one visitor. We also spoke with the company director, the manager, deputy manager, three members of the care team and a member of catering staff. We reviewed records associated with the care of four people, including daily notes, assessments of risks to which they were exposed and guidance for staff about support each person needed. We checked records of recruitment for five staff, systems for managing medicines, and a sample of records associated with the quality and safety of the service. We looked around the home and observed how staff interacted with people and supported them. We also received feedback from two health professionals.

We asked for the manager to supply us with an updated list of staff training during the day following our second visit. This information was supplied promptly when we reminded the manager and director.

Requires Improvement

Is the service safe?

Our findings

The safety of the service needed to improve. Risks to people's safety and welfare were not robustly assessed. Information was sometimes incomplete or inconsistent. It was not always clear about guidance for staff to follow to minimise risks and promote people's safety. However, staff could tell us about risks to people's welfare.

A visiting health professional was satisfied that staff understood risks associated with people developing pressure ulcers and used pressure relieving equipment appropriately. However, care records lacked clarity, consistency and guidance about risks. For example, we found that one person's assessment of risk for their skin breaking down was not fully completed to indicate the level of risk. The same person had a section within their care records showing "My personal safety risks." This was largely blank.

We checked the person's records for repositioning and assistance with personal care. The person's records showed they were to be supported to move every two hours in the daytime and every four hours during the night. However, there was no record of support or refusal for a period of four hours during the afternoon of the first of our visits and there was no information about assistance to change position during the night until 8.10am on 13 December 2017. Their care plan was not sufficiently detailed to determine their expressed wish not to be woken if they were asleep.

Staff recognised that the person was at high risk of developing pressure ulcers and had already done so as they were becoming increasingly unwell. The person understood the risks of refusing assistance to maintain their skin integrity and was able to express their views. This was confirmed when their care was reviewed and discussed with them by a professional involved in monitoring their placement. Staff told us how they would try to explain risks before leaving the person in the same position but records did not always show they were offered the support. Some showed refusal of assistance but practice was inconsistent and needed to improve to show that risks were properly managed.

Measures to ensure people's safety within the home and in the event of an emergency needed to improve. There was a box containing emergency information about evacuating people safely in a fire, by the fire panel in the entrance hall. However, this lacked personal emergency evacuation plans for five of the 15 people who used the service. There was therefore a lack of guidance about emergency arrangements for getting them safely out of the home.

There was emergency information for staff to refer to in the event of a fire. This provided for an assessment of where people usually spent their time in the home. This should help staff to prioritise their checks and to support people to leave the home safely. We found that some of the information recorded that people spent their time in the car park. This was the assembly point and not where people spent much of their day. The information was not properly completed to constitute personal emergency evacuation plans. It did not therefore properly guide staff about the action they should take. A staff member spoken with was very unclear about their responsibilities in an emergency such as a fire.

The safety of systems for medicines management needed improvement. One staff member interviewed during the first of our inspection visits, told us they were currently training to manage medicines. They told us that they observed others to learn how the system worked and were then observed themselves so they could be signed off as competent. The training matrix showed that they completed their 'in house' training on the second day of our inspection but they were already responsible for medicines administration before that day. However, they were able to describe clearly the processes that they followed to ensure people received their medicines correctly and in a safe way.

There was a declaration for staff to sign that they would abide by the medicines management policy. This was contained within the medicines administration record (MAR) file, but was largely incomplete, including in relation to staff we were told were authorised to administer medicines. We found a further copy for staff to sign but this was partially complete and presented a risk of confusion. The system was disorganised for showing who was responsible for medicines, what their usual signature or initials were, and that they understood the policy for administering medicines.

We found that three people had not received some medicines because they were out of stock. For example, one person did not receive pain relieving medicine they were prescribed, but which could have been secured over the counter if there were problems with the pharmacy supply. This was recorded as not given because it was out of stock from 1 December to 11 December 2017 inclusive. Another person had a medicine to assist with constipation, unavailable for the same period. These people therefore did not did not have access to the medicines prescribed for them and where the home took responsibility for obtaining and managing their medicines.

One person's MAR showed a medicine prescribed for one or two tablets twice a day. There was no guidance or confirmation in their MAR to suggest it was for use only when needed (PRN) and no indication it was discontinued. Their chart therefore showed that one or two tablets should be given regularly. The MAR showed none were supplied at the beginning of the month and there was nothing to indicate whether any were carried forward. This presented a risk that the person did not have access to the medicine they needed. There was no guidance for staff to follow if it was intended as a PRN medicine, when they should consider using it and why.

There was guidance for staff about the use of paracetamol to relieve pain on a PRN basis. People were prescribed two tablets to be given at each dose. The home's guidance said that people could receive a maximum of eight doses in 24 hours. It should have stated a maximum of eight tablets in 24 hours, not eight doses. Although staff spoken with knew the maximum number of tablets people could have, written guidance was inaccurate and presented a potential risk of misinterpretation and overdose.

Another person was prescribed an alternative pain-relieving medicine that could be used at the same time as paracetamol. However, there was no guidance for staff to consider which of them they should consider administering first and why.

For one person prescribed a pain-relieving patch, there was no body map in place to show where staff applied the patch. Staff could not therefore easily check that it remained in situ when they delivered personal care. Arrangements therefore compromised how promptly they could check with the prescriber if it became detached between the weekly applications. Likewise, staff could not be sure they were applying it in different places to avoid potential skin problems and that they always removed it at the end of the week before applying a new one.

Staff had dated the majority of medicines packages or bottles when they were opened to ensure they

remained safe and effective to use. However, we found two medicines administered via aerosol inhalers that were undated although the box seals showing they were opened. These lose their effectiveness after time and so need monitoring to ensure they remain useable. One person had two bottles of identical eye drops that were opened. Both were dated but as both were in use this meant that both were at risk of contamination at the same time. There was an open tub of a skin cream without any date showing when staff opened it. Creams in tubs are at risk of contamination and so should be dated so they can be disposed of within recommended timescales.

One person was prescribed a tablet to be taken early in the morning and at least two hours before another medicine. We saw that night staff gave the medicine during their shift to ensure the person received it early. However, they did not record the actual time of administration to show exactly when they had given it. This meant that day staff could not be sure they always allowed two hours to elapse before they gave the other medicine, risking side effects and adverse reactions.

There was a supply of medicines in a cupboard used for returns, which the deputy manager told us had been sent in error by a hospital. The person named on them did not live at the home. The deputy manager told us they had contacted the hospital about return but they had not arranged it. In the meantime, the presence of these medicines in the home was not recorded or accounted for. This placed them at risk of misuse or misappropriation pending disposal.

These concerns represented breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, for safe care and treatment.

People were satisfied with the way that staff supported them with their medicine. All but one person said staff waited with them while they took their medicine. One person said that staff left their medicines with them to take when they were ready. For example, one person said, "I like the idea that they help you with your medication. I would sooner them do it so I don't make a mistake." Another person told us, "They [staff] stand at the table and watch me take my medication." One person commented to us, "They give me tablets that upset my stomach. I think they over prescribe." However, the responsibility for prescribing rested with their doctor. They needed to discuss it further with their doctor, with staff support if necessary.

We noted that records of medicine administration were complete and showed which staff were responsible for giving them.

The provider intended a programme of major works to extend the home and then to provide for better infection control measures. They had already refurbished one area to provide a 'wet room' on the first floor of the home. Floor coverings were intact and properly sealed so that they did not harbour germs.

We noted that, in the wet room, there was a shortage of personal protective equipment immediately accessible for staff to use when they assisted people with personal care. However, a member of ancillary staff showed that this was available in a cupboard through another nearby door. We considered that storage arrangements would benefit from review so that the equipment was available at the point of use and supplies could be more easily monitored.

The provider's representative described how they had not yet been able to address concerns about infection control in the ground floor bathroom because it was needed for regular use. They explained that refurbishment and extensions due to progress in six to nine months would improve facilities. However, there were some concerns about infection control measures that needed addressing more quickly. We found a very strong odour associated with difficulties managing continence and which needed addressing in one

part of the home. We also noted a split covering to a commode seat exposing foam filling. This risked harbouring germs.

Staff told us that people shared slings when they used the hoist rather than having been assessed for and provided with their own. Staff also told us that there was only one support sling for using with the 'stand-aid' used for some people. They were not able to tell us about the expected laundry arrangements for slings, presenting the potential for cross-infection.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, for safe care and treatment.

People were satisfied with standards of cleanliness around the home. For example, one person said, "They [staff] keep everything lovely and clean." Another said, "Yes they clean my room. I've no complaints about it." A third person confirmed that staff had just been in to ensure their room was clean and tidy. We found that most areas of the home were visibly clean with access to wash basins, soap dispensers, paper towels and antibacterial gel. There was also a staff member allocated as an infection control lead. That staff member assessed the important area of hand hygiene among their colleagues as a key method of controlling and preventing the spread of infection. Staff were able to describe in detail how they were managing a health care associated infection and promoting good hygiene practices.

We noted that the director had identified a concern about the inappropriate conduct of two staff members between our inspection visits. The director needed to make arrangements to monitor ongoing performance because the manager left shortly after our inspection visits, while the inspection report was being drafted. The director needed to ensure they implemented robust and fair processes to ensure the staff involved remained suitable for employment within the service.

Recruitment measures were not sufficiently robust and did not ensure full checks were completed before staff were appointed. All of the recruitment records we reviewed showed shortfalls. We were concerned at the failings in recruitment measures since the provider took over the service and a lack of awareness about what the law requires. Practices were not robust in contributing to safeguarding people from the employment of staff who were not suitable to work in care.

There was conflicting information about applicants' employment histories. For example, information about one staff member said that they were unemployed at the point they applied to the service. However, the curriculum vitae (CV) they supplied said they were working in another care service. There was further information for the same staff member indicating recent employment at a second care service. Neither of these services had been contacted for references to establish satisfactory conduct in those caring posts. A referee described as the staff member's last employer was not for the care service they told us they were working at and included in their CV. The conflicts in the information were not properly explored and accounted for.

For another staff member we found their "contract for casual employment" gave a start date of 24 July 2017. The person had completed their 'in house' induction at the home between 1 and 8 August 2017. However, neither of the staff member's references was obtained at that point to check their conduct and background. Those received were dated for 22 September and 5 October 2017, almost two months after they had already started work.

One staff member's file showed a reference request in May 2017 was chased up in September 2017. This was more than three months after the staff member started work in an ancillary role. For yet another staff

member, dates in their file showed they had completed their induction working in the home before their enhanced disclosure with the vetting and barring service (DBS) was completed. The director could not therefore be sure that the applicant was not barred from working in care. They could not be sure that an applicant did not have a criminal record that might make them unsuitable for the work or required a risk assessment to promote people's safety.

In none of the records reviewed, was there any indication prospective staff completed a declaration about medical fitness or about criminal records before their detailed checks were completed. There were no photographs of staff on file. There was no application form in use to prompt prospective staff to provide the information required by law. This included the provision of information about health, a full employment history and an account for any gaps in their working lives. The dates of employment in previous posts and reasons for leaving were not all recorded.

These concerns were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, for fit and proper person's employed.

During the course of our second inspection visit, the manager showed us the application form and checklist they had drawn up to ensure recruitment practices improved. This covered the information required and now needed to be implemented.

Residents felt there were enough staff to support them safely. For example, one person told us, "There seems to be a lot of staff here, you don't have to wait very long for someone to come and help you if you need them." Another person said, "I feel safer here than in hospital. There is always someone around to keep an eye on me and they come quickly if I need them." A third person explained, "I like someone with me when I am getting dressed in case I fall and they always come and help me."

However, the reported and rostered staffing levels supported concerns raised by the ambulance service. They were concerned about the adequacy of staffing when they had needed to attend to an emergency during the afternoon and found only two staff on duty. There were only two staff rostered to support people from 2pm to 5pm. A third member of staff arrived at 5pm but needed to prepare tea for people when they first reported for duty. If they needed to assist colleagues in delivering personal care before they finished this there was a risk to food safety.

Staff told us that the manager or deputy manager would assist if they were asked. However, they were not always available on the premises, particularly outside office hours or at weekends. We discussed staffing levels with the staff on duty who shared our concerns about how people's needs were met during the afternoon. They told us that sometimes people had to wait for assistance. They said that, of the 15 people who received either permanent or respite care, about seven people needed assistance from two staff to move and transfer safely. A further two people needed assistance from two staff in order to change their position and manage the risk of pressure ulcers. A staff member described to us that they were not always able to provide assistance to move promptly within the required time limits and records confirmed this.

As there were only two staff on duty for part of the afternoon, who were entitled to a short break if they were working long days, this compromised the way that staff were available to attend to people and ensure their safety. It also compromised how they were able to attend to people's social and emotional needs properly. The director and manager told us they used a 'dependency tool' for the purposes of assessing the staffing levels that were required. However, this took no account of people's social and psychological needs. It did not take into account how people living with dementia may respond to staff and need additional time to deliver their care as well as ensuring they did not present a risk to themselves or others.

During the second of our inspection visits, the manager ensured an additional member of staff covered the afternoon period for that day. The provider assured us this would be arranged on other days to ensure there would be three staff on duty and that they would explore other methods for reviewing staffing levels and people's dependency.

People told us that they felt safe at the home. For example, one person told us, "I feel safer here than in hospital." Another person told us, "Nobody hurts you. Nobody says anything nasty…if they [staff] get me out of bed they tell me they won't let me fall." One person did express a contrary view about how they felt a particular member of the staff team treated them. However, we reviewed how these were addressed and that there was no one fitting the description of the staff member, which the person gave. We concluded from this review that the person may be confused or disorientated at night-time and staff may need to be sensitive to this.

Staff confirmed that they completed training to enable them to recognise and respond to suspicions of harm or abuse, so they would know how to safeguarding people. Training records confirmed this was the case. Staff told us about the kinds of things they would consider abusive and understood that they must report their suspicions. The manager was aware of obligations to report suspicions of abuse to the safeguarding team and to notify the Care Quality Commission. The provider had a clear policy guidance about the obligations of staff and the duty of managers should there be any safeguarding concerns.

The manager and administrator raised one concern with us. This was an example about use of a person's money held for safekeeping arising before the current manager took up their post. A small amount of a personal allowance had been used to subsidise petty cash and could render the service liable for an allegation about financial abuse. The administrator recognised this as problematic. They ensured that the person had been reimbursed. We discussed with the manager and administrator that, regardless of how clear records were, there must be no such use of people's personal monies to subsidise either petty cash or one another. We have also made a member of the safeguarding team aware of this.

It was difficult to evaluate systems for analysing incidents and implementing improvements as the result of lessons learned as the service had only been operating under the current owners since 6 February 2017. This was further compromised by changes in the management team presenting a lack of continuity and stability in how systems were developed and embedded.

Requires Improvement

Is the service effective?

Our findings

The effectiveness of the service people received needed improvement in a number of areas. There had been considerable recruitment following the change of provider and an increase in numbers of people using the service. This, and changes in management arrangements, compromised how effectively training and supervision could be delivered to ensure staff were fully competent in their roles. The process for assessing people's needs and choices and planning appropriate care was not effective.

People spoken with did not express any clear views about whether they felt staff were competent to support them. However, they did say that they were happy with the staff and felt that staff treated them well. For example, one person said, "I feel really well looked after here."

We found that arrangements for developing and monitoring staff, including through induction and supervision, needed improvement. One staff member employed for "three or four months" said they had completed some training with their previous employer, but lacked confidence in what this covered and said they had only worked in care for a short time. They said the administrator for Ashill Lodge provided printed workbooks for them to complete and the training records confirmed this. However, the same records showed they had not completed any of the practical training delivered by external trainers. They described having been shown how to use the hoist by colleagues although there was nothing to confirm proper evaluation of their competence in using the equipment. They had not completed the practical training to do this effectively. They were also missing practical training in first aid and falls prevention. This was despite supporting people who were at high risk of falls and had a history of falls.

The staff member described completion of a "few days shadowing" more experienced colleagues. They told us that they felt they were learning something new every day and were always asking questions. However, they also said they felt that staff would benefit from learning how to manage and support people who were living with dementia. We found that the training record listed this as available through workbooks. However, the list showed that some members of the care team were not identified as needing to complete it at all. This was despite the service supporting people who were living with dementia. The majority of staff had not completed training in dementia awareness and so did not have the underpinning knowledge to respond to people well who experienced cognitive difficulties.

There were gaps in practical training in fire safety for staff. We found that not all staff were identified as needing this training when we considered everyone employed should be aware of their responsibilities. We found from discussions that not all staff were confident about the action they needed to take if a fire broke out, to support people effectively and safely. There were also gaps in training for staff in moving and handling. The training matrix showed that the completion of workbooks for safe handling of medicines was required for the role of 13 staff but only one had completed it.

Training records did not show evidence that staff had completed the Care Certificate either at the home or in previous work in care services. The Care Certificate represents a proper process for delivering induction and training for staff, as well as checking competence, when they first take up posts in care.

Some staff told us that they needed to complete the workbooks issued and evaluated by the training provider in their own time. They lacked clarity about whether they were paid to do this and how much time would be provided for completion. This was despite the responsibility of registered providers and managers to ensure staff are competent in their roles and to be clear about arrangements for staff training.

We spoke with a health professional who had delivered training in an aspect of supporting people with diabetes. They described some confusion in the allocation of staff to attend the training so attendance was poor and some staff were reluctant to attend. We concluded this was likely because the manager was newly in post. The date and time of the training had not been properly shared so staff were aware of it and allocated to attend.

Staff told us that there had been a lot of changes in the service but most felt they could seek informal advice and support from the manager. However, formal mechanisms for reviewing staff performance and development needs through supervision were lacking, leading to inconsistent support for staff. All of the care staff spoken with confirmed shortfalls in this area and records confirmed what they told us.

One staff member told us, "We are supposed to have supervision. Mine was supposed to be last week but there was no time to fit it in." They explained they had completed the three month probation period stated in their contract, but had received no supervision during that time. Another staff member told us they had formal supervision with the new manager recently but that was the first they had since starting employment around four months previously. They said they thought they were monitored during their three-month probation period. However, they told us there were no formal discussions with them about how well they were doing or whether they needed to improve anything.

A third member of staff in post since February 2017 said they had received only one formal supervision since they started work. They also told us that they had completed their probation period but had received no feedback about their performance, areas to improve or training and development needs. This presented a concern that staff would 'drift' into employment on a permanent basis with no proper, organised evaluation of their performance and skills. Changes in the management arrangements within the service raised concerns about how improvements could be made.

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

We found that care plans were not holistic and information was not always accurate. For example, one person's care planning information contained two separate and conflicting dates of birth for the person. This presented concerns that inaccurate information could be shared with other health providers or in the event of a medical emergency. The same person had three separate versions of "Do Not Attempt Cardio-Pulmonary Resuscitation" on their file, lacking clarity about when and how the relevant parties were involved and what was the most up to date.

There was conflicting information for the person about their falls risk, stating that the person had impaired balance. However, on discussion with the management team, they were not weight bearing and they told us the person had not been weight bearing since they were admitted to the home. This meant the information did not clearly document their needs and the support they required. For another person, their "handling assessment" lacked clarity about how staff were to support them with their mobility to deliver support that was consistent with their needs. For example, this said that they could use their frame, get in and out of bed, on and off their chair, all with the "assistance of one or two staff." Their information labelled "My mobility" said that they could do these things with two or more staff. The level of assistance required was not clearly

expressed together with guidance about how staff should were expected to provide it.

Assessments lacked clarity in showing people's individual needs and preferences, including their social and spiritual needs. The director had identified that all care plans needed to be checked and updated to ensure they properly reflected people's needs. They showed us one that was supposed to have been completed properly but this again lacked detail and a holistic approach to assessing needs.

We noted that a member of the quality assurance team from the local authority had provided support and advice to the management team about assessments and completing appropriate care plans. The information the quality assurance office showed us took into account best practice and provided examples for staff to follow to improve the process. The management team agreed that they now had a clearer idea about the process of assessing and planning to meet needs following the provision of this advice. They said they had not yet had time to implement it. The director agreed that considerable improvements were needed to the assessment of people's needs and choices and planning how to meet them. They told us they felt their initial timescale for action to be completed had been over-ambitious but they were reviewing it further. However, staff spoken with were able to tell us about people's needs so they could deliver appropriate care.

Care plans lacked clarity in about people's nutritional needs. For example, we found that one person's records from hospital when they were admitted showed they were at risk of weight loss and had dietary supplements. The home's sheet labelled as for their nutrition showed staff should encourage a high calorific and fortified diet but did not refer to prescribed supplements. Part of their guidance from September 2017 said that, due to weight loss, staff should increase monitoring and weigh them weekly. The person refused to be weighed in October but there was no guidance about an alternative measure such as their mid-upper arm circumference (MUAC) for future use, to determine whether their weight was stable. However, for another person, also at high risk of poor nutrition, we could see that there was better information and they were checked regularly. Staff were able to tell us who was at risk and needed additional support and encouragement. We therefore concluded that people had enough to eat and drink.

The mealtime routine on the first of our inspection visits, was not well organised. Staff provided one person, who did not want to eat their main meal, with a sandwich but left the meal they refused next to them. The sun was low and shining very brightly through a large window. We were concerned that this was not recognised as having the potential to cause mobility difficulties as well as discomfort. The light shining directly in people's eyes made it difficult to see properly when entering the room and for those people who were sitting opposite it. However, on the second of our inspection visits, a blind had been fitted.

During the first of our visits, there was no alternative offered for the main meal. The menu was sweet and sour chicken with mashed potato and a dessert of Angel Delight. The cook had confirmed that, as the occupancy is under 20, they did not routinely provide a choice of meal. They told us however, if a person did not like what was on offer, they would prepare something else. People told us that they did not get a choice but that staff would make them something different if they did not like their meal. One person told us, "I get enough to eat and drink. You don't get a choice but I will eat anything." Another person said, "Touch wood they have not dished up anything I don't like … I know staff would get me a sandwich, I had one in the early hours one morning." A third person commented, "The food is ideal, I haven't had anything I don't like." A visitor to the home told us, "The food is brilliant. [Person] always clears the plate. They don't give a choice but I have seen them make something else if someone doesn't like what is on offer."

We saw that one person showed no interest in the meal presented to them. A staff member asked the person if they were going to eat but there was no response. The staff member went into the kitchen to

discuss this with the cook. They said, "In the last couple of days [person] has not been eating much." The cook made the person a jam sandwich, which they eventually ate. Another person asked what the meal was and staff said, "We've got sweet and sour chicken. Are you okay with that?" The person said they did not know, as they had never tried it. Having taken a mouthful, they said they did not like it. The deputy manager offered to get them an omelette. The person was served scrambled egg on toast, which they ate eagerly. We discussed with the management team that scrambled egg was not an omelette. They told us this was what the person normally meant when they accepted omelette and they knew that they enjoyed scrambled egg. We observed that two people were given their dessert with tinned fruit. However, staff did not offer a choice of fruit or ask people whether they would like to have fruit at all with the dessert.

Mealtimes could be improved to make a more social occasion. For example, we noted that there was little conversation between staff and people using the service, other than encouragement to eat. However, staff did check that people had finished their meal before clearing plates and offering dessert. One person also told us how they felt staff understood what they liked to drink, and having asked for coffee with milk, that was how staff now made it for them.

On the second of our inspection visits, and despite there being no more people living in the home, there was an alternative main meal displayed so that people could make a more meaningful choice. The cook was able to tell us who needed their meals prepared in a particular way to avoid choking risks and who was diabetic needing attention to their diet.

The service worked together with other professionals to contribute to ensuring there was a coordinated approach to people's care. We spoke with a visiting health professional who said they felt that staff were able to answer their queries and give them the information they needed about people's wellbeing. We also noted that, for one person, requiring regular hospital treatment, the service shared information about the person's risks and mobility needs. This included information about pressure ulcers so that hospital staff could offer the appropriate support and were aware of the person's other problems, in addition to those they were treating.

People were confident that staff would enable them to seek advice about their health and wellbeing when they needed it. For example, one person told us, "If I don't feel well they will soon call the doctor and they come fairly quickly." Another person said, "The doctor comes if you need them. The staff will call them out." They said that the chiropodist came to support them with care of their feet. We saw that the district nurse was regularly involved with some people. A diabetic nurse specialist was also contacted where there were specific issues, including training needs.

The provider's plans for developing the service included increasing accessibility. This was a long-term project and had not yet progressed but would improve facilities for people when completed. We discussed with the manager the importance of properly considering people's mobility when they accepted placements. This was because the first floor was not accessible to anyone who was not able to use the stairlift. Anyone living on the first floor who became unwell and unable to use the lift, would not be able to access communal areas and company on the ground floor.

There were signs on doors to tell people which rooms were bedrooms or toilets and bathrooms. However, signs on people's bedroom doors were not personalised to help people orientate themselves. The manager told us about the plans they had to revise these so that people with cognitive impairments would be more able to find their way around.

We found that there was a 'chandelier' ceiling light in the hallway needing replacement bulbs to improve

lighting for people with a visual impairment, as some of these were not working. Natural lighting in that area was limited.

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.

People told us that staff asked for their consent before delivering care. For example, one person said, "The staff always ask me before they touch me or help me. There's no need really but it is nice." Another person told us, "They always ask me before they help me."

Care plans were not always clear in how they reflected people's capacity to understand and make decisions about specific aspects of their care and to reflect proper implementation of the MCA. Staff therefore lacked proper guidance within care records about how to support individuals to make specific decisions before taking action they considered was in people's best interests. However, staff understood the importance of respecting people's wishes but also where care might be essential for people's wellbeing. They described how they explained to people what needed to happen and how they were flexible in their approaches. Where people refused they described how other staff members would try to secure the person's agreement and how different approaches at another time of day was frequently successful.

The manager was able to explain to us how they considered people's abilities to understand essential aspects of their care. We could see that the service had involved a person's family and doctor in discussions about the person's wish for treatment and arrangements if they needed to attend hospital. This showed how the person's capacity to understand decisions about their care was considered. Their care records reflected discussions about their best interests, depending on the circumstances surrounding any proposed treatment.

The manager understood when applications should be made and the requirements relating to DoLS. Applications had been made predominantly by the previous manager to ensure that any restrictions on people were lawful. The outcomes of most of these were awaited.

Requires Improvement

Is the service caring?

Our findings

Improvements were needed to the way people were supported to make choices about their day-to-day care and to ensure their dignity and self-esteem was consistently promoted.

During the first of our inspection visits, we noted that one person was wearing a stained jumper and had a lot of dandruff on their collar. Another person had a marked coat and trousers. Later in the day, staff had attended to this and the situation had improved on the second day. We also saw that, on the first day of our inspection, another person had worn and chipped nail varnish and their fingernails were not clean underneath. One staff member told us that, when they had time, they helped people with manicures. Some of the women using the service had facial hair and could benefit from additional attention to help promote their dignity, although they did not express concerns to us. Staff told us that they felt sometimes staffing levels meant they could not attend to what they described as the "niceties" of people's care.

One person said that staff tried to respect their wishes when staffing constraints allowed. They told us, "I find it embarrassing when the young girls come to help me. I ask how old they are and if they are really young I tell them to go away and send someone older. They now seem to try and send a male carer or someone older." Others accepted that they had limited choices about what went on. For example, one person said, "I am not given a choice of when I go to bed or who I want to help me but I am not really bothered … it is how it is and you just accept it." Another person told us, "I don't get much of a choice of anything I just fit in with what they want." One person said, "They let me stay in my room but I can't think of anything else they have helped me with, although they did get me a TV for my room which was nice of them." One person told us, "I just do what I am told."

However, people were not critical of the attitudes and approach of staff. We saw that staff treated people in a kind and compassionate way and people spoke positively about the staff. For example, one person said, "It is lovely here. They [staff] are ever so nice; they would do anything for you." Another commented that, "I didn't think it would be as good when I first got here but it is marvellous really." One told us that staff were affectionate towards people and sometimes gave them a cuddle when they needed and wanted it. A visitor complimented the approach of staff and said, "The staff are really lovely with my [family member]. They treat [person] really well."

One person singled told us how a particular staff member promoted their independence. They said, "If I had a choice, I would always have [named staff] looking after me. I wouldn't have anyone else. [Staff member] stands back if I don't need them and is there if I do."

People also told us how staff respected their privacy. For example, one person told us, "The staff cover me up when they help me to get washed." Another explained, "The staff take care to cover me up and shut the doors and close the curtains when they help me to get dressed." A third person commented, "They [staff] say 'let's cover you up to keep things private.' I like that. They don't leave you standing around naked, they get it done quickly."

A visiting professional felt that one staff member, subject to some insults while the professional was providing treatment, dealt with this calmly and in a reassuring way. One person became upset and anxious when we were present and while talking to the manager. The manager spent time with them, getting down to the person's level and sitting with them offering gentle touch and reassurance until they became calmer. A staff member stroked a person's hand while they were offering encouragement and trying to engage them during their meal.

We also observed that staff recognised when one person wanted to move in their wheelchair but was having trouble. They intervened as soon as they noticed to take off the brakes and ask if the person wanted help. Staff also took action promptly when a few people said they felt cold. They ensured they got either a jumper or blanket as they wished.

We saw that staff spoke respectfully to people. For example, one staff member asked, "Is it alright for me to put this plastic apron on you so it protects your clothes?" This was when they were supporting the person with their lunch. Staff also spoke with us about people in a way that was respectful and caring. For example, one staff member told us, "I try to make every day the best I can. Most of the staff here try and do that."

The quality of people's care records was variable in the information they contained about people's histories and what was important to them. Some people had information about their backgrounds but others did not. However, staff knew people well and were able to tell us about their needs and backgrounds. One staff member came to tell the management team about some information they had found out. This had happened when they were chatting to a person while they delivered their care. Another staff member told us, "We build up information about people after they come to us. We talk to them, their families and find out from relatives."

Although not always well reflected in records, staff understood what was important to people. For example, staff recognised that one person liked to carry belongings in shopping bags around with them. They knew this was important for the person. We saw that they offered prompt assistance to the person when they got into difficulty planning how they would go upstairs. Staff carried their bag for them. Another person obtained comfort from carrying a baby doll with them. Staff knew this was important to the person and they were able to keep the doll with them on their lap or nearby when they ate their meal.

People said that they could have visitors when they wished. One visitor to the home said that they felt welcome and came every day. We noted that one person's records contained detailed information about their family and who they would accept visits or calls from. It also reflected who they had agreed for staff to share information with. This contributed to respecting their wishes about contact with their family and the confidentiality of information about their care.

Requires Improvement

Is the service responsive?

Our findings

Improvements were needed to the responsiveness of the service. This included how people were able to receive care that matched their preferences and ensured they received support in accordance with those. There was variable practice in showing how people were involved in planning their care and some assessments were incomplete or conflicting. This compromised how person-centred care was planned. Arrangements for ensuring people's preferences were respected at the end of their lives were not always robust.

Only one of the people spoken with could confirm they were involved in discussions about their care plan and the support they required. The person told us, "We had some sort of chat about what I need; they will talk to you anytime." None of the other people we spoke with could recall any such discussions and their involvement and views were not always recorded in care records.

People's preferred routines were not always met and they did not always know what was going to happen in relation to their care. For example, one person said, "I think I am having a shower today but I don't know when I last had one." Another person told us, "I am awake at 5am but I can't get up because there are no staff to help me. I get myself out of bed by 6am but then I have to wait for them to come and get me sorted. I never know when they are going to come and help me." Another person told us, "I get moaned at for getting up early at 7am. I go to the main living area but there aren't any staff about to see to me. The night staff are still on but they've got too much work to do."

We found that some records were incomplete. For example, part of one person's care plan relating to their continence was blank, as was information about their personal safety. For another person, their records contained conflicting information about what they liked and disliked, including for their food. One part of their information in relation to activities they enjoyed listed a number of television programmes they enjoyed but other information showed they did not like television or radio. There was nothing in their care records about their friends and family, their younger years, hobbies or religious beliefs. This presented a risk that that staff would not be able to meet their individual preferences because the information was either missing or inconsistent.

For this same person, their records for mental state and cognition showed they had "no mental capacity." The information was not specific to individual decisions about their care. There was nothing to guide staff about how best to communicate information and help them to be involved in any aspects of planning their care. Another person's records showed that they were involved in some discussions. However, they also indicated in relation to medical information, that another person had the power to consent to medical treatment on the person's behalf. Their care plan ticked "Yes" to show there was a lasting power of attorney (LPA) in place for decisions about health and welfare. On further discussion with the deputy manager, they were only able to confirm that the LPA related to finances and not to decisions about treatment. We were concerned that the way that assessments of needs, preferences and treatment were not therefore properly taken.

We found, and staff told us, that there was little provision of any meaningful activity. Staff said that they did not often have time to organise group activities or to spend time with people individually. Records showed that some people were identified as possibly being able to benefit from one to one activities. For example, one person's records showed, "May benefit from one to one activity e.g. reading books." Another person's records indicated that the person might benefit from one to one activities such as a "chat" with staff. For one person, their records showed no engagement in activity at all for more than two months. Their last recorded activity was "listening to football" when they had been in their room. This risked that the person would become bored and isolated, potentially affecting their mental wellbeing.

All of the people we spoke with expressed some concerns about the lack of activities and not feeling stimulated. For example, one person said, "I do get bored. There are plenty of books to read but I can't get into them anymore." Another person told us, "It is very boring, there is nothing to do here." One person commented, "Some carol singers came but that is the only activity I have heard about. They all seem to sit about watching TV all day."

During our inspection visits, there were no activities planned. The proposed hairdresser visit displayed as happening on Tuesdays was not happening during the first of our visits due to holiday. The noticeboard in the hall displaying the activities programme was for a week in September, approximately three months before our inspection. The lack of provision of activities was contrary to statements made in the provider's statement of purpose, about what opportunities they would offer for people.

There was variable practice in assessing people's preferences at the end of their lives and in taking into account any views they had expressed before they became unwell. We could see that one person was supported at a review with their GP and family members but a clear plan for the end of their lives was not in place. Others had no information. One person had paperwork from a local health trust for recording priorities for care, thinking ahead and advanced care planning. It was blank. A person's funeral arrangements were specified as for cremation, but there were no other considerations about the care they may wish to receive at the end of their lives.

We found that people's social, emotional and spiritual needs and preferences were not properly assessed and care was not designed properly to meet them. These concerns represented a breach of Regulation 9 of the Health and Social Care Act 2008

The provider had a procedure in place for dealing with complaints. People spoken with said that they had not needed to raise any formal complaints. However, they were not always clear about who they should talk to. For example, one person told us, "I would talk to someone on the same level if I had a problem. I wouldn't talk to some of the younger girls, they are too young to understand my problems." Another person agreed with this saying, "I would speak to the older carers if I had a problem, the young ones don't understand." A visitor to the home told us about a specific situation that had caused them concern and they had been told their family member would refuse assistance. They told us, "Nothing else has happened about it."

One person told us, "I would speak to the manager. She will listen or the carer that I see the most." However, there were regular changes in management arrangements, with the manager at the time of the inspection visits, having only been in post for a short time. Shortly after our visits, and while the report was being drafted, we were informed that they were no longer managing the service. This means that the director needed to take a clear lead in establishing people's views and in receiving and investigating complaints.

Requires Improvement

Is the service well-led?

Our findings

The leadership and governance of the service was not fully effective. The service had been registered for 10 months at the point of our inspection visits. We acknowledged that the current provider had taken over the home at a point when it was operating inadequately and so widespread improvements were needed. However further improvements were needed to ensure a safe, good quality service for people. There were difficulties in how the service could demonstrate a clear vision and strategy for delivering high quality care. Systems and processes had not embedded consistently.

We were concerned that initial improvements reported by relatives on a "care home review" website, were not sustained. This was compromised by changes in leadership. Some improvements the director had identified, were not achieved in line with their own timescales. As the registered manager had left, and the new manager who was to register left while our report was being drafted, the provider needed to take responsibility for driving these forward.

The manager in post at the time of our inspection visits had been leading the service for only two weeks, the previous registered manager having left the service. One person using the service told us about the new manager and said, "I met the manager the first day they arrived and I saw them this morning. We see them about all the time." Another person told us, "Yes, I see the manager but I have not had much to do with them." The deputy manager was in post for around a month. The confidence of staff had not yet had time to develop while they were getting to know the manager. The culture was not as open as it could be in part due to anxieties about management changes.

Many of the staff were still relatively new in post and had not been properly supported and encouraged in their roles due to management changes. There were some concerns that changes in both the team and leadership had affected morale although staff were generally confident this would improve with the new manager. We found that the manager had already built up a good understanding about the people living in the service. They had a clear vision for where they wanted to improve the service. Between our inspection visits, they devised improvements for recruiting processes, including a checklist and application form. They recognised that the service needed to improve in a range of areas and responded constructively to our feedback and discussions. However, the manager left the home while we were drafting this report. This compromised the development and sustainability of a positive and empowering culture.

The director's systems for monitoring and assessing service quality did not proactively identify the shortfalls we found and the breaches in regulations. For example, the fire risk assessment identified that some staff did not know what to do in the event of a fire. The action plan completed in October 2017 recognised that practice scenarios needed to be clearer and that an emergency 'allocation' of staff should be planned into hand over. Despite identifying these improvements were needed in October 2017, we found that concerns remained. Staff still lacked clarity about what they should do in the event of fire and how they should promote people's safety. The director, in the absence of a permanent manager, had not identified that personal emergency evacuation plans for five of the 15 people using the service, were not available. Some information about this, showing where people spent most of their time, was inaccurately completed.

Where the director had delegated actions to other staff, including the former manager and deputy manager, systems did not ensure actions were properly and competently undertaken and followed through. They did not ensure that records were fully and accurately completed. In addition to shortfalls in recruitment records, there were gaps in care records. We found shortfalls in the care planning process. Some records were conflicting, some were missing and there was a lack of a person-centred approach to assessing individual needs. The records that were in place were not always dated and signed to show who was responsible for completing them and when.

The director showed us their programme for improving care plans and care records. However, their expected timescales had not been achieved. They told us that they felt they had initially been over ambitious about the schedule. They showed us one care plan that was supposed to be complete in the new format. The layout was improved and indexed so that staff could easily see where to find information. However, again there was a lack of detail about the person's preferences, needs and risks, and how they were to be supported.

The director expected the previous manager to complete and update care plans. We found that the previous manager had audited some of them to see where improvements were needed. Three were checked in September 2017, one in April and May. No checks were recorded as completed in June, July and August. We reviewed the audit findings in relation to the care plan for one person still living at the home. The audit from October 2017 showed that they lacked a front page and photograph. It also showed that more information was needed about the person's hygiene needs and nutritional screening required updating. It identified that the care plan lacked information about the person's social life, history and spiritual needs. We found that this was still missing almost two months later and there were similar gaps in other people's care records. This was despite a note dated 6 October 2017 indicating that it did "not make sense to review care plans as they are being revamped over the next 10 days."

Staff told us that the service operated a "resident of the day" scheme so they could focus on one person's care. However, this had not led to improvements in gathering background information about people, meeting social and recreational needs or demonstrating their involvement in care plan reviews. Staff were not fully clear about who the "resident of the day" was during our inspection and which of their colleagues was supposed to be pursuing this.

There was an undated checklist completed by the director, showing that staff supervision was supposed to be completed by 10 December 2017. We found that some staff had been without supervision for a prolonged period that could not be attributed to the manager in post when we inspected. Likewise, the checklist showed that staff should encourage people with more baths and showers. However, we found that these were still not happening as often as people thought they might like.

There was a "daily manager walk round audit" but no evidence of regular completion since April 2017. We found that this provided for room checks to ensure cleanliness, décor and safety. However, on the report we reviewed, the only room checked was the staff toilet. We considered this to neither be a reasonable process for checking the premises, nor proportionate to the size of the building.

We noted that the schedule for checking medicines, the storage of medicines and cleaning the medicines room showed the checks staff should make on a daily and weekly basis. However, this contained numerous gaps. For example, the schedule for daily cleaning of the trolley and contents as well as work surfaces, contained only three entries in the two weeks leading up to our second visit. These could be easily seen at a glance as it was displayed on the wall but there were infrequent and irregular records to confirm that staff had completed the required schedule. The system for monitoring and auditing medicines was not robust in

identifying when some medicines were likely to run out so replacements were obtained promptly.

These concerns represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We noted that the statement of purpose for the service was not up to date in reflecting current arrangements within the service, including management arrangements. The telephone number for the care home was not consistent with that for the care home and held on our registration information. The information refers to a registered manager no longer in post. There is reference to named staff, including ancillary staff, rather than the structure of the staff team, who were no longer in post. The information referred to specific recruitment checks, which have changed and had already done so when the information was compiled.

The director had not kept this under review to ensure it was accurate and needed to do so, including making a notification in relation to changes.

This was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

None of the people spoken with could recall being asked for their views about the quality of the service and how it could improve. However, they had no suggestions for us about what they thought could improve, other than for activities. We noted that the quality management policy supplied to us when the new provider took over the home showed that questionnaires would be completed and evaluated. The staff team was relatively newly in post and also had not been surveyed for their opinions. However, we considered it was not proportionate to consider these needed to be carried out earlier. Numbers of people living in the home when the provider took over were very low and there were many staff changes. A period of consolidation was necessary.

The manager told us at inspection, they were intending to improve the information they shared when people moved between services to ensure they worked in partnership. This included for example, when a person needed admitting to hospital. They told us that, at the time of our inspection, only information about medicine was shared. The local authority's quality assurance and safeguarding team members told us about investigations they required from the service. In the absence of a manager, who left while our report was being drafted, the director needed to ensure they take these issues forward to demonstrate partnership working.

We noted that the director had devoted resources to improving the décor of the home, including redecorating bedrooms and communal areas. They had provided a wet room on the first floor. This helped to improve the environment for people, subject to some action to create a more 'homely' atmosphere as some walls were bare. The director confirmed to us that, over the six to nine months following our inspection visits, they intended to invest in the new, partially complete extension. This would allow for further improvements in the environment. This would include the ability to improve infection control measures by refurbishing the existing ground floor bathroom and creating better laundry facilities. It would also provide for proper lift access between floors and so be more accessible to people with mobility difficulties.

We found that, at this stage and attributed to management changes as well as staffing constraints, staff were not confident they would wish for one of their relatives to be cared for at the home. They felt this would improve with time. We will monitor this at future inspections as we have concerns about the inconsistency and instability of management arrangements at the service. The frequent changes compromised the speed

with which improvements could be made and how incidents were analysed to learn from and improve.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider's statement of purpose did not contain accurate and up to date information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment did not always reflect their needs and preferences. Their needs and preferences were not always properly assessed so that care and treatment could be planned to meet them and they (or appropriate others) were not always involved in decisions about their care. Regulation 9(1), (3)(a), (b), (c), (d), (e) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety and welfare were not always properly assessed and addressed. Guidance about managing risks and supporting people's safety in a fire was missing in some cases and inaccurate in others. Staff lacked confidence in the action they should take if a fire broke out. There were some risks to people's safety associated with the control of infection.

There were risks to people's welfare associated with the management of their medicines, including occasions where they did not have access to the medicines prescribed for them.

Regulation 12(1), (2)(a), (b), (d), (f), (g) and (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes for assessing and monitoring compliance with regulations were not operating effectively. They did not properly assess, monitor and improve the quality and safety of the service and people's experiences. Systems did not ensure that risks were properly assessed, monitored and mitigated and that records were complete, up to date and accurate. Regulation 17(1), (2)(a), (b), (c), and (d)(i) and (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices did not ensure that staff employed were of good character and health so that they were suitable for the work required. They did not ensure the required checks were completed and records obtained in relation to staff conduct and character. Regulation 19(1)(a) and (c), 19(2) and Schedule 3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate development through training and supervision, to ensure they were competent to carry out their duties.

Regulation 18(1) and (2)(a)