M Iqbal

Shassab Residential Care Home

Inspection report

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21 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 and 21 March 2016. The first day was unannounced which meant the service did not know we were coming. The second day was by arrangement. At the last inspection in August 2014 we had found the service was not meeting the regulations in two areas, management of medicines and records. We asked the service to submit an action plan, which they did on 7 October 2014. At this inspection we found the service was meeting the regulation about records, but we found new concerns regarding the management of medicines.

Shassab Residential Care Home is a family-run home which caters for people of different ages from the Asian community, and offers support to people with mental health needs and/or learning disabilities. It can accommodate up to eight people; there were six people living there at the date of our inspection. They each had their own bedroom. There are four bedrooms on the ground floor and four on the first floor. The home has been open for over twenty years.

Shassab Residential Care Home has a registered manager who has been registered since 2010. He is also the registered provider. 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.

A minimum of two staff were supposed to be on duty at all times, according to the staff rota. When we arrived at 9.05am there was only one member of staff in the home and the second person arrived at 9.30am. This was a breach of the Regulation relating to having enough staff on duty.

Medicines were stored securely and the administration of medicines was recorded. In one person's case the numbers of tablets remaining in two boxes showed that they had not received all the medicines that they were recorded as having received. This was a breach of the Regulation relating to the safe and proper handling of medicines.

Recommendations made by a fire officer after our last inspection had been carried out. Plans for emergency evacuation needed to be improved. This was a breach of the Regulation relating to reducing risks to people living in the home.

All the necessary checks had been done for the recruitment of staff, both regular staff and volunteers.

The registered manager had responded to suggestions made after an infection control inspection. However, there were no dedicated cleaners. Care staff were expected to complete cleaning tasks on a schedule. Hand cleaning gel and paper towels were missing. There was a breach of the Regulation relating to infection control.

Staff we spoke with had a basic understanding of safeguarding and knew how to report any incident of abuse or potential abuse. We have recommended better training in safeguarding.

The registered manager had told us that all staff were trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), but we did not see evidence of this training. We saw that some people had mental capacity assessments, and in one case a best interests decision had been made that a person should stay in Shassab Residential Care Home. However, no application had been made for authorisation under DoLS. This was a breach of the Regulation relating to depriving people of liberty without lawful authority.

Training in a wide range of areas had been delivered to all staff in the autumn of 2015. Staff were supported with supervision and appraisals; although there had been no supervisions for six months they were about to resume.

Food was appropriate to the culture of most of the people living in the home. People told us they liked it. However there was one person who preferred another style of food. Failure to meet that person's preferences was a breach of the relevant Regulation.

The building was suitable for its purpose as a home. Records were kept of people's access to health professionals.

People told us they were well supported and were happy in the home. Their personal care needs were met. People were encouraged to be as independent as they could be. Staff respected their privacy. Some people were free to come and go when they wanted. People got up when they chose to.

Care plans were detailed and provided enough information for professionals to understand the care that was being delivered. Care plans were reviewed regularly although on some files successive reviews were identical. People were assessed before they moved into the home, and also given a trial period to see whether they wanted to live there.

The activities schedule was identical for everyone even though people's needs differed widely. Some activities were available for each person but in an unstructured way. Weekly access to an activity centre had ceased. There was a breach of the Regulation relating to meeting people's needs.

Shassab Residential Care Home had not met all the requirements to report significant events because they had failed to report a death. This was a breach of the relevant Regulation.

There was a self audit checklist in use but it did not cover all areas. There was a separate audit of medicine administration but the findings of this inspection indicated it needed to be used more effectively. There were some improvements needed to the premises which had not been identified by the provider. The lack of an effective audit system was a breach of the relevant Regulation.

The service used volunteers as well as employed staff. This was within the culture of the Asian community to provide help and support. Documents were being translated into Urdu to enable staff to understand them better.

Staff meetings were infrequent but were planned to take place more regularly. Surveys were used to obtain family members' views of the care provided at Shassab Residential Care Home.

We found breaches of six Regulations. You can see what action we told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff on duty at all times.

The recording of medicines administered was not always accurate. Cleaning of the home was done by staff, but some of the bedroom furniture appeared in need of cleaning.

The registered manager had made changes following an infection control report and a report by a fire officer. There were no personal emergency evacuation plans, and improvements were needed to infection control.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments were in use and there had been a best interests meeting. However, an application under the Deprivation of Liberty Safeguards that was needed had not been made.

Training had been delivered by an external trainer. There had been no staff supervisions for six months.

Culturally appropriate food was served, except for one person who had expressed a preference for different style food. People had access to healthcare.

Is the service caring?

Good

The service was caring.

People's personal care needs were met. People were supported to be independent and could choose when to get up and go to bed. Some people were free to leave the home and come back.

Staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were not arranged specifically for each individual. When access to a day centre once a week had stopped no alternative provision had been provided.

Care plans and risk assessments were detailed. Reviews of care plans took place regularly.

People were assessed before they moved into Shassab Residential Care Home and allowed to visit and stay overnight before accepting a place.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had not met all the reporting requirements of the regulations.

An audit checklist was in use but it did not cover all areas. The auditing of medicines needed to be more effective. Governance needed to be improved and might have prevented the many breaches and areas of improvement found in this inspection.

Volunteers gave their time to help support the people living in the home.
Staff meetings were infrequent.

Shassab Residential 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.

The inspection took place over two days on 17 and 21 March 2016. The first day was unannounced which meant the service did not know we were coming.

On the first day of the inspection there were two adult social care inspectors, one of whom could speak Urdu and other Asian languages. On the second day one adult social care inspector returned to complete the inspection.

Before the inspection we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. It was submitted to us on 21 January 2016. We reviewed the PIR along with other information we held about the service, including statutory notifications received from them.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. We contacted the clinical lead for health protection in Public Health Manchester and obtained a copy of the most recent infection control report for the home (dated 20 October 2015). We also received further details from the author supplementing the information in that report.

During the inspection we had a tour of the premises. We spoke with four people living in Shassab Residential Care Home, and three members of staff. We also spoke with the registered manager and the deputy manager. We looked at four people's care records, three staff recruitment records, three medicine administration records and other documents relating to the maintenance of the building.

Inadequate

Is the service safe?

Our findings

One person living in Shassab Residential Care Home said to us, "I like living here, I like my room. The staff are really nice, I have no problems." Several of the other people living in the home were unable to speak with us due to their health conditions. We observed that the environment inside and outside the building was safe, except that there was a short wooden ladder on the ground in the back yard. This posed a potential risk if someone decided to try to use it. We mentioned this to the registered manager who said it would be removed immediately.

We asked about staffing levels. The registered manager told us, and the staff rota confirmed, that there were two staff on duty each night from 11pm until 9am. One of these staff stayed awake while the other slept on the premises and could be called on if needed. During the day there was a minimum of two staff on duty, according to the rota.

When we arrived at 9.05am on the first day of our inspection the night staff had left and there was only one member of staff on duty. They were busy giving personal care in the bedroom of one person who needed a lot of support. This meant that the other people living in the home were unattended. The second member of staff arrived at 9.30am and told us they had been delayed unexpectedly. They added that this did not normally happen. The night staff had not waited until they arrived. This meant that there had only been one member of staff in Shassab Residential Care Home for about half an hour.

This posed a risk to people living in the home if there had been an emergency of any kind while only one staff member was present. This was therefore a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that medicines were stored securely in a locked cabinet. One person was administering their own medicine. This was recorded in their care plan and a risk assessment had been completed. The person showed us that their medicines were stored in a cupboard in their bedroom and told us they took it as prescribed the same time each day. Other people received their medicines from the staff, and the staff recorded this on medicine administration records (MARs).

One person had been prescribed two new medicines which had started on Friday 11 March 2016. Our inspection was on Thursday 17 March 2016. The MAR recorded that they had received the medicines on each occasion they were due. One of the medicines was an antibiotic, which meant it was important to complete the course of tablets. However, when we counted the tablets remaining in each box, we saw that there were more tablets remaining than there should have been according to the MAR. We raised this with the deputy manager who said that the person concerned always ensured that they received the correct medicines. Nevertheless, the evidence showed that some doses had been missed and both medicines had not been administered correctly.

This was a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in August 2014 we had found that a MAR had been completed before the medicine had been taken. We found this was a breach of the regulations, and we asked the provider to submit an action plan. This action plan stated, "We have had a staff meeting… Staff are not to sign any medication records unless staff have seen the service user taking the medicine."

The breach of regulations at this inspection was the same type of breach as the previous inspection, because on each occasion staff had signed the MAR at times when the person had not taken the medicines. This meant people were at risk of not receiving their medicines.

After our last inspection a fire officer had issued an enforcement notice that an interior window near the downstairs fire exit should be sealed, in order to protect the access to the fire exit. We saw that there was a new window frame and the window was sealed. The fire officer had also insisted that a magnetic lock be fitted to the front door which would open in the event of a fire, and we saw this was now in place. There was a fire evacuation procedure for staff on the office wall. This was in need of updating and the advice to staff should be checked with fire officers. There were six people living in the home, five of whom were independently mobile. However, there were no individual personal emergency evacuation plans (PEEPs) to assist the emergency services to evacuate the building in the event of a fire or other emergency.

The absence of PEEPs and the outdated fire evacuation procedure meant that insufficient precautions were being taken against the risk of fire. This was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records of three staff. We saw that all the necessary checks had been made to verify people's identity. References from previous employers, or character references, were on file. A separate record was kept of checks made with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. The same checks had been carried out for volunteers who were working in Shassab Residential Care Home. This meant that for both volunteers and employed staff the necessary precautions had been taken to ensure they were suitable to work.

We asked whether there had been any staff disciplinary issues. The registered manager stated that all staff including volunteers were committed to their work, as part of a religious duty to care for people who needed help with daily living. Therefore, he said, disciplinary issues were very uncommon. We discovered there had been only one example, where one staff member had spoken rudely to another. This had been investigated and resolved with an apology.

Shassab Residential Care Home had no dedicated cleaners. Staff (including volunteers) would undertake cleaning tasks while on duty. We saw there was a detailed schedule of cleaning tasks to be done, some daily, others weekly or less frequently. But there was no cleaning rota. Staff undertook these tasks when they were able to. There was a spreadsheet which staff signed to show the tasks had been done. We saw that the same member of staff had signed for all the tasks for the ten days prior to 21 March 2016. We queried this and the member of staff stated that they signed the record even when someone else had completed the cleaning task. This increased the risk that tasks might not get done or not get done properly, if there was no record of who had done them.

Our observation was that the communal areas of the home, including the kitchen, bathrooms and toilets, were clean. Two of the bedrooms were vacant and contained old stained furniture and other items. We examined two mattresses which were stained and needed new springs, or replacement.

We saw that Shassab Residential Care Home had responded to an infection control report following an inspection on 20 October 2015. For example, the report had recommended a legionella risk assessment. The deputy manager showed us a series of emails proving that they had obtained several quotations to provide such an assessment, and were arranging a date for it with the chosen company. The report had also suggested installing hand cleaning gel dispensers around the home. We saw that these had been installed although on the first day of our inspection there was no gel inside them. We queried the reason for this, and by the second day the gel had been inserted. When we looked round the home on the first day of the inspection we saw there were no paper towels in the upstairs bathroom and toilet, which created a potential risk if people could not dry their hands properly.

We were concerned to see that in the downstairs toilet there was a bottle of toilet cleaner on a shelf. This could pose a serious hazard to people living in the home. Staff assured us that this was the staff toilet and was kept locked, although there was a risk that one of the staff might leave the door unlocked. We mentioned the hazard to the registered manager and the toilet cleaner was removed immediately and placed in a locked cupboard.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The provider was not doing enough to prevent and control the spread of infections within the home. This was a breach of Regulation 12(1) and 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about their understanding of safeguarding. They told us they had received training in safeguarding and we saw certificates which confirmed this. The training had been delivered in the home by a specialist trainer. The staff we spoke with had a basic understanding of the types of abuse that might occur in the home, and what to do if they witnessed or suspected any abuse. They told us they would report it immediately to the registered manager. They were less certain of what to do if, in a hypothetical situation, the registered manager was involved in the abuse. They were unaware of other means of reporting abuse, to the local authority, or the CQC, or if necessary to the police.

We recommend additional training in safeguarding to ensure better knowledge for all staff.

We looked at an accident and incident book, which would be used to record accidents to people living in the home. No accidents had been recorded within the last four years.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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). Providers are required by legislation to notify the Care Quality Commission, (CQC) when an application for a standard DoLS authorisation is either refused or granted. No such notification had been received since the service was registered with CQC in 2010.

We checked whether the service was working within the principles of the MCA as some of the people living at the home did lack mental capacity in relation to some decisions.

We saw there were consent forms in care files to record that people consented to the care and treatment they were receiving. The consent related to the use of photographs, medication, and finances. Some of the consent forms were signed by the person using the service. In one case where the person was unable to sign due to a learning disability, their parent had signed the form which indicated that they had seen the document. We discussed with the deputy manager that under the principles of the MCA a family member cannot give consent on behalf of a person who lacks capacity (unless they have a relevant power of attorney) but can be part of a best interest decision making process.

In the PIR the registered manager stated that all staff had received training in the MCA and DoLS, but we did not see evidence of this in the form of certificates which were available in all the other subject areas. We did see that there was a policy on DoLS dating from July 2014. In our two previous inspection reports we commented that there were no mental capacity assessments on file, which showed that the service was not engaging with the procedures around MCA and DoLS.

At this inspection we found that mental capacity assessments had been completed. For example, one person had a mental capacity assessment on 10 December 2015 to determine if they had the capacity to consent to living and receiving care at the home. They were deemed to lack capacity to make this decision, so there had been a best interests meeting to decide whether the person should remain at the home. It was decided that it was in their best interests to stay. As the person lacked capacity to decide to remain at the home, a DoLS application was required in order to obtain proper authorisation for the person to stay in the home. We saw that no DoLS application had been made.

Two of the people living in the home were considered safe to leave the home on their own whenever they wanted. We were told that the other four people could not leave the home unaccompanied by staff and

would be brought back for their own safety if they did try to leave. This meant they were also being deprived of their liberty and DoLS applications were required. We discussed this with the registered manager and deputy manager. They said they had recently been given contact details of the DoLS team at Manchester City Council. However, in our last report published in September 2014 we suggested that the provider should investigate the current rules on DoLS. This did not appear to have been done.

Depriving people using the service of their liberty without lawful authority was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about the training they had received. They told us that everyone, including volunteers, had received training in a wide range of subjects. We saw evidence of this in the form of certificates all supplied by the same trainer. There had been intensive training activity in October and November 2015, when the external trainer had come into Shassab Residential Care Home to deliver training. The topics covered all the mandatory areas and additional relevant topics.

In one staff member's file we saw certificates showing successful completion of training in: manual handling, health and safety, risk assessment, safe handling of medication, safeguarding, pressure area care, person-centred planning, nutrition, infection control, safety at work, catheter and stoma care, food hygiene, first aid, fire awareness, equality and diversity, end of life care, control and restraint, and challenging behaviour. Together these represented a comprehensive range of training. Each certificate also listed the breakdown of the topics covered within that training session.

Staff, including volunteers, had received supervision sessions in June 2015 and September 2015, but we found no evidence of supervision sessions since that date. The deputy manager showed us a schedule of planned supervision dates commencing shortly after our inspection. Supervisions took the form of an observation of the staff member at work, followed by a one to one discussion about how work was going. For example, in one supervision the deputy manager had observed the staff member completing paperwork, and had then asked them about the paperwork. The sessions were recorded in an individual notebook for each staff member, which was kept on their personnel file in the office.

We saw records of annual appraisals which had taken place in May 2015. These were more in-depth discussions which included any training or development needs. The registered manager emphasised to us that eight out of nine employed staff were part time, and they and the five volunteers were happy with their working arrangements and did not have career aspirations.

When we arrived at the home some people had already had breakfast and others followed. We saw lunch being served, which was a wholesome culturally appropriate dish. People told us they liked the food. One person said, "I love my chappatti and meat dishes and sweet dishes." Another person said, "I like my meals here, I like chappattis, rice and sweet desserts. I get plenty of fruit juice drinks, I like bariyani, I eat halal and they provide it for me." Juice and water were offered with the meal, and a cup of tea afterwards.

We noted however, that one person was originally from a different part of the Indian subcontinent, and was therefore used to a different style of food. They told us that they did not like the variety of food served in Shassab Residential Care Home. They added that they had told the registered manager about this, but they were still not always receiving the kind of food they liked. There was a note in this person's care plan regarding their preference. We asked the registered manager who said that they did their best to accommodate this person's wishes. We observed that this person was given their own choice of the food available at lunchtime, and said they were happy with the food. We considered, however, that the service was not doing everything possible to meet this person's particular needs. This was a breach of Regulation

9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each care file had a front sheet which could be used in the event of someone going to hospital or another professional needing to see it. The details included information about each person's mental health diagnosis and their medication. We saw on people's files that they had regular visits to or from their GP, dentist, psychiatrist and other health professionals as required. We asked whether the home kept a record of people's weight, and the registered manager told us that this was done by their GP or in one case at the hospital where the person attended for regular appointments.

People could choose to spend time in their own bedrooms or in the communal lounge which had comfortable sofas. The dining table was in the same room. There was a small smoking room which had an extractor fan. The room was compliant with relevant regulations. People could also smoke in the back yard, where there were seats arranged under a rainproof shelter. The registered manager stated in the PIR that "the care home is not institutionalised and the atmosphere created is like that of a family home." Our observation was that the layout of the building was suitable for achieving this purpose.

Good

Is the service caring?

Our findings

We spoke in their first language with four of the six people living in Shassab Residential Care Home. They told us they felt they were well looked after. One person said, "I like living here. Staff are nice here. [The registered manager] will sort out any problems I have. I am very happy here." Another person said, "I don't have any problems in the home, the staff are all really kind." One person expressed some reservations about life in Shassab Residential Care Home, because they were living some distance away from their family and wanted to be nearer. However, they told us, "I like the staff here, they are all very nice. The staff respect me, I am very happy here."

Two relatives responded to a survey in January 2016 asking their views of the service and the care provided to their family members. Both were very positive. One described it as a "five star service" adding that the staff were "really good." Another relative said, "I am very happy with the service provided."

The registered manager told us that there was a family atmosphere within the home, and our observations during the inspection confirmed this to be the case. We saw that staff, including volunteers, had established friendly relationships with the people in the home. The registered manager said, "We try to ensure each person has their needs met. We give a personalised service. We don't regard looking after people as a job."

We saw that people's personal care needs were met. Everyone was clean, well groomed and well dressed. One person needed support with all aspects of their personal care. Their care plan stated that they should have a shower every day, and we saw from their daily notes that this happened. Other people were more independent, and were encouraged to take responsibility for caring for themselves. We observed staff knocking and waiting for an answer before going into people's room which showed us they respected people's privacy.

People's care plans contained guidance for staff on how to maintain people's dignity while supporting them with personal care tasks. People's independence was encouraged. One person who was able to come and go freely said, "I can leave the home if I want to go out, I just tell the staff where I am going and what time I will be back." We saw a note on the kitchen hatch stated that the front and back doors were locked from 10pm to 8am, but we understood that one person regularly stayed out later than 10pm, and was let back into the home by night staff. There was a risk assessment in their care plan which set out the basis on which this happened. This meant that people had the freedom to live independent lives if it was safe for them to do so.

This freedom extended to the time that people got up. Most people got up early, but one person regularly got up at 3 or 4pm. The person had the mental capacity to choose when to get up, and staff at the home were respecting their rights.

We found that staff showed respect to people living in the home. At one point we were initially concerned about one person's comfort. The first day of our inspection was quite warm for the time of year, and we saw that this person lay down in the sun on the paving stones in the back yard for a short time. We asked the

registered manager why there was no mat or cushion made available for them. He told us that in the summer there were garden chairs but these had not been put out yet. The registered manager was respecting this person's choice, as the person was not at any risk from this behaviour.

The home catered only for people of Asian origin who were all Muslims. The staff were also all of the same ethnic origin. There were religious texts on the wall, and people were encouraged to pray during the day and especially on Fridays. This meant that people were living with and supported by people who shared their culture and religion.

Requires Improvement

Is the service responsive?

Our findings

We looked at four care plans and saw that they set out in detail people's individual needs and how they were to be met. Relevant information was included about each person, including their medical conditions, current list of medication, dietary requirements and need for assistance with personal care (if any). Risk assessments relating to individuals' behaviour had been drawn up. They covered areas such as smoking, agitation, financial awareness, moving and handling, personal hygiene, and leaving the building alone (where relevant). Each assessment included measures to reduce and control any risks associated with that activity. The information available would enable new staff or visiting professionals to see what each person's needs were and their daily routine.

We saw that these care plans and assessments were a great improvement on those seen at previous inspections. We also saw that the plans and assessments were now being reviewed regularly, and staff signed to show that the review had taken place. We noted, however, that on one person's file the comment made by the reviewer was identical on three consecutive reviews. We mentioned this to the deputy manager who had conducted the reviews. They pointed out that this particular person had been living in Shassab Residential Care Home for over 15 years and that their needs had not changed recently. Hence the review of their care plan had not resulted in any changes.

One person had arrived in Shassab Residential Care Home recently. We asked the registered manager about the assessment process used to ensure that the home could meet that person's needs and also that they would fit in with the other people living there. The registered manager told us they had been to assess the person in the hospital, which the person themselves confirmed. The person had visited the home and stayed there overnight on two occasions before the decision was finalised that they should move in. This meant that both the person concerned and the registered manager and staff were able to assess whether this was a suitable placement before they moved in. This person also told us that initially they had been given a bedroom on the ground floor but had asked to move upstairs because of the TV reception. This move had happened, showing that the registered manager was responsive to people's needs and preferences.

We asked what activities were available for people living in Shassab Residential Care Home. There was an identical 'Service user's activity sheet' on each person's care file, which set out a daily routine for everyone. We commented in our previous inspection report that the people living in the home were of different ages and abilities, and therefore individual activity schedules geared to their needs would be more appropriate. This time one person told us that they had a laptop and enjoyed working on it, and was hoping to find employment. Whereas another person who had profound learning disabilities enjoyed a game in which a ball was thrown towards them. We saw this game taking place while we were there. But at other times we saw this person was sitting in their wheelchair, with no activities and no interaction with anybody. Their care plan also recorded they liked being taken out for drives and to the shops. We saw that the staff were able to provide activities for both these people with different needs and abilities, but in an unstructured way as there were no specific activity schedules for each individual.

We saw records of frequent 'chat sessions' with people living in the home, in which staff recorded people's

indications of which activities they liked doing. This meant that the service had a method of regularly consulting people about their preferred activities and responded to their wishes where possible. In the past there had been a weekly outing to an activity centre which people had told us they enjoyed. We learnt at this inspection that these outings had ceased because the activity centre had closed and the nearest alternative was outside the radius of the taxi firm used by the home.

The provider had not responded to comments in an earlier report about creating individual activity schedules, and had not replaced outings to an activity centre. The provider was not ensuring that there were enough activities for people in order to improve their quality of life. This was a breach of Regulation 9(1) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I get choices to sleep when I want, and when to get up. I can pray here. Nobody tells me what to do." We saw that within the home people could choose where and how to spend their time. People engaged with each other to different degrees. One person, whose sleeping habits differed from others, got up at 3pm and immediately left the building. It appeared this person might be socially isolated from the others but that this was their choice. Their mood and mental state was being monitored by staff and recorded in their daily notes.

The registered manager told us there had been no formal complaints received since our last inspection. He added that the door to his office was usually open and that people living in the home, or their families, could always raise issues with him. One person said to us, "I can go to [the registered manager] if I have a problem." There was a complaints policy which set out how more formal complaints would be dealt with. We did not see the policy translated into Urdu.

Requires Improvement

Is the service well-led?

Our findings

Providers are required by the regulations to notify the Care Quality Commission (CQC) of certain events that occur within their service. Reporting such events is important as it enables CQC to monitor care homes and take action when needed. When we enquired about the people living in Shassab Residential Care Home the registered manager told us that one person had died in the home in February 2015. He had not submitted a statutory notification of the death.

This was a breach of Regulation 16(1) of the Care Quality Commission (Registration) Regulations 2009.

We asked what audits were conducted and we were shown a 'self audit checklist'. This was a set of questions covering policies procedures and records, clinical waste, drugs storage, moving and handling, and reporting of violence. There was then a series of questions relating to the maintenance of the building, such as floors, stairs, lighting and ventilation. Questions followed about electrical safety and kitchen safety. The checklist formed a good basis for monitoring most of the areas that required an audit. However, in the most recently completed checklist we saw that all the boxes had been ticked but no comments had been made in the space allowed on the form. We were unsure how effectively the audit tool was being used, in the light of areas for improvement identified at this inspection.

Missing from the self audit checklist was an audit of medication administration. The only question in this area related to whether drug storage cupboards were locked securely. There was a separate audit called a 'dispensing medication audit', which had last been completed in November 2015. The errors we found in relation to the recording of medicines at this inspection indicated this audit had not been effective in reducing the risks associated with the administration of medicines.

Although the self audit checklist covered areas relating to the safety and maintenance of the building, there was no record of a 'walkround' or overview of the state of the building and furniture. During our inspection we noticed a number of areas that needed updating: old mattresses, stained floors and furniture, and a net curtain in the stairwell which did not fit the window. We drew these matters to the attention of the registered manager and deputy manager. They said they would take action in relation to those areas.

The continuing breach of the Regulation relating to management of medicines, together with the other breaches and areas for improvement, indicated that the system of audits was not working effectively. Some improvements had been made especially in relation to care plans and fire safety of the building. But not all areas had been addressed and we found new breaches at this inspection. The lack of PEEPs, and the absence of one member of staff for half an hour at the start of the day, also indicated a lack of management intervention to improve the service. The failure to have an effective system to assess monitor and improve the quality of the service was a breach of Regulation 17(1) and 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

About a third of the staff working in Shassab Residential Care Home were volunteers, and some of them worked up to 15 hours a week. The registered manager told us he could always call on volunteers to work an

extra shift if needed, or to provide cover. The registered manager explained that volunteering in this way was a tradition within the Asian community, to support and care for less privileged members of the community, and that the volunteers were equally dedicated as the regular staff. One of the volunteer staff said to us, "Everyone seems to be happy here. We try our best."

In our report of the previous inspection we referred to the difficulty some staff had with understanding policies written in English. At this inspection we saw, for example, that all the staff had signed the policies on safeguarding, confidentiality, food safety and infection control. It was clearly important that staff understood these policies in order to apply them. At the previous inspection, the deputy manager conceded that some of the staff had problems with English literacy and needed help to understand the policies. However, following similar comments made by the contract officer of Manchester City Council during 2015, Shassab Residential Care Home was in the process of translating essential policies into Urdu. This was a positive but belated response to the issue raised at our last inspection. It would enable staff to have a greater understanding and take greater responsibility for their work. We considered that care documents needed to be made accessible to people living in Shassab Residential Care Home whose first language was not English and who might benefit from them being translated into Urdu and /or being made available in an easy read or picture format.

In the PIR the registered manager wrote, "Staff meetings are held regularly in which everyone can express their views." However, the most recent meeting had been held on 18 July 2015, eight months prior to the inspection. The meeting prior to that had been in June 2015. Only three staff in addition to the registered manager and deputy manager had signed the register in a diary to show they attended the meeting in July 2015. Notes of the meeting were kept in the diary, but no minutes were produced for the use of staff who had not attended the meeting. At that meeting the registered manager had reminded staff about the use of personal protective equipment, so it was a message that all staff needed to hear. The registered manager told us it was his intention to hold staff meetings every two months from now on.

We saw the results of a survey of family members in January 2016. Two survey forms had been returned from the five families of people living in Shassab Residential Care Home at the time. No concerns had been raised. This meant that the home had sought the views of family members with a view to improving the care provided.

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 16 Registration Regulations 2009 Notification of death of a person who uses services A notification of the death of a service user had not been submitted. Regulation 16(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not meeting people's needs for activities Regulation 9(1)(b) The provider was not doing everything practicable to meet the dietary preferences of service users Regulation 9(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no Personal Emergency Evacuation Plans and the fire evacuation procedure was outdated. Regulation 12(1) and 12(2)(b) The provider was not acting effectively to prevent and control the spread of infections Regulation 12(1) and 12(2)(h)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was depriving a service user of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed at all times Regulation 18(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely and properly. Regulation 12(1) and 12(2)(g)

The enforcement action we took:

Warning notice

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 an effective system to assess monitor and improve the quality of the service Regulation 17(1) and 17(2)(a)

The enforcement action we took:

Warning notice