Greenleaf Healthcare Limited

Livesey Lodge Care Home

Inspection report

Livesey Drive
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out our inspection visit on 16 and 18 November 2016. The inspection was unannounced on the first day.

At the last inspection on 9 April 2015 we asked the provider to take action to make improvements. We asked them to improve practice relating to ensuring that people's care was centred on their wishes and assessed needs and with regard to the way that the service was run. At this inspection we found that the provider had not made the necessary improvements. We identified that the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see at the end of this report the action we have asked them to take.

The service provides accommodation for up to 24 older people and people with dementia and physical disabilities. On the day of our inspection there were 22 people using the service. Some of the people that used the service had advanced levels of dementia.

There was a registered manager. 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.

People did not feel safe at Livesey lodge. Staff had received training to keep people safe and understood how to raise concerns. The registered manager was not aware of their duty to report and respond to safeguarding concerns.

Some people displayed behaviour that could have caused harm to themselves and others. Staff were not clear about how best to support people whose behaviour posed a risk. Staff did not always have the knowledge and skills to meet the needs of people who were living with dementia.

Safe recruitment checks had not taken place prior to staff employment. There were not always enough staff to meet people's needs.

People were not protected from risks relating to their support needs for example when they needed support to maintain a balanced diet.
People could be assured that they received their regular medicines as prescribed by their doctor. People's health needs were met and when necessary, outside health professionals were contacted for support.

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was not routinely asked.

Where people were at risk of dehydration this was not monitored appropriately. People were not

consistently offered choices about their meals.

Staff treated people with dignity and respect but people's bedrooms were not respected as private. People were not offered the opportunity to contribute to the planning of their care. People were not consistently supported to engage in activities that they enjoyed

Records were not always detailed and did not always reflect the support that people had received particularly around people's anxieties. People were at risk of being over medicated when experiencing behaviours that could cause harm or distress to themselves or others.
People's care plans did not include enough information to guide staff on the activities and level of support people required for each task in their daily routine. There was a risk that people would not receive the care that they needed. People's changing needs were not formally assessed.

Feedback about the service had not been sought and complaints were not dealt with in line with the provider's policy. People could not be confident that the registered manager would act on their concerns even when these were expressed to staff. There were no systems in place to challenge poor staff practice and take action where concerns had been raised.

Systems were in place to monitor the quality of the service being provided however, these were not always effective. Not all of the concerns raised at our last inspection had been addressed.

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.

People did not feel safe. The registered manager was not aware of their duty to report and respond to safeguarding concerns.

People were not protected from risks relating to their health conditions. Environmental risks were assessed and managed.

There were not always enough staff to meet people's needs.

People could be assured that they received their regular medicines as prescribed by their doctor.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported in line with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was not routinely asked.

People were not consistently offered choices about their meals. People's health needs were met.

Staff had received training to meet people's needs however they did not always have the knowledge and skills to meet the needs of people who were living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's bedrooms were not respected as private.

Staff treated people with kindness and they were respected.

People were not involved in planning and making decisions about the care that they received.

Is the service responsive?

Inadequate

The service was not responsive.

People's care records were not always detailed and did not always reflect the support that they had received.

People were not asked for feedback about the service that they received. Complaints had not been addressed in line with the provider's policy.

People were not supported to engage in activities that they enjoyed.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider had not implemented effective quality assurance processes and did not effectively review and monitor service delivery.

The provider's audits had not always identified areas that required improvement.

The registered manager had not provided staff with clear guidelines in order for them to fully perform their role. Staff felt supported. They were clear on their role and the expectations of them.

Livesey 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.

We carried out our inspection visit on 16 and 18 November 2016. The inspection was unannounced on the first day. The inspection team consisted of an 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 our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law. We also reviewed the Provider Information Return (PIR). This is a form completed by the provider, where the provider gives key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority we were responsible for the funding of some people that used the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had feedback about the service.

We spoke with six people who used the service, relatives of five people who used the service, two care workers, two senior staff members, the activity coordinator, the person who oversees the maintenance of the building, the cook and the registered manager. We also spoke with a person's advocate. An advocate is a trained professional who can support people to speak up for themselves.

We looked at the care records of five people who used the service and other documentation about how the service was managed. This included policies and procedures, staff records, training records and records associated with quality assurance processes. We observed staff and people's interactions, and how staff supported people. From our observations we could determine how staff interacted with people who use the service, and how people responded to the interactions. This was so that we could understand people's experiences.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that the service had failed to ensure that people's risk assessments had been updated following incidents to ensure that they continued to meet people's needs and reduce the risk of them occurring again. At this inspection we found that the provider had not made the necessary changes in order to address these issues.

Some people displayed behaviour that could have caused harm to themselves and others. We saw that risk assessments and support plans were not in place to guide staff on how to support people when they became anxious. Staff were not clear about how best to support people whose behaviour posed a risk. Staff had received some training regarding how to support people and keep them safe. However, one staff member told us that they felt that this training was not sufficient. They said, "Staff are not sure how to deal with it, possibly due to a lack of knowledge."

People were not protected from risks relating to their day to day care. We found that risk assessments had been completed on areas such as moving and handling, nutrition and skin care. However, we saw that when people's needs changed staff guidance was not updated to reflect people's current needs. This meant that staff did not have the information they needed to minimise the impact of the risk. For example, we saw that one person's mobility had decreased and as a result required support from staff to move positions in order to maintain healthy skin. We saw that staff were not given guidance around how best to do this. This person's nutrition and hydration risk assessment stated that they had lost weight and were identified as having a reduced appetite. They therefore required encouragement to eat. On both days of our inspection visit, we saw that this person had been offered food that their care plan stated that they disliked. This meant they were at increased risk of further weight loss.

These matters constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us that they did not feel safe. They told us that they did not feel safe when other people who used the service displayed behaviour relating to their anxieties. One person described themselves as feeling "threatened." Another person said, "I feel safe but not all the time. When some residents play up and come in to my room at night it worries me". A third person said, "We have some residents who are not very nice, they are a bit threatening." This person also confirmed that other people sometimes came into their room at night. They said that they now locked their door as they were frightened. A person's relative said, "When residents get out of control it frightens the other residents." We saw in a person's records that they had kicked another person when experiencing heightened anxiety.

Staff were aware of how to report and escalate any safeguarding concerns that they had within the organisation and if necessary with the local authority, police or Care Quality Commission (CQC). They told us that they felt able to report any concerns. One staff member told us, "I would first go to the manager but if I didn't think I was getting any joy I would go to the council or CQC." The registered manager was not aware of their duty to report and respond to safeguarding concerns. We saw that a concern had been raised by a staff

member regarding an unsafe moving technique that had been used on a person. This should have been investigated and reported to the local authority and CQC but it had not been. We also saw that the incident of a person kicking another had not been reported and no action had been taken to prevent this happening again. In these ways people could not be assured that they would be protected from harm.

These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff to meet people's needs. We received mixed feedback about whether there were enough staff to meet people's needs. One person told us, "Most times, yes. But sometimes there's no carers around and you can't find them". Another person said, "The care staff are under pressure." A relative said, "At times there is not enough staff. They struggle to employ people and cope with being understaffed. It causes delays when washing and bathing". Another relative told us, "I think they are running round a bit. There should be more staff." However another relative said, "Oh yes, very safe. There are enough carers to look after [person]." The registered manager did not have a formal system for assessing people's dependency levels and ensuring that staffing levels were suitable to meet people's needs. Staffing levels remain the same as they had been at our last inspection however five more people were currently being supported. Staff told us that in the evenings, when staffing levels were lower, there were not enough staff to meet people's needs and that as a result people might not receive the care that they needed or wanted. For example if someone wanted to have a bath they would not be able to have one.

Safe recruitment checks had not taken place prior to staff employment. We checked three staff member's recruitment files and found that for two people references from their most recent employer had not been sought. The third person had not fully completed their application form. This meant that the registered manager did not have all the information that they would have required to make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services.

Risk associated with the environment and equipment used had been assessed to identify hazards and measures had been in place to prevent harm. One person told us, "I think it is all quite safe. I can't think of anything that isn't". Where regular testing was required to prevent risk, such as water temperature testing and weekly fire equipment checks these had taken place. The provider had not ensured that where people used bed rails these were checked regularly in line with the risk assessment. This meant that there was a risk that the rails were not safe to be used. The registered manager told us that they would ensure that these checks were implemented. We saw that other equipment checks were in place to ensure that it was safe for people to use, for example hoists. The was a fire risk assessment in place and the support that people would need to evacuate in case of fire had been assessed.

The environment was kept clean and free from clutter or other environmental hazards. One person told us, "It's very clean." Since our last inspection the registered manager had employed a staff member to complete cleaning tasks. We observed that there was no odour and the home seemed to have been cleaned to a high standard. One staff member told us, "It's kept clean." A person's advocate confirmed this, they said, "It never smells here."

People could be assured that they received their regular medicines as prescribed by their doctor. Medicines were stored securely. We saw that medication administration record (MAR) charts were used to inform staff which medicine was required and this was then used to check and dispense the medicines. Staff had received appropriate training before they were able to administer medicines to people.

Staff understood how people liked to receive their medicines. The staff member who we observed administering the medication understood why people took their medicines. One person asked the staff member why they should take their medicine. We observed the staff member discreetly inform them. Where people had PRN [as required] medicines protocols were not always in place. This was important so that staff had clear guidance about when they should give the medicines. On the second day of our inspection the registered manager had ensure that all PRN protocols were in place.

Requires Improvement

Is the service effective?

Our findings

People were not consistently offered choices about their meals. One person said, "They told me off for not eating. I don't get a choice of food". Another person said, "No, they don't ask what I want for dinner." A person's relative confirmed this, they said, "I don't think they give a choice" People's preferences were not respected. One person told us that they disliked meat but alternatives were not offered. They said, "With not eating meat the alternative is not there." On the day of our inspection every person had the same meal at lunch time. We were told that they had been offered a choice of two meals however each person had chosen the same which was faggots and potatoes. One person said, "They took it that's what I wanted. Faggots it was, no choice given". We checked people's care plans and found that two people were recorded as disliking meat. On the second day of our inspection we saw that people were offered a choice of two meals from a trolley in front of them. We were told that people were offered a choice of sandwiches for their evening meal. The registered manager told us that people could also choose to have a hot evening meal if they wished. People that we spoke with were not aware that this was an option. One person had expressed that they enjoyed soup but that this was not an option despite them having requested it in the past.

People were at risk of not having enough to eat and drink. We saw that people were offered drinks as part of the daily routine. One person said, "We get drinks at set times, biscuits sometimes. Never asked outside the set times". Where people required specialist diets these were catered for. We saw that some people were identified as being at risk of urinary tract infections and that in order to prevent these they should be encouraged to drink. We observed that one person was encouraged by staff but that staff did not keep a record of the amount that this person drank in order to ensure that they were getting enough to drink.

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 Act. 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 we found that it was not.

Staff had received training regarding MCA and had an understanding of the principals and what they meant. One staff member told us, "We have to get people involved to make decisions, somethings are done in their best interest." We saw that where people's capacity to consent to their care was in question mental capacity assessments had not been undertaken and the appropriate records about how decisions were reached were not in place. We saw that there was some reference to people's ability to make decisions in their care plans. We saw that one person had been with the service since June 2016. The registered manager confirmed that they suspected that this person lacked the capacity to consent to their care and that they were being deprived of their liberty. The registered manager had failed to make any assessments of this person's capacity or make an application for DoLS. This meant that this person was being unlawfully deprived of their liberty. We saw that a condition of a person's DoLS authorisation was that staff take a person for a walk

regularly. On the day of our inspection visit we was that this person was offered the opportunity to go for a walk after lunch but then was not taken. Some people had a lasting power of attorney (LPA) agreement in place regarding their care and welfare and finances. This is a legal agreement that allows another person to manage a person's finances or make decisions on their behalf with regard to their care. It was not clear within people's care plans where LPA's were in place. This meant that there was a risk that the relevant people would not be consulted when decisions were being taken.

People were not asked their consent when they had the capacity to give it. One person told us, "I don't think they ask for consent, it just happens." We saw that one person was deemed to be able to make decisions about the care that they received. However we saw that their family members had been consulted when this person's bed was fitted with rails for their safety. On another occasion we were told that a person's family member had requested that items be removed from a person's bedroom for safe keeping. The person themselves was not consulted on this despite the registered manager confirming that they would have been able to consent to this.

We saw that people were supported to maintain good health. One person said, "The doctor visits us. I have a home chiropodist. I've had an eye test since I've been here". A staff member said, "I think we do our best to keep on top of things." A senior staff member told us, "If I'm concerned I ring the nurse or doctor." People had access to health care professionals. The records that the service kept with regard to health professional advice were clear and in depth. We saw that one person had refused their medication in the past. This was respected but they had been encouraged to see their GP to discuss their concerns about their medicines. After a discussion with their GP they agreed that they would take certain medicines at the time of day that they were prepared to take them.

Staff did not always have the knowledge and skills to meet the needs of people who were living with dementia. One staff member told us that they were unsure if some staff knew about "advanced dementia." We saw that staff had received on line training around supporting people with dementia. Staff also demonstrated a lack of understanding around the behaviour that some people displayed and how best to support them. The registered manager had not identified the skills that staff supplied by an agency would need to have in order to work at the service. We saw that night shifts were predominantly staffed by agency staff however the registered manager could not confirm if these staff had received training around supporting people with dementia and those who display behaviour that may challenge.

Staff told us that they received training when they started working at the service that enabled them to understand and meet people's needs. Training included manual handling and health and safety training. Staff confirmed that they had completed manual handling training and shadowed more experienced staff members before they supported people on their own. Staff told us that they had attended courses such as, dignity in care, safeguarding and practical sessions where they used people's safety equipment to practice their moving and handling skills. One staff member told us, "Staff know what they are doing". The staff training records showed that staff received regular refresher training and ongoing learning. We saw that staff's understanding of the training materials used had been assessed when they had completed on-line training. The registered manager had implemented work based competency checks for staff which had been completed in 2015. The registered manager told us that they intended to complete competency checks before the end of 2016.

Staff told us that they felt supported in their roles. The registered manager had conducted regular group supervisions with staff. During these supervisions a topic was identified and staff were given guidance around how best to achieve the aims identified by the topic. For example, 'maintaining a high level of cleanliness within the home' and 'meeting people's health needs.' These supervisions offered staff guidance

around best practice and offered them an opportunity to pool ideas. The registered manager did not conduct regular individual supervisions with staff members. We saw that three staff members had received only one individual supervision in 2016. During supervision staff's progress, competency in their role, training and support needs were discussed.

Requires Improvement

Is the service caring?

Our findings

People's bedrooms were not respected as private. One person told us, "Other residents walk into your room without a by your leave." During our inspection visit we saw that two people had entered the bedroom of a third person. Staff were only alerted to this when the two people began to talk in raised voices. People told us that staff did not always ask permission to enter their bedrooms. One person said, "They knock on the door and shout my name. They don't ask permission".

We received mixed feedback about whether people felt that their opinions about their care mattered. One person told us, "They do listen to me, they are fair with me, I get on with them." A person's relative told us that they had been consulted with regard to their relatives care. However other people and their relatives told us that they had not been consulted about the things that were important to them. One person said, "I don't remember them discussing my care." A person's relative told us, "I'm not aware of a care plan. They have not sat down with me and discussed updating her care." People's opinions were not routinely sought. One person told us, "They don't explain things."

People felt that staff were caring. One person said, "Care staff are very, very good and very nice." Another person said, "I'm happy with the way they look after me." "A third person said, "They are caring except when they are rushed off their feet". A person's relative told us, "We are happy with her care so far." A person's advocate told us, "The staff are very nice here." We observed that staff treated people with kindness but that they did not always give them the time that they needed. A staff member told us, "It would be nice to be able to sit with them." During our inspection we observed several examples of considered and compassionate care.

When people were receiving personal care their dignity was maintained and they were treated with respect. One staff member told us that it was important to "Be private with people and make sure they are not exposed." A person's advocate told us, "I've never seen anyone be disrespectful." We observed staff interactions with people throughout our inspection which confirmed this. We observed one member of staff ask a person discreetly if they would like to use the toilet before they took their lunch. Staff had received training regarding how best to support people's dignity.

People were offered support to maintain their independence. One person said, "They are all very good to me, they encourage me." Another person went on to tell us how they are able to compete care tasks for themselves. A person's advocate told us that they thought it was important for a person to be engaged in tasks such as polishing and maintaining their environment and that this was respected. People's care plans offered staff some limited guidance around how to support people to maintain their independence.

People were able to receive visitors without undue restriction. One relative told us, "I can come when I want; they always offer me a drink." Another relative told us, "I can come when I like". We saw that the visitors signing in book reflected this. People could meet with visitors in communal areas or in their bedrooms. People told us that their bedrooms were comfortable. One person described their room as being "Comfortable and warm." We observed another person taking about their bedroom with pride. They told us

that they liked their room.

Inadequate

Is the service responsive?

Our findings

The provider had not established an effective system for handling complaints. We saw that the provider's complaints procedure was included in the service user guide that was kept in each person's room. We also saw that the procedure was on display on a communal notice board. However, most of the people and their relatives that we spoke with told us that they were not aware of the service complaints procedure. One person said, "Who would I raise concerns to?" This meant that it had not been provided to people in a format that was easy for people to access. We saw that people had raised concerns to staff members. They had told staff people's behaviour was upsetting them. Their complaint had not been acted upon in line with the provider's policy. The registered manager had not been made aware of the concerns and had not taken action to address them. This meant that people remained worried. We saw that a member of the public had raised a concern about the noise coming from the home and had been particularly worried that people were not being cared for. The complaint had not been recorded in line with the provider's policy or investigated. Again the registered manager had not been made aware of the complaint. No investigation had taken place into the cause of the sound and whether people were receiving the care that they needed. A relative told us that they had made a complaint but that this had not been resolved to their satisfaction.

These matters constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had failed to assess people's needs prior to them receiving care. We saw that a person who had recently moved into the service had not had all of their care needs assessed by the registered manager. As a result their support needs had not been fully identified. Staff had not been given the guidance that they needed to ensure that this person's needs were met. The registered manager told us that they were surprised by the person's confused state. Another person who had been admitted to hospital had returned back to the home however, the registered manager had not reviewed the person's needs prior to them returning to the home. As a result staff had not been prepared to meet this person's increased needs and staffing levels had not been reviewed in order to ensure that they were suitable to meet the person's needs. There was a risk that staff were unable to meet this person's higher needs due to the increased amount of time they took to support.

People had not contributed to the assessment and planning of their care and care plans were not reflective of how they would like to receive support and was not centred on them as individuals. We saw that the information within people's care plans did not provide in-depth detail about how people wished to be supported and fully take into account their preferences. For example whether they would prefer to have a bath or a shower and at what time of day they would like this. We saw that detail about people's life history and the things that were important to them was limited and in some cases completely lacking. These included information about people's family and their previous occupation. Information about these things would be particularly important for staff to have when supporting people with dementia. This information could be key to helping people be reassured during times of confusion and anxiety.
People's care plans included information that guided staff on the activities and level of support people required for tasks as part of their daily routine. We saw that the level of detail in the care plans was not

always sufficient for staff to have all the information they needed to provide care as people wished. For example we saw that one person's care plan did not offer staff guidance around the level of support that a person required to maintain good oral hygiene. This meant that there was a risk that the person would not receive the dental care that they needed to maintain healthy teeth and gums.

People's care plans were reviewed regularly but they were not involved in the review process. Where reviews had taken place care plans had not been updated to reflect changes in people's support needs. For example, we saw that one person was described in their care plan as 'a little confused' at times. When we met with this person we found that they were extremely disorientated and unable to give their own name. This meant that the person was at risk of not receiving the care that they needed because staff were not guided about what level of care they needed. Another person's mobility had decreased and as a result they required more support from staff but this had not been recorded in their care plan. This meant hat staff could not be confident that they were supporting a person to move safely and in line with their specific needs.

We saw that records relating to peoples mood and behaviour were not consistently completed by staff. We saw that people had been given medicines that had been prescribed to help them become calmer when they were displaying signs of anxiety. We were unable to find records which to demonstrate that the person had been displaying signs of anxiety before they received their medicines. The registered manager confirmed that the records had not been made. This meant that people were at risk of being given medication when they did not need it. This was of particular concern as the medication that people were given when anxious could make them less alert and affect their balance. This would make them more likely to experience falls and further confusion. Staff had not been given clear guidance about how and when to complete these records. We discussed this with the registered manager who was not able to demonstrate that they had a clear understanding of the function of these records. People's mood and behaviours needed to be recorded so that the registered manager could see if there was anything in the support offered by staff that required changing. We reviewed the records that had been completed and identified that a person seemed to experience increased anxiety at times when they needed to use the toilet or had been incontinent. This had not been identified in their care plan as a potential cause of anxiety. This meant that staff were not given clear guidance about how to prevent the person from becoming anxious and increased the amount of time that the person was experiencing anxiety and upset.

People were not supported to follow their interests. "There isn't much choice of anything here. Sit around usually, don't do much". Another person said, "I just sit here most of the time". Relatives confirmed this. One relative told us, "Don't see any activities here". Another relative said, "No activities when short staffed. They have got better, making things for Poppy Day, Firework night. There is group singing and dancing sometimes." A third relative said, "I've not seen any activities."
Since our last inspection the registered manager had employed an activities co-ordinator for five and a half hours per day, five days per week. They were required to split their time between completing domestic duties and supporting people with activities. We saw that there were photographs of some people engaging in activities. The records that staff kept with regard to the activities that people were involved in showed that people were not offered activities that had been identified as of interest to them in their care plan. For example we saw that one person had been offered craft activities and watching television which they had refused. Their care plan stated that they enjoyed knitting. They had not been offered knitting as an activity. During our inspection visit we saw that staff attempted to encourage people to sing along to music that was popular when most people were younger. Some seemed to enjoy this however most people seemed to be disinterested. People were at risk of social isolation and boredom

These matters constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

People were not asked for feedback about the service that they received. One person said, "They have never asked my opinion". A person relative told us, "I don't think they have mentioned residents meetings." Another relative said, "No-one has asked me my thoughts". The registered manager confirmed that they did not routinely conduct residents meetings or in other ways communicate with people to keep them informed about changes in the service or ask for their feedback. This demonstrated that the provider did not encourage feedback in order to drive improvement. The provider told us that they had conducted surveys with relatives of people who used the service in January 2016. This was to establish their views on whether they were happy with the support provided by staff and what things could be improved. We saw that the feedback received was mostly positive. The provider told us that they had shared with people how they planned to address the comments that where not positive.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that the service did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service. At this inspection we found that the provider had not made the necessary changes in order to address these issues.

The registered manger had not provided staff with clear guidelines in order for them to fully perform their role. Staff were not clear under which circumstances they should complete behaviour charts for people. We saw that records with regard to people's behaviour were not competed. We pointed this out to the registered manager on the first day of our inspection. On the second day of our inspection we saw that the registered manager had not ensured that staff completed the records of a person who we had expressed concern about on the 1st day of our inspection. Systems were not in place to oversee records to ensure that these had been completed accurately.

People's plans of care were reviewed monthly by a senior staff member or the registered manager but we saw that they had not been updated as a result of the review to ensure they reflected people's changing needs. For example we saw that where positional charts had been identified as important to ensure that staff were helping people to reposition regularly. These were not in place. The registered manager's checks of care plans had not identified these concerns.

The registered manager did not have effective systems for gathering information about the service. We saw that some processes for identifying areas of concern and analysing how to improve on quality to ensure the smooth running of the service and drive improvement were not in place. For example the registered manager did not routinely monitor how long people were required to wait when they pressed their call bell. They had not formally assessed people's dependency levels to ensure that the correct number of staff were deployed. Nor did they have any other formal way of ensuring that there enough staff employed or on duty.

Systems were not in place to drive improvement. At our last inspection we identified concerns. The registered manager had not taken all the necessary action to address the areas of concern. The registered manger told us that they had endeavoured to "Make sure I keep on top of my paperwork." However they admitted that they had not done so when we identified concerns at this inspection.

The registered manager had not acted on feedback from external professionals for the purpose of continually evaluating and improving the service. A person's advocate had identified in September that the person's behaviour chart had not been filled in on an occasion when they had displayed increased anxiety. At our inspection we found other occasions when records around people's behaviours had not been kept.

The registered manager did not have effective systems in place to challenge the practice of staff where concerns were raised. We saw that a concern about staff practice had been reported to the registered manager. The concern had not been fully investigated and the appropriate disciplinary action had not been taken against the staff member. This meant that people could not be assured that they were supported by

staff who were suitable to carry out their role.

The was there was a person present at the home at the time of our inspection who was not visiting anyone receiving the service and who was not employed to work there. She told us that she assisted the registered manager with administrative duties and confirmed that this included having access to people's confidential information. The registered manager also confirmed this. No recruitment process had been undertaken and as they were not formally employed by the service they were not subject to any disciplinary process or codes of conduct. This meant that people could not be assured that their personal details were safe and that the registered manager understood their role in ensuring systems and processes were in place to ensure only people who were suitably employed could access people's records.

These matters constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people that we spoke with did not know who the registered manager was. One person said, "The manager comes around sometimes, don't know her name, speaks sometimes". Another person said, "Have we got a manager?" A third person said, "No, I don't know the manager". However a person's relative told us, "She is, definitely [approachable]. We always have a chat when she is here." Another relative said, "I know the manager, I have spoken to her".

The staff that we spoke with gave mixed views about whether they felt supported by the registered manager. One staff member told us that "The support is brilliant." Another staff member told us that the registered manager was "Very approachable but not a strong leader." Some staff told us that they were present at the home five days per week but other staff told us that they were there less often. Staff confirmed that the registered manger was assessable via telephone if they ever needed to contact them.

Staff had a clear vision of their role and the service ethos. On staff member told us, "Our basic role is to make sure our residents are looked after to the best." Each person had a service user guide available to them with in their bedroom which gave them guidance about what service they should expect to receive. This guide was written as if addressing people's relatives rather than people themselves. This meant that people were not clearly at the centre of communications.

We saw the provider's registration certificates were displayed. However, the latest Care Quality Commission (CQC) inspection report was not available and the provider's overall performance rating from the last inspection visit was not displayed. The provider has a legal duty to ensure the rating of its performance by CQC is shown at the service. We raised this with the registered manager and a copy of the overall performance rating was displayed by the end of our inspection visit.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not appropriate to their needs and did not reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established and did not operate effectively to prevent abuse of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received had not been investigated and necessary action taken in response to the complaint.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not in place to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Issue warning notice.