Ashgate Care Limited

Ashgate House Care Home

Inspection report

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Ashgate
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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Ashgate House provides care and support, including nursing care, for adults with a variety of needs. At the time of our visit we were told that all the people in the home were living with dementia. The home is registered to support 45 people. At the time of our visit 42 people were living there.

There was a registered manager in post. 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 of the Health and Social Care Act and associated Regulations about how the service is run.

As all the people living in the home were living with dementia the information and evidence in this report is mostly drawn from relatives, observations and discussions with staff.

Relatives told us they were satisfied with the care and support provided and felt the needs of their family members were being met. People were treated with kindness and respect and relatives told us they felt their family members were safe living in the home. Plans were in place for health care if this was required. However, risks to people's safety were not monitored consistently. Also people's needs were assessed and plans put in place to meet those needs but these were not always followed through.

We saw people were supported by a staff team that, mostly, understood their individual needs. We saw that staff were friendly and kind and supported people to maintain their dignity. However, on several occasions we saw people try to attract the attention of staff and they did not receive a response.

People were not supported to follow their own interests or wishes and there was no specialist equipment in place for people living with dementia to enable them to engage in meaningful activities.

People's nutritional and dietary requirements were met and a nutritionally balanced diet was provided.

Staff recruitment procedures were in place and there were appropriate checks carried out before staff started work. Staff received an induction and felt they had received the appropriate training to provide the support to people that was required.

Staff were aware of how to protect people from the risk of avoidable harm and were aware of safeguarding procedures, however, these procedures were not always followed through. There were insufficient staff on duty in all locations, at all times, to ensure people were kept safe.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008 were not met in all instances.

Medicines were not always managed safely.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were insufficient numbers of staff on duty some of the time to ensure people's safety. This meant people were not always protected from avoidable harm.

Risks were identified for individuals and plans put in place to mitigate the risks. However, plans in the risk assessments were not always followed through.

Medicines were not managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

People were supported by staff who were skilled in good practice, though this wasn't always put into practice.

People were supported to have enough to eat and drink.

People were supported to access health care when this was necessary.

Is the service caring?

Good

The service was caring.

Care staff supported people appropriately and were kind and respectful.

We saw that staff built up a rapport with the people they provided care for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to follow their own interests and spent a large part of the day without interaction from staff.

People knew how to request improvements in the service.

Complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems and processes to maintain quality and safety in the home were not monitored sufficiently.

Best interest assessments were not always carried out where these were required.

People and staff had confidence to approach management with any concerns or issues.

Ashgate House 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 on 12 September 2016 and was unannounced there was a follow-up visit on 16 September 2016 which was announced.

The inspection team was made up of an inspector, two inspection managers, an expert by experience and a specialist adviser. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service. The specialist adviser had a nursing background as this home provides nursing care.

Prior to the inspection we looked at the previous inspection report. We contacted the Local Authority and Healthwatch to ask if they had any information which might inform the inspection. We looked at statutory notifications sent to us by the provider. A notification is information about important events which the service is required to tell us about by law. We also looked at the provider information return (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. The PIR also provides data about the organisation of the service.

During our inspection with spoke with seven people living in the home, four relatives, the registered manager, deputy manager, a registered nurse, four care staff, both activities co-ordinators, the cook and the administrator. After the inspection we spoke with two professionals involved with the service.

We used our short observational framework for inspection (SOFI). SOFI is a way of observing care specifically to help us understand the experience of people who could not talk to us.

During our inspection we looked at a number of records including six care plans and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The manager told us they were aware of their responsibilities in promoting the safety of people living in the home. However, CQC had not been informed of safeguarding concerns and incidents when people had put other people at risk. We drew this to the attention of the registered manager who said they were not aware this was necessary but said they would undertake this in the future.

We saw risks were identified in care plans though consistent measures were not put in place to help keep people safe. For example, we saw from records there was an increase in falls for one person living in the home. Records stated there should be a referral to the enablement team if there was an increase in falls for this person. This had not been done which meant there was no action being taken to reduce the risk of falls for this person.

When we looked at how people's skin was protected from pressure area damage we saw position changes were not always undertaken for people. We saw in records two examples where people's skin condition had deteriorated and there was an increase in size in the damaged skin. . This meant that although risks assessments had been carried out, and risks identified, the action to reduce the risk had not always been carried through.

We saw there were behaviour charts in place and these were used to inform care planning. However, the risks identified on the behaviour charts tended to focus on staff rather than people living in the home. This meant risk assessments were not as effective as they could be in protecting people who lived at the home.

Recording of incidents was inconsistent. There was information in the daily notes and behaviour charts for individuals but these did not cross reference to provide a full overview of all that was happening in the home. There was no evidence these incidents were analysed to reduce the risk of future occurrence and future harm to people using the service. This meant we could not be sure the registered manager had a full overview of risks to people living in the home.

We saw one person who was moved staff, in a way which was not safe and could have caused injury. We discussed this with the registered manager who told us this should not have happened and they would talk to the staff concerned.

During the night people were helped to be kept safe by hourly checks from a member of staff. We looked at records and could see this happened. However, where people chose to spend the day in their room, monitoring checks were not recorded. A member of staff told us people were checked regularly to help ensure they were safe but there were no records that confirmed this.

The medicines trolley was left unlocked each time the staff member went to administer medicine to someone. This meant people who were mobile would have been able to access the medicines in the trolley. This put people at risk from swallowing medicine which was not prescribed for them.

We looked at the records for people who were using skin patches delivering medicines. Records were not always filled in to show where the patches were being applied to the body. This means that there was an increased risk that the patches were not being applied and removed in line with the manufacturer's guidance which could result in unnecessary side effects.

We saw a record of an incident that occurred when a person fell and banged their head. The person was then given a medicine which could mask signs that the person was becoming drowsy and unwell as a result of the fall and the bang to the head. This meant the person was at risk of a serious medical condition which would not have been noticed by staff.

There was a covert medicine in place for one person to ensure they received their medicines regularly, even when they refused them. We saw the person had refused to take their medicine on more than one occasion but staff had failed to give the medicine covertly. When we discussed this with a member of staff and asked why the medicine had not been given, even though a covert medicine plan was in place, they were unable to explain the reason. This meant the person had not received their medicine for their condition.

One of the care plans had weights recorded but there were discrepancies in the information recorded and it appeared one person's weight fluctuated up to 10kg from month to month. However, there was no comment in the notes to explain this. When we discussed this with the deputy manager they told us the scales had been malfunctioning and they now had another set. This meant staff could not be sure the person's weight had been monitored safely.

We talked to the registered manager about the risk of Legionnaires disease in the home. Legionella bacteria are commonly found in water. Health and Safety Executive guidance states that health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures are in place to control the risk. In March 2016 Legionella was detected in the water at a low concentration, but there was no policy to address this matter. This meant that the continuity of checking for Legionella in the water could have been compromised.

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

One relative told us there were not always enough staff available to monitor people and they had to wait for staff to come back into the room before they were able to leave. We saw there were not always enough staff on duty to care for people and keep them safe all of the time. There were times when there was only one member of staff on duty in the large communal sitting room to support up to sixteen people. This meant the member of staff was unable to monitor or support all the people who were in the room. This put people at risk from a loss of their dignity or physical harm from themselves or others. When we spoke with a visiting professional to the home they told us it was sometimes difficult to find a member of staff to speak with and they believed sometimes people were at risk due to insufficient staff being available in the main communal sitting room.

There were various occasions when a number of people were unsettled and staff were not able to respond to them as there were insufficient staff in the room at the time. We saw one person become very distressed in the communal sitting room as another person was trying to talk to them and they were not welcoming of the interaction. However, at the time there was only one member of staff in the room and they were assisting other people to their chairs for lunch. This meant people were not always protected from abuse from other people living in the home. When we discussed this with the manager they explained how staffing levels were calculated.

Relatives told us that, mostly, they believed there were enough staff on duty to meet people's needs in a safe way. One member of staff told us there they believed there were enough staff on duty unless there were members of staff off sick. Following the inspection we spoke with the nurse on duty overnight and they told us they believed there were enough staff unless there was sickness or annual leave. On the occasions they were short of staff overnight they were quick to get agency staff in.

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

Relatives told us they felt their family members were safe living at Ashgate House Care Home. All the relatives we spoke with told us they were content with the care provided by staff and they did not have any concerns about the safety of their family members. One relative told us their family member was not restricted and staff, "Keep an eye open all the time". Another relative said "I never go home with any concerns at all". A third relative said, "Communication here is brilliant, we trust them to look after [relative]".

People were free to walk around the communal areas in the home and staff were watchful and quick to offer support if a person required this when they were available. For example, we saw people being offered their zimmer frames if they were attempting to walk without them. However, there were sometimes insufficient staff available.

Staff demonstrated they were able to identify concerns and were clear they were responsible for people's safety. When we spoke with staff they demonstrated they had an understanding of different types of abuse and were aware of how to report any safeguarding concerns. However, when we looked at safeguarding records we could see that alerts had not always been forward to the appropriate authority for investigation. Staff knew about the Whistleblowing policy in place and they knew how to escalate their concerns if necessary.

In order to keep people safe all call bells had been replaced with pressure mats. This was because the majority of people in the home were living with dementia and were unable to use the call bells when they required assistance. By the introduction of pressure mats staff were made aware of when someone tried to get out of bed. This meant either during the day if people chose to remain in bed, or at night, staff were alerted and could assist a person to help keep them safe.

Relatives told us medicines were given appropriately and two relatives told us they were pleased their family members had their medicines reduced since living in the home. One relative went on to tell us this meant the home were managing their family member in a safer way with reduced medicine. Another relative told us the medicine for their family member had been reduced, they said "They took [relative] off it, [relative] is noisier without it but they manage it well". A third relative told us their family member's medicine had been reduced in the home and told us they were now more themselves.

We observed that most medicines were administered and signed for correctly. All medicines administration records (MARs) were completed correctly. They had photographs in place so staff could ensure they were giving the correct medicine to the right person. Allergies were noted on the MAR's to help ensure people were not prescribed medicine that could have caused them harm. Medicine reviews were carried out by the pharmacist or GP for most of the people.

There was a procedure in place for the recruitment of staff. Discussions with staff and a review of the records showed identity and security checks had been carried out on staff before they started working in the home. This included taking up references for staff and completing Disclosure and Barring Service (DBS)

checks. DBS is a way of helping to ensure that only people of suitable character are employed in the home. Staff did not take up employment until the appropriate checks had been carried out.

There was a personal evacuation plan in place if people were required to be evacuated from the building in an emergency. This helped to ensure people were kept safe as there was a planned process for emptying the building.

We saw communal bathing spaces were clean and contained soap and towels to help prevent the incidence of cross infection.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they believed their family members were supported by staff who had the appropriate skills and training to undertake their responsibilities. One relative told us the staff were regularly having training sessions. Another relative said "They seem to know what they're doing". A third relative said "There's a consistency of staff and standards, they know how to handle people with dementia". They also said "It's seamless when new people come". When we spoke with staff they could tell us how they provided appropriate care for people. During our inspection we saw some skilled and knowledgeable interactions from staff to the people they cared for.

Staff told us their induction had involved shadowing a more experienced member of staff until they were competent to undertake care independently. They also told us they were able to use this time to get to know people living in the home. One member of staff told us they had the opportunity to get to know the people before they began supporting them. They said "That's what I like about here". All staff we spoke with said they could ask for help and support if they needed this.

Staff told us and records confirmed they undertook training in moving and handling, fire safety training, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff told us they had also undertaken training in palliative care, catheterisation and breakaway techniques. However, another member of staff told us they had worked for the organisation for several months and still had not received their MCA and dementia training. This meant training had not been consistent across the staff team and a lack of knowledge and skill could have a negative impact on people living in the home.

The registered manager told us how special training was being arranged for all staff around working with people with dementia. This was a new way of staff understanding what it is like living with dementia through experiences.

We found the home were not working within the principles of The Mental Capacity Act 2005 (MCA). 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 helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that the procedures in the MCA had not been followed for all people living in the care for home. For example, we saw other examples of where initial capacity assessments were in place but there were no details or evidence of best interest decisions or least restrictive options. We also saw that consent forms for the influenza vaccine for people was signed by the next of kin on behalf of people living in the home and there was no best interest assessment to support this. This meant that people living in the home, or those lawfully acting on their behalf, had not given consent before decisions were made on behalf of people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). When we talked to staff they had some understanding of the

principles behind DoLS but were did not fully understand what this meant for people. When we looked at records we saw some evidence that DoLS had been requested from the local authority and some were already in place. We saw people being asked to consent to care before they were supported by staff.

Relatives told us they believed the food was adequate and some thought it excellent. One relative said "The food is excellent I had Sunday lunch here yesterday, it was very good". Another relative said "I think , [relative] is healthier than they've been for years, due to the food they eat". One relative noticed their family member had a problem eating, and thought they had difficulty swallowing. The relative said staff seemed to be able to handle this well. They also said they were happy that staff kept a record of what his family member ate and drank.

There was no menu in the dining room but when we observed the lunch time meal we saw there was a selection of sandwiches on offer and people were given a choice. The food on offer at lunch time looked appetizing and there was a choice of sandwiches and cakes. The registered manager explained they used to serve the main meal at lunch time but had changed this as they noticed people had a better appetite late afternoon. In this way people were encouraged to maximise their nutritional intake. They were also given a choice of drinks from a trolley. We did not see the drinks trolley at any other time in the day though we did see some people have drinks when they requested these. One person told us they always got a drink when they asked for one. However, for those who were unable to ask this meant that they may have gone without a drink for several hours.

Staff helped people to eat their meal in a dignified way and offered people a bite of their sandwich at a time. One member of staff we spoke with said how important it was to give encouragement for people to eat their food and they did this by talking to them and giving them time to eat their meal. They went on to say they encouraged people to eat by letting them enjoy the smell of the food and touch the spoon to the lip so they were aware to open their mouths. However, no utensils were used to serve the sandwiches which were handled by members of staff. This could have caused cross contamination.

On the day we visited the care home some of the fresh food in the fridges did not have a date when it had first been stored. This meant people may have been put at risk from eating food that was not fresh. We drew this to the attention of the kitchen staff and when we visited a second time a few days later the food was all dated to state when it had been opened and was within safe dates.

People's relatives told us that when health care was required this was available. They said the GP called regularly and their relative could see them when necessary. Records showed there was evidence of referrals to health care agencies and professionals outside of the home. People's health and well-being was monitored and responded to. One relative told us the chiropodist visited regularly.

However, one person had their weight recorded and there had been a reduction of almost 6 kgs in two months. Information in the care plan demonstrated the person had been seen by a dietitian and supplements were prescribed. Instructions to staff were to ensure the person was offered a varied, nutritious, fortified and high calorie diet. The person was also prescribed supplementary food to increase her nutrition. However, they continually refused the dietary supplements and no further action had been taken regarding their weight. This put the person at risk of unhealthy weight loss.

Good

Is the service caring?

Our findings

People's relatives told us staff were caring. One person said "[Relative] seems very happy and content. I can't fault them, they're wonderful, very approachable, very affectionate". Another relative told us "[Relative's] happy here, I feel comfortable with staff, I don't know how they manage, they're very kind and caring". A third person said "There's a good friendly vibe and we can speak to them here, they're approachable and helpful".

We saw caring relationships and interactions between the people who lived in the home and the staff. For example, we saw good eye contact and staff getting to the level of people so they could communicate with them. One member of staff explained how they introduced new people to those already living there so they could help to be integrated into the community within the home. Staff showed an understanding of what it was like to feel lonely and empathised for the people living in the home. They said they approached people with a "Little touch and a smile" to help people feel comfortable and welcome.

One member of staff explained they supported people in a caring way by getting to know their facial and body expressions. In this way they could provide care that the person was comfortable with. Another member of staff said one of the ways of understanding if someone was feeling sad or lonely was if they became withdrawn and their appetite reduced. In this way staff were using different types of information to respond to people's emotional needs.

When staff spoke with people we observed they very calm and spoke clearly to people. They waited for a response and listened to what people said. We saw an example when we observed a sensitive and caring interaction from staff when a person required assistance with their continence care. We also saw a member of staff put a cushion under someone's head when they fell asleep in the chair. Staff asked people whether they wanted to continue to sit in their armchair or go to the table for lunch.

People's involvement in their care planning was not evident. However, all the people in the home were living with dementia and we saw that people's relatives had been involved and included in care planning for their family member. People's relatives also told us people were supported to be involved in decisions about how they received their care. One member of staff told us they encouraged people to do as much of their personal care as they could to help maintain their independence.

Relatives told us they were consulted about the care and treatment of their relatives and everyone was treated with dignity and respect. We saw one occasion where a member of staff was quick to identify a person was not dressed properly and assisted them. They supported the person to maintain their dignity by assisting them with putting their clothes back on. Staff also told us they maintained people's dignity by using towels to cover parts of the body when they were providing care. We observed staff knocking on people's rooms before entering and one relative said "They [staff] always knock on [relatives] door" before they enter.

Staff explained how they used different methods to support people with their personal care to maintain

their dignity. This depended on the person and they adapted their techniques to suit different people. Staff said they always ensured doors were closed when they were assisting with personal care. In this way people were supported to maintain their dignity when they required help with this.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they didn't think there were enough meaningful activities for people living in the home to be engaged in. One relative said "I do wonder why there aren't more activities". Another relative told us they believed there were more activities in the afternoon and while we were there we saw a short religious service.

The activities co-ordinator said they believed the activities people enjoyed the most were visits from musicians and some communal singing groups. There was a piano in the communal sitting room but when we spoke with staff they couldn't remember the last time someone had been in to play it. One member of staff said it required a repair to work properly. We saw for part of the day the activities co-ordinators were carrying out caring responsibilities rather than one to one support or planning for future activities. This meant time designated to support people with their preferences and interests was being spent undertaking care tasks.

There was no orientation for people about the day of the week or the month of the year and the two clocks in the communal areas did not display the correct time. This meant people were not supported to orientate themselves to the time of day or day of the week. We saw very little in the way of activities for people on the day of our inspection and there was no up to date programme of activities on display. This meant support was not designed to meet people's preferences. Nor did it provide opportunities for people participate in decisions about how they received their activity support.

In the morning people were dozing in their chairs or walking around the communal space. Later in the morning we saw a member of staff put on a DVD for people to watch. However, we did not see any one to one time between staff and people living in the home apart from when they were receiving personal care and most people spent most of the day in a chair. We saw staff were not always engaging with people who lived in the home which meant people were spending time without social interaction of any kind. One member of staff told us they were able to spend some one to one time with people on a regular basis and everyone living in the home was supported in this way every day. However, when we talked further we understood that this was while they were assisting with personal care and not one to one activities that a person had chosen.

We saw several instances of people shouting to get the attention of staff but they were ignored. We saw one person leaning out of their chair with their head resting on a table. This was not noticed by staff until we drew it to their attention. The staff member repositioned the person and said "[person] always does that". This showed a lack of responsiveness to the person but also a lack of empathy.

Care plans contained "This is me" which gave information about people, including their past history and preferences. They had been reviewed monthly to ensure they remained reflective of needs but when we talked to a member of staff about the likes and preferences of one person they were unable to tell us. We spoke with another member of staff who had been awarded a dignity champion and they were unable to describe to us what person centred care meant. This meant staff did not fully understand the importance of

supporting people in a way that met all their needs and preferences.

When we spoke with the registered manager about person centred care in the home they told us that team meetings were designed to help inform staff of how important it was to work with people in this way. However, there was no formal process for doing this. The consequence of this was that person centred care was only slowly being integrated into the care provision in the home.

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

A member of staff told us people living in the home loved singing and dancing and they would "Pop some music on" so they could enjoy this. During the inspection we noticed a DVD was playing a musical film and some people were watching this. One relative told us their family member enjoyed music and singing and the activity co-ordinator would play CDs and sing along with her sometimes. Another relative said "There's always an activity in the day time when we come, church service or singers".

A member of staff told us the registered manager had agreed for one entertainer per month to be invited into the home and families were to be informed so they could take part if the entertainment if they wished. This showed relatives were encouraged to be involved in the life of their family member while they were living in the home.

Staff told us it was difficult to plan to work with people on an individual basis, and in a meaningful way, as their moods changed regularly. For this reason the planning for activities was flexible and changeable. Activities were mostly ad hoc on the day as they were responding to people's likes and dislikes at that particular time. We saw people were brought through to the main communal sitting room in the afternoon for a short religious service. However, we saw no-one engaged in one to one activities with a member of staff on the day we were there.

We looked at the activities diary which, for large parts of the summer months, had contained no information. However, we could see that activities were being increased and the up to date information recorded more activity time for people. A more structured approach was being taken to undertaking activities and interests for people. We could see from records that people were receiving some activities but they were insufficient to support their emotional needs. What we saw on the day confirmed this.

We saw staff adapted the way they approached people depending on whether they were agitated and upset or not. For example, we saw one member of staff talking to a person about what they were doing at the moment as a way of distracting them from their frustration. Also, as a way of responding to people's wishes the registered manager had arranged for signs to be placed around the home and in people's rooms which read "Does it Have to Happen Now". The notice was used as a reminder to staff that people should be supported to make personal choices, for example whether to get out of bed or not. People were supported to identify their own rooms as they had their name and a picture on the door.

Compliments and complaints were recorded and we could see investigations were undertaken by the registered manager. Full written reports were provided in response to people making complaints. Relatives were aware of the complaint procedures and said this information had been included in the information pack they received when their family member first entered the home. All the relatives we spoke with said they were comfortable raising any concerns to staff and felt they would be listened to. One relative said "I haven't had to make a complaint, I've made some observations and would go to the senior carer or the manager". They went on to say I'm not aware of the formal procedure but staff and the manager have acted

on what I've said. This means people were confident that their concerns would be acted upon.

Requires Improvement

Is the service well-led?

Our findings

We checked to ensure the maintenance of equipment in the home was up to date. Records showed the equipment used for safe moving and handling of people was not. When we mentioned this to the registered manager they were quick to give direction to a member of staff to ensure this was rectified. This meant the weekly maintenance checklist hadn't identified that the hoist services were out of date which could have put people at risk from unsafe care.

There was no formal review of care plans by the registered manager which meant they could not monitor if they were person centred. We were informed that twenty nine members of staff were dignity champions but when we spoke with one member of staff they did not understand what person centred care was. This meant there was not a full understanding by all staff about person centred care and so it could not be supported in the culture in the home.

Audits to ensure the Mental Capacity Act and Deprivation of Liberty Safeguards were followed had not been effective in ensuring best interest assessments had been undertaken for people. Although there was a plan in place to review the documentation monthly the only review evidence in the records was 23 July 2016.

There was a malodour in the main sitting room of the home and the carpet was stained. The dining area part of this space had a hard floor but was sticky. We looked at cleaning schedules in the home but there were gaps in the recording and the manager was unable to provide an explanation for this. This meant there was insufficient quality monitoring of the cleaning in the home.

Safeguarding incidents had not been reported to the appropriate authority where the safeguarding concerns had involved only the people living in the home. Accidents and incidents were not cross referenced across different records and monitored by the registered manager.

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

Two relatives told us they believed the staff took a "Team approach" to caring and would support each other to provide support to people. Another relative said "I feel comfortable with the staff. They do listen to me, they have a family's survey annually. Relatives of people who lived in the home told us they were satisfied with the care their family members received. They said they felt comfortable with the registered manager and other staff. One relative said "I can talk to the manager, [manager's] very approachable. Some relatives mentioned the support they received from the registered manager and they appreciated that staff were always approachable. Another relative said "I would be quite happy to talk to the manager or senior carer".

Staff felt they could ask for advice when they needed it from the registered manager or other senior staff. One member of staff told us that "Staff morale is really good". They told us they saw the registered manager several times a day around the home and they saw [registered manager] talking with people who lived in the

home. One member of staff said "I love it here, it's very friendly as you walk in". They also said "The staff are happy" and there was "Good team work".

Staff told us they got good support from their line managers and the registered manager was approachable. They also said they believed high quality care was delivered in the home and there was a positive culture. Staff understood their roles and responsibilities. When we spoke with a professional involved with the home they told us they believed the registered manager knew the people living there well.

There were relative meetings on a three monthly basis and they told us they welcomed this as an opportunity to look at how they could contribute for fund raising for entertainment. Funding for entertainment came out a resident's budget. Relatives also told us about a regular survey which took place to gather their views. We saw the most recent results were posted in the entrance hall.

There was evidence from staff meeting minutes that relatives had requested staff photographs be displayed in reception and we could see this had been done. The registered manager told us the home had been awarded the Bronze Dignity Award but were aiming for the silver. They were undertaking a project, involving people at the home, to change the culture of the working practices away from task orientated to personalised care. For example they were looking at doing things in a different way so that people were more involved in the running of the home.

A new quality audit was now being undertaken by the Operations Manager. When they visit the home they undertook quality checks, on a random basis, of the structure and maintenance of the building and care plans. However, they had only just commenced and there was no conclusive evidence they would be effective.

Staff said they felt supported in their work responsibilities and they had three monthly supervisions and appraisals. When we looked at records we could see staff supervisions and appraisals had been carried out. We also saw that staff meetings occurred which helped to support staff in their caring responsibilities

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 17 HSCA RA Regulations 2014 Good governance Auditing and MCA not adhered to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staffing to keep people safe.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's views and preferences were not sought regarding how they wanted to spend their time.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines and risks not safely.

The enforcement action we took:
Warning notice