Ash House (Yorkshire) Limited

Ash House Residential Home

Inspection report

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Dore
Sheffield
South Yorkshire
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 5 and 9 September 2016 and was unannounced on the first day, which meant the provider did not know we were coming. We last inspected the service in July 2014 when it was found to be meeting the regulations we assessed.

Ash House provides personal care and accommodation for up to forty older people. The service was divided into two units. Beech Walk unit, which cared for people living with dementia and Beech View unit, which was classed as the residential unit. There were two double and thirty six single rooms. Communal lounge and dining rooms were provided on both units. An outside seating area overlooking the grounds is provided. The home is a detached building in its own grounds. It is situated in the Dore area of Sheffield. At the time of the inspection the home was providing care for 36 people, some of whom had a diagnosis of dementia.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The current registered manager is in a temporary position since February 2016 until a new manager is recruited.

People told us they felt the home was a safe place to live. Systems were in place to protect people from the risk of harm. Staff were knowledgeable about safeguarding people from abuse, and were able to explain the procedures to follow should there be any concerns of this kind.

At the time of our inspection we found there were adequate staff on duty to meet people's care needs in a timely manner. Although staff told us that at weekends and at night it could be busy. They said during the week they had the assistance of the registered manager and the activity coordinator, who did not work at weekends.

The registered manager told us they did not have or use a staffing dependency tool. This would determine people's so they were assured there were adequate staff on duty at all times to meet people's needs based upon their level of dependency. Some of the care records we saw lacked detail, were out of date or contradictory. When care records were reviewed, the reviews did not always result in relevant changes being made to people's care plans or risk assessments. We identified instances where there was no care plans in place, so staff were not aware of people's needs and how to meet them safely.

Medicines were stored safely and procedures were in place to ensure they were administered correctly. However, we found these systems were not always followed and people did not always receive their medication as prescribed.

The manager was aware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place and key staff had been trained. This helped to make sure people were safeguarded from excessive or unnecessary restrictions being place on them. We found some

improvements were still required to ensure mental capacity assessments and best interest decision records were more individualised and decision specific.

We found staff approached people in a kind and caring way. However, some of the interactions we observed were task orientated. Signage around the home was not dementia friendly. Notice boards were not kept up to date and menus were not always displayed.

People were supported appropriately to eat and drink sufficient to maintain a balanced diet and adequate hydration. However we found the meal time experience was not as pleasant an experience for people who were living with dementia, as it was for others.

We saw the provider followed safe recruitment procedures to ensure people employed to work with vulnerable people were fit to do so. However, we found staff had not received supervision in line with the provider's policies.

The company's complaints policy was available to people using or visiting the service and people and their relatives we spoke with raised no concerns. We saw that when concerns had been raised these were documented, but there had been a period of time for which we found no documented evidence of investigation undertaken and outcomes. There was a system in place to enable people to share their opinion of the service provided and the general facilities available. We also saw an audit system had been used to check if company policies had been followed and the premises were safe and well maintained. The registered manager was aware of all the shortfalls we had identified during our inspection and they had been identified, either by the registered manger or the consultant that the provider had commissioned to improve the services provided. The registered manager acknowledged there were significant improvements required to be made, but told us they were supported by the provider to ensure improvements were implemented and sustained.

We found the service was in breach of four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back 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?

Requires Improvement

The service was not always safe.

Individual risks to people were not always assessed or mitigated.

There was no dependency tool used to determine people's needs to ensure adequate staffing levels were maintained to meet people's needs.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff lacked understanding on how to meet people's needs when they demonstrated behaviours that may challenge others.

Nutritional and health needs were not consistently met for people living with dementia.

Appropriate referrals had been made using the mental capacity and deprivation of liberty safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw care staff mostly interacted with people who used the service in a kind and sensitive manner and ensured their privacy and dignity was maintained. However, we found some staff at times did not interact positively with people and were task orientated. Care was not always individualised or person centred when caring for people living with dementia.

People were supported to maintain important relationships. Relatives told us they could visit when they wanted to, and were always made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's health, care and support needs were regularly assessed and reviewed. However, we found these were not meaningful and did not respond to any changes in people's needs.

People accessed activities. However, activities did not always meet the needs of people living with dementia.

People told us they would feel comfortable raising any concerns with staff. There was a system in place to tell people how to make a complaint and how it would be managed. However, there was no formal documentation to show investigation or outcomes.

Is the service well-led?

Requires Improvement

The service was not always well led;

People we spoke with told us the registered manager was approachable and would always listen to them and acted promptly to address any concerns. .

Audits and checks of practice had identified shortfalls and action plans had been developed. However, these were in the early stages of being implemented and ensure these were embedded into practice.

Ash House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

One adult social care inspector carried out the inspection on 5 and 9 September 2016. The inspection was unannounced, which meant the provider and staff did not know we would be inspecting the home that day.

Before our inspection we reviewed all the information we held about the service. The provider had completed a provider information return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also looked at concerns received from the local authority and relatives, and any statutory notifications we had received from the service.

During the inspection we spoke with four visiting health care professionals for their views on the service. We also contacted by telephone the Local Authority contracts team and the safeguarding team to gain feedback.

We also sought advice from a pharmacist specialist who is part of CQC's medicines team in relation to our assessment of medicines management.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care, including care plans, risk assessments and daily records. We looked at five people's support plans in detail.

We spoke with eight people living at the home; some people were unable to engage with us fully due to their limited capacity. We also spoke with five relatives to gain their views on the care provided.

During our inspection we also spoke with three team leaders, four care staff, the administrator, the activity coordinator, the registered manager and the provider. We also looked at records relating to medicines management and how the home monitored the quality of services. A health care consultant was present on the second day. The provider had recently engaged them to help identify improvements and help the registered manger implement the improvements required.

Requires Improvement

Is the service safe?

Our findings

We spoke with people who used the service to assess if they felt safe in the home. Everyone we spoke with told us they felt safe. Some people were living with dementia and we have not been able to include some of their responses. All of the relatives we spoke with told us they felt the home was safe.

Throughout the two days of the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that at times people had to wait for assistance from staff. However, when it was busy the registered manager and the activity coordinator also assisted, which meant people did not have to wait. For example; we saw they both assisted at meal times to ensure people received assistance in a timely way.

We asked the registered manager how they determined staffing levels they told us they had not used a dependency tool, they determined staffing by number of people who used the service rather than needs. However, they were aware they should be using a dependency tool, and had identified this was required and this was planned to be implemented. Staff told us at nights and at weekends it could be busy at times and could do with more staff.

Staff told us there was only three staff on duty at night form 8pm until 8am. The service was arranged in two separate units. Staff told us there was one care worker on each unit and a team leader worked between the two. There were people on both units who required two staff to assist with personal care and moving and handling. We were also told that people were still up when night staff arrived, so required assistance to get ready for bed; this could mean communal areas would be left unattended by staff, so people's safety could be at risk.

We also found that although there were not many accidents that occurred, out of the accidents we saw recorded most had occurred at night and many were un-witnessed. This had not been reviewed by the registered manager to determine if this was due to inadequate staff or ineffective deployment of staff to ensure people were safe. The registered manager told us this shortfall had been identified and would be actioned. They also explained that they were going to introduce a dependency tool to determine people's needs and ensure adequate staff were provided, particularly at weekends and nights.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

The temperature of the medication storage room and the medication refrigerator were checked daily. However, the room thermometer was not a minimum and maximum thermometer, so it was not possible to determine what temperatures the room reached throughout the 24 hour period. The registered manager agreed to purchase the correct thermometer to ensure the room was maintained within the recommended temperature range to store medicines.

We found a large number of medicines administration record (MAR) charts were hand written and these

were not checked and signed by a second member of staff, which is good practice. We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, for pain relief and to alleviate agitation. We saw PRN medication was not always given as prescribed. We found people did not always have PRN protocols, or if they were in place they were very generic and did not give sufficient detail to determine when to give PRN medication or explain how people presented when they were in pain or agitated. This is important when people are living with dementia, as they may not be able to verbally communicate to staff when they were in pain or distressed.

We found on occasions people did not receive medication as prescribed. For example we found for two people there was a discrepancy in amount administered and the number of tablets in stock. We found there were more tablets in stock than had been signed as given therefore not all of the tablets had been administered as prescribed. This could have had a detrimental effect on the person.

Not maintaining accurate records of administration contravened the homes policy and NICE guidance.

We also found one person was prescribed and administered a medication to help with anxiety and agitation. This was to be given as and when required. There was no care plan to direct staff when they were required, no PRN protocol to explain when to administer the medication and staff had not recorded why they had been given. There was nothing recorded within their daily records to detail if the person was anxious or agitated at the time they were given. Therefore, it was not possible to determine why the medication was given.

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

We found the service had policies and procedures to manage risks. There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. However, not all people had their risks assessed and we found two care files we looked at did not have any care plans or risk assessments in place. For example one person who did not have a care plan in place had been recently admitted, the assessment from the local authority that we saw stated they lived with dementia and could at time present with behaviour that may challenge. This could put them at risk of harm or at risk of harming others if this was not managed. There were no care needs identified and no risk assessments in place. This meant staff did not understand how to meet the person's needs or reduce and manage risks, putting people at risk of harm.

We identified another person was at risk of developing pressure sores. They were cared for in bed and had the appropriate pressure relieving mattress. However, the repositioning changing charts had not always been completed, so it was not possible to determine if they received the care to meet their needs.

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

The staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Staff told us they would not hesitate to report any safeguarding

concerns. They told us if they felt the management of the home did not respond appropriately they would report to the local authority. Staff had received training in safeguarding of vulnerable adults and whistleblowing procedures. However, staff were not following procedures as during this inspection we identified medication errors that constituted a safeguarding concern as people had not received medication as prescribed. This had not been identified by the registered manager, although following our visit they carried out a full investigation and met with staff to discuss concerns and they made two referrals to Sheffield safeguarding authority following the completion of the inspection.

As part of the inspection we looked around the home and found some areas required a thorough clean. This included the bath hoist chairs that were encrusted in dirt underneath the chair and had not been thoroughly cleaned. There was carpet on the floor in store rooms and was unable to be thoroughly cleaned. We found mops were stored in buckets wet, which could cause bacterial growth and risk of cross infection. We found that toiletries were stored in cupboards in communal bathrooms; we also found a prescribed cream in a bathroom cupboard. We saw this had been identified by the registered manger and on the second day of our inspection that the areas we identified as requiring attention had been actioned and either cleaned, items removed or practices changed to ensure people were protected by the prevention and control of infection. The registered manager told us this would be followed up with staff to ensure practices were embedded into practice.

Requires Improvement

Is the service effective?

Our findings

People who used the service and the relatives we spoke with told us that the care provided was good. One relative said, "The manager is very good, hands on and aware of [my relatives] needs."

Staff we spoke with were knowledgeable regarding people's needs and were able to explain how they met their needs. However, the care plans did not always reflect people's current needs and the reviews we saw were not effective. For example we found one person had been identified as at risk of presenting with behaviour that may challenge, there was a care plan in place but no risk assessments. The daily records recorded episodes of agitation and unsettled behaviour, the behaviour chart and mood chart however, were not completed and no reviews had been carried out. This meant it was not possible to determine if there was a trigger for the behaviour so staff could manage the person's behaviour effectively.

We also saw another person was at risk of poor nutritional intake and the care plan directed staff to keep this under review. There was also an entry following a GP visit requesting the person was weighed every two weeks to monitor and referred to the GP if they had any weight loss. The care plan showed they had suffered weight loss but there had been no review and there was no evidence they had been referred to the GP. This meant the person risk of weight loss was not being monitored and managed effectively.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw evidence that DoLS applications had been submitted to the local supervisory body although most were still waiting for a response.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that although predominantly people's conditions were being met, this was not always the case. One person had conditions that they were to be able to access the community, and had not been supported to do this and the information from the supervisory body detailed that they should access where they used to live as this was important to them. This had not been facilitated. The registered manager told us they were aware this required organising and would plan this following our inspection.

We saw in care files that capacity assessment and best interest decisions were included. Staff were also

aware of how to ensure decisions were made in people's best interests. However, the documented decisions did not give enough detail to be able to determine if the decision was being made in their best interests and followed the principles of the Act.

People were supported by staff to eat and drink sufficient to maintain a balanced diet or adequate hydration. We also saw that most people's weight was regularly recorded and no one had lost significant weight. We looked at people's food and fluid charts and found however, that these were not always completed and people's intake was not clearly documented. It was therefore not possible to determine if people had received adequate food and hydration. For example, one person who had been identified as at risk of poor nutritional intake had this monitored by staff completing a food and fluid chart. This person had not lost weight but we found the records were not always completed and when they were, it just stated they had eaten either a quarter, half, three quarters or all the meal. However, staff had not detailed what the meal was or how much was served, to be able to determine how much was eaten. These had not been reviewed so were not effective in ensuring people received adequate food and hydration. The registered manager told us they had identified the charts required improving and they were working at developing a better system for recording.

We carried out a SOFI observation of lunch on Beech Walk unit on the first day of this inspection. From our observations we found the mealtime experience for people was poor. Meals were placed in front of people without any explanation, staff cut up people's food without asking first if this was required. No choice of drinks was offered, as these were already poured and placed on the tables before people came to sit down. There were no condiments on the tables for people to choose if they wanted them and none were offered.

During the observation one person continually banged the cutlery on the table making a very loud noise and shouting at other people and staff. They appeared to be very distressed. Staff did not offer appropriate assistance and eventually the person threw their food on the floor. Staff responded to this by moving their chair away from the table. They were still very distressed and the staff did not know how to support the person, or provide appropriate assistance. This was also very disruptive to other people who were having their meal. The registered manager went to get the person some alternative food and explained to us that they did not always like the meals, but would eat a breakfast cereal. The registered manager provided this and the person calmed down and ate the cereal.

One person required a soft diet due to swallowing difficulties; this was served in a dessert bowl as a brown thick soup consistency. We asked the member of staff what it was and they said it was the meat, potatoes and vegetables liquidised together. The staff member pulled a face to indicate the food did not look appetising and told us it was always served in that way. They said, "We suggested sectioned plates so that each food can be liquidised separately and placed in different sections of the plate." This would mean the person could see from the colour what the food was and make it more appetising for them.

The choice of food was written on a black board but there were no pictures. People living with dementia may not always understand what was written but would be able to make choices when shown a picture of food. We also found good practice regarding meals for people living with dementia was not followed. For example, the food was served on white plates and on a pale tablecloth with no colour contrast. Best practice guidance, for example the 'EHE Environmental Assessment Tool' from Kings fund 2014, suggests that food should be presented on coloured plates to provide a contrast so that it is appears more appealing to people living with dementia.

The meal time experience was not conducive to an enjoyable experience for people. We saw staff assisting people to eat while kneeling on the floor next to them or leaning over them. There was lack of engagement

form staff when they were offering support .This was not person centred and did not meet people's needs.

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

During our inspection we looked round the home and found many environmental improvements were required. The registered manager told us these had been identified and they had an environmental action plan that had commenced. They had replaced a number of carpets and new chairs for the lounge were delivered on the day of our visit. However, the environment in Beech Walk unit which cared for people living with dementia was very clinical and sparse and did not follow best practice guidance for dementia friendly environments. The walls were all painted cream the curtains were cream and the floor was a light blue hard floor covering that was very shiny. There were no pictures or items of interest for people to see or use. The nursing and care dementia care survival guide suggests environments that are designed specifically for people living with dementia can reduce the incidence of agitation and challenging behaviour can encourage meaningful activities and increase feelings of well-being.

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

We also observed the meal on the second day of our inspection, we did see some improvements. For example, the liquidised food was better presented and people were shown the food to make a choice. However, staff still knelt and leaned over people to assist and we saw very little positive interaction or encouragement for people to eat their meal. The registered manager had identified the meal time experience needed to be improved and this was part of their action plan, but had not been implemented at the time of our inspection.

We identified that 12 staff out of 28 had received supervision in 2016 and 11 had only received one supervision session. This was not in line with the provider's policies. The registered manager told us staff should receive supervision every two months. Staff we spoke with told us they did feel supported and could go to the registered manager at any time and her door was always open. This did not ensure staff were able to do the job they were employed to do. We have been informed since our inspection that progress had been made with this, in that 20 staff had received supervision and the rest were planned in line with the policies, to ensure staff were adequately supported in their roles.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives about the care they received. Most of the relatives we spoke with told us that they thought staff 'did their best' to care for their family members. One relative told us, "It is a nice welcoming atmosphere." Another told us, "Good communication and (the staff) seem to know the residents. I am very happy."

Everyone we spoke with spoke very highly of the registered manager, who had commenced back after a two year break in February 2016. They told us she was always available to listen and nothing was too much trouble. One relative told us, "The manager is extremely caring and passionate about the residents, you see her about and she is always approachable."

The registered manager told us they had been requested by the owner to return to the service, as the owner had identified improvements were needed. The registered manager had agreed to return until a new manager could be recruited. They told us they had since their return identified the care needed to be improved and had concentrated on this with staff, ensuring care and support was provided in a person centred and individualised way to meet people's needs.

During our visit we spent time in communal areas observing people who used the service and talking to relatives and staff. We saw some very good positive interactions between people and staff. We observed a difference in atmosphere between the two units. On Beech View staff interacted with people and there was an inclusive, welcoming and relaxed atmosphere. Staff had a warm and inclusive rapport with the people on this unit. People were treated with respect and their dignity was maintained throughout.

However, at times staff did not interact or engage with people who lived on Beech Walk. This may have been as staff did not fully understand how to communicate with people living with dementia. We also saw at times staff were not in communal areas on this unit and people were left unsupported by staff. During our observation in the lounge on Beech Walk who was not able to maintain their dignity, there were no staff around to assist this person and ensure their dignity was maintained. The registered manager was aware of the issues and staff training needs on this unit, and was addressing the issues with staff and looking at ways to improve the quality of care for people they supported living with dementia.

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

Staff understood the need to respect people's confidentiality and not to discuss issues in public, or disclose information to people who did not need to know. Any information that needed to be passed on about people was discussed at staff handovers, which were conducted in private.

To enable staff to understand their role in supporting people we saw they had received specific training in topics such as equality and diversity and dignity in care. However, the registered manager told us although staff had been identified as dignity champions this was in name only and they required more training and

support to fulfil this role to be able to promote dignity in the home.

A healthcare professional told us, "The staff are usually very good, but the registered manager is exceptional, I have seen improvements since they have come back to manage, more organised."

We spoke to staff regarding caring for people who were receiving end of life care. They were able to explain how they would keep them comfortable, pain free and safe, ensuring they had regular contact with staff so they were not isolated. However, we found people who were cared for at the end of their lives did not always have their needs clearly documented. Staff explained their needs, but this was not reflected in the documentation. For example, staff explained that the tissue viability nurse had requested specialist footwear was used and the person's feet placed up on a pillow to relieve pressure from their heels, but this was not documented anywhere in their plan of care. We were also told the person was repositioned every two hours and this was recorded, but we could not locate any records after 7 September 2016, as the records for 8 and 9 September 2016 were missing. All staff we spoke with told us they were repositioned as required at least every two hours but it was not clear from documented evidence if the person's needs were being met.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us that activities in the home had improved greatly since the new activity coordinator had commenced. We observed activities taking place they were enjoyed by people who used the service and when they were on-going people were laughing and joking with each other and told us they were really enjoying the activity. We saw armchair exercises, cards, skittles and crafts taking place. However, most activities took place on Beech View unit. The people living on Beech Walk, which was the unit for people living with dementia, did not have access to many activities, and so lacked engagement and stimulation. Staff we spoke with told us people would benefit from more activities on the dementia unit.

We discussed this with the registered manager who informed us that the activities coordinator was very new in post and was getting to know people and what their needs were. They also said they were looking at ways to improve the activities and stimulation on the dementia unit and were looking at any relevant training courses for the coordinator to attend.

We checked care records belonging to five people who were using the service at the time of the inspection. We found that care plans did not always have sufficient detail or set out how staff should support each person so that their individual needs were met. For example, one person's plan we looked at had an assessment carried out by the local authority in March 2016 when the person was being assessed for care to be provided in their own home. The file did not contain any other information. Staff told us they had been recently been admitted. The local authority assessment detailed the person could present with behaviour that may challenge and gave other details of needs that had not been incorporated into a care plan. Another person who had been in the service for a short period of time although some care needs identified, not all their needs had been assessed and incorporated into a care plan. The lack of assessment and planned care to meet the person needs put them at risk of not receiving the care they required.

We also looked at care files of people who had lived at the service a while. We found these included people's need, but they were not up to date and had not always kept pace with or changed to reflect their current needs. We also saw that some people's reviews were not meaningful and did not identify any changes to people's needs. For example, one person was meant to be weighed every two weeks and this had not been carried out, but the review did not identify this.

As part of our inspection we spoke with the local authority commissioners they told us at their last visit in March 2016 they had identified that some areas required improvements. These included care planning documentation. They said people's needs had not always been identified or reviewed effectively.

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

The registered manager was aware of the shortfalls in the care files and was training staff in how to write a care plan and how to review appropriately. We looked at one file that had been updated and this was much better. It identified the person's needs and the reviews were relevant. The registered manager explained that

this was to be completed in all files. This was also detailed in their action plan.

There was information available in the communal area of the home, about how to make a complaint. Relatives we spoke with told us they would feel confident in making a complaint should they feel the need to. One relative told us, "The manager is very approachable and always resolves any issues promptly." We looked at a record of one complaint which a relative had raised about staffing levels. The record showed no evidence how the complaint had been investigated. The lack of detail on the form meant we could not determine how the complaint was addressed. There was no date to establish if the complaint had been investigated in the timescales agreed within the provider's policy. There was not an accessible system in place to identify, record, respond and record complaints. The administrator was able to print off the letters sent to the complainant, but there was no other record of the investigation of how the outcome was reached. This had not been identified through an effective monitoring system. The registered manager acknowledged the records needed to be improved and ensured us this would be put in place following our inspection.

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

Requires Improvement

Is the service well-led?

Our findings

There was a manager in place who had returned to the service. They had retired over two years ago, but the owner had asked them to return when they had identified improvements were required. They took up post at the end of February 2016. They were registered with Care Quality Commission as the registration had not been cancelled when they retired. The registered manager told us they had returned and had concentrated on improving the care delivery to ensure people received care that was more person centred.

People and relatives we spoke with told us the registered manager was a very good manager and was managing the service well. Relatives commented that things had definitely improved since they had returned. One relative said, "We see the manager, she is always about ensuring things are right, she always has time to talk and find out how you are and if you have any concerns." A health care professional we spoke with said, "The manager is good, follows thing through when requested and it is better now she is back."

All care staff we spoke with told us things had improved and were aware of what improvements were required. One staff member told us, "We work well as a team; it is coming together now [the registered manager] is back."

We found there were shortfalls across all aspects of the service. For example, medication concerns. Since our visit the registered manager had met with all staff that administer medication and discussed correct procedures to follow. Competency assessments have been arranged and the registered manager has implemented daily checks of medication until systems are embedded into practice.

We found audits and quality monitoring had been carried out and these had identified areas that required improvement. For example the environment and health and safety audit had identified actions, including replacing floor coverings, redecorating rooms and replacing arm chairs. We saw the registered manager was working through the action plans and work had commenced and some actions had been completed. The registered manager was aware of all the shortfalls we had identified during our inspection and they had been identified, either by the registered manger or the consultant that the provider had commissioned to improve the service. The registered manager acknowledged there was still significant improvements to be made but told us they were supported by the provider to ensure improvements were implemented and sustained. Although the provider and registered manager had identified significant improvements were required, these had not yet been implemented and will require embedding into practice to ensure improvements made are sustained. The monitoring systems in place had not been effective in early identification of concerns within the services provided to ensure these could be quickly identified and addressed.

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

We spoke with the provider and they explained that they wanted a succession plan and wanted to appoint a deputy manager who could be trained to become the registered manager. However, they had struggled to

recruit a suitable candidate, so had gone to a recruitment agency. They had then successfully recruited and the new deputy manager was due to commence on 19 September 2016. They had also recruited a new activity coordinator who had been in post in three weeks. They also explained they were looking at ways to improve the dementia unit and were considering a dementia unit manager.

The provider to assist the registered manager had also commissioned a health care consultant to assist and they visited approximately once a week to audit and assess quality of service provision. The provider acknowledged that they may also, on a temporary basis, require additional administration hours to enable the registered manager to induct and mentor the new deputy manager. The administrator worked three days a week and this was to be increase to four. The provider and registered manager had responded to the shortfalls and had identified what was required, but had not successfully implemented systems at the time of the inspection. They were committed to ensuring they were implemented and embedded into practice.

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 People did not always receive care and treatment that was person centred and that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and did not always ensure their privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care and treatment in a safe way. Assessment of to peoples health and safety were not always carried out and management systems were not in place to mitigate any such risks. People were not protected against the unsafe management of medicines. People did not receive their medication as prescribed and sufficient quantities of medicines were not always in stock to ensure the safety of people and to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The providers' monitoring systems had not been effective in early identification of concerns within the services provided.