Ackroyd House Limited

Ackroyd House

Inspection report

Ackroyd House
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South Yorkshire
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Tel: 01709364422

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27 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 27 February 2018. The inspection was unannounced, which meant the people living at Ackroyd House and the staff working there didn't know we were visiting. The service was previously inspected in November 2016 and was meeting all the fundamental standards. However, we had received concerns regarding this service so we bought the comprehensive inspection forward.

At the time of our inspection the home had 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. The registered manager did not manage the home on a day to day basis. This led to some confusion about who was in charge. Other members of the management team were in place to support the registered manager in the day to day running of the home.

Ackroyd House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It provides accommodation for up to 52 people in one adapted building. There were 49 people using the service at the time of our inspection.

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and they were confident management would take any concerns they had seriously and take appropriate action. However issues we identified during the day did not support this and we submitted a safeguarding referral to the local authority.

We found there was a dependency tool to determine staffing levels, on the day of our inspection we found there was adequate staff to meet people's needs. However, we found staff were task orientated and not person centred.

Risks to people had not always been identified and if they were identified we found these were not always followed. Systems were in place for safe management of medicines. However, we identified some areas of documentation could be improved.

Infection prevention and control systems were not effective. We found areas of the service were not kept clean or hygienic to ensure people were protected from acquired infections.

We found procedures were followed for the recruitment of staff. Staff supervision took place and staff told us they feel supported. Staff received training that should have ensured they had the competencies and skills to meet the needs of people who used the service. However the training was not effective.

We found the service did not always meet the requirements of the Mental Capacity Act 2005 and Deprivation

of Liberty Safeguards (DoLS). Most staff we spoke with did not have a satisfactory understanding and knowledge of this, and people who used the service had not been assessed to determine if a DoLS application was required. We also found people's best interest decisions were not always considered.

People were offered a well-balanced diet; however, we saw people were not always supported to maintain a balanced diet. People accessed health care services when required. Referrals were made quickly to health care professionals when people's needs changed. However, advice was not always followed.

People and their relatives we spoke with all said that some staff were kind and caring. however, we received some negative comments regarding staff attitude and observed some poor interactions between people and staff.

Care plans varied in detail some identified people's needs while others had limited information and meant staff did not have the necessary plans of care to be able to manage people's needs.

There was no activity coordinator and people told us there were not activities. therefore people's social needs were not met.

There were processes in place to monitor the quality and safety of the service. However, these had not always been completed or if they had, actions had not been followed. This meant the quality monitoring systems were not effective.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections are 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?

Inadequate

The service was not safe.

Staff understood the safeguarding policies but we found staff had not always reported further when action was not taken to ensure peoples safety.

Risks had been identified but were not reviewed accurately so the level of risk was not correct putting people at risk.

Infection prevention and control systems were not safe. We found areas of the service was not well maintained and was not kept clean.

Recruitment procedures were followed to ensure the right people were employed to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

We found people were offered a well-balanced diet however; appropriate support was not provided to ensure people received adequate nutrition to meet their needs and people were not given choices.

Staff monitored people's healthcare needs, and made referrals to healthcare professionals. However, the advice given was not always followed.

Staff received training to fulfil their roles and responsibilities but this was not effective.

People's consent was not sought in line with legislation and guidance.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that some staff were kind, considerate and caring. However, we received some negative comments about staff

attitude.

We saw that staff respected people's privacy and dignity.

We observed that care and support was task orientated at times and not individualised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records varied some identified people's needs, others lacked detail and did not always reflect the person's current level of need.

There was no activities taking place to meet people's social needs.

There was a complaints system in place; complaints had been recorded and resolved.

Is the service well-led?

Inadequate

The service was not well led

The registered manager did not manage the home on a day to day basis. Other members of the management team were in place to support the registered manager. This led to some confusion about who was in charge.

The registered provider had systems in place to monitor the quality of the service; however, these were not being implemented effectively.

The provider listened to and acted on the feedback, but the outcome had not always been effective.

Ackroyd House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection. This inspection took place on 27 February 2018 and was unannounced. The membership of the inspection team comprised three adult social care inspectors 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. The expert by experience had experience of supporting and caring for older people including people living with dementia.

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We did not request the provider sent us a Provider Information Return as we bought the inspection forward. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection visit we reviewed the service's current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We contacted commissioners of the service and safeguarding to ascertain whether they held any information about the service. This information was used to assist with the planning of our inspection and inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. Observations helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spoke with the registered provider, the deputy manager, the registered manager, a nurse, four care staff, a member of the quality team, a domestic and the cook. We also spoke with 12 people who used the service and six relatives.

We reviewed a wide range of records, including people's care records and staff files. We checked the medication administration records. We observed people having lunch in two dining areas. We reviewed a new member of staff's personnel files. We looked at six people's care plans in detail. We also reviewed the policies, procedures and audits relating to the management and quality assurance of the service provided at Ackroyd House.

Inadequate

Is the service safe?

Our findings

People and their relatives who we spoke with all told us that they felt safe. One person said, "It's a nice place, nice staff".

Staff we spoke with were knowledgeable about safeguarding people from abuse. They told us how they would recognise abuse and that they would report any concerns to their line manager. However, we found staff did not always identify and meet people's needs safely and we referred two safeguarding's to the local authority following our inspection.

People's moving and handling risks were not always managed. We saw one store room which was used to charge up equipment. We also saw that this area was used to store slings which were to be used with the hoist equipment for moving and handling purposes. The slings were not labelled so it was unclear who they belonged to. We also saw one sling which was kept on the back of the bathroom door which had no label to indicate who the sling belonged to and the manufacturer's label was beginning to wear. This means that people were at risk of being moved and handled using the wrong sling. The head of service told us this was an area they needed to address. The plan was for each person who required a sling would have two allocated to them which would be labelled up for their use only.

We looked at care plans belonging to people who required moving and handling equipment to transfer and found they did not contain enough information to keep them safe. For example, one person had a care plan in place for mobility which stated they required a hoist and two members of staff for all transfers. The plan did not detail what type or size of sling to use of where to position the loops.

We found staff did not move and handle people following best practice putting people at risk of harm. For example, one person's mobility care plan stated they required a stand aid and a large sling to transfer. We observed this person being moved in this way and could see the person was not able to weight bear. As the person attempted to stand, the sling moved up the person's body. The two staff then placed their arms under the person's arms to support them. However, this was not a safe way to move the person.

We also observed another person moved and handled inappropriately using equipment they were raised by staff from a lounge chair to the equipment by pulling them up under their arms. The person only had on socks and nearly slipped as the staff turned them around to the wheelchair. This put the person at risk of falling.

Risks associated with people's nutritional needs had been identified but care records lacked detail regarding minimising the risk. For example, one person had a malnutrition universal screening tool (MUST) in place. This identified the person was at risk of losing weight. However, the score on this tool indicated the person was at low risk of weight loss. This had been recorded incorrectly as due to continued weight loss the risk should have been scored as a medium risk.

We found medication procedures were in place to guide staff and ensure safe medication administration.

We saw most of the procedures were followed by staff. However, we found errors with the recording of medication that was prescribed to be administered as and when required. We checked the amount received minus the amount administered and we found the medication that was left in stock did not tally. In one instance we saw 112 pain relief medication tablets had been received, there was a record of 46 being administered, there were 53 left in stock. However, there should have been 66 this meant there were 13 tablets unaccounted for. There was no carried over amount documented and staff did not complete the correct paperwork on the administration record when these medications were given so it was difficult to ascertain when they had been administered. The registered provider agreed to look into this to implement better recording methods and audit systems to manage medicines safely.

Monitoring of medication storage rooms was not always completed. We also found the rooms did not have a minimum/maximum thermometer so it was not possible to determine that the temperature of the rooms over a 24 hour period was maintained within guidelines.

Topical medication records were not maintained to show people's creams had been applied as prescribed. Some people required care workers to apply creams which had been prescribed by the GP. We looked at how prescribed creams were administered and saw that 'as required' medicines were not signed for which made it difficult to know when or why they had been applied. There were no guidelines developed to give instructions on the administration of PRN, "as and when required" or short course medications. We spoke with care workers about this and we were told that they applied the creams when they thought it was necessary, but there were no protocols in place and no topical medication administration records in place for staff to record when they had applied them.

Infection, prevention and control of infection systems were not effective. We completed a tour of the service with members of the management team. We found some areas were unclean and in need of attention. We saw store cupboards had items stored on the floor preventing the floor to be cleaned effectively. Linen trollies were being used for both dirty and clean laundry with a bag attached to them for clinical waste. This meant that there was a risk of cross infection.

We observed staff wore jewellery and watches and were not bare below the elbow to ensure they could wash their hands effectively when they had supported people with personal care. Stone rings also put people at risk of skin tears.

During our tour of the home we saw many areas were not well maintained to be able to be effectively cleaned. We identified a number of floor covering that were not properly fixed and were damaged. The laundry was in a poor state of repair wall damaged and an accumulation of debris behind the washing machines. The fridge and microwave in the dining area on the upstairs unit were not kept clean. The microwave required a thorough clean but was also rusting in parts. The fridge seal had broken and engrained dirt was noticeable in the fridge and seal. The freezer compartment was so frozen that the foods stored there could not be removed. We spoke with the registered provider about these concerns and they took immediate action to address the issues. We saw at the end of the inspection areas that could be addressed immediately had been and we received confirmation in writing following our inspection that other areas were included on the action plan and would be addressed very quickly.

This is a breach of regulation 12 (1)(2) (a)(b)(g)(h) of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Safe care and treatment.

The registered provider had systems in place to ensure safe recruitment of staff. We looked at staff recruitment files and found the systems were followed and all relevant checks were carried out prior to

employment of staff.

There was enough staff to ensure people's needs were met safely. Although staff did not always follow safe practices. The registered manager showed us a dependency tool; this was used to determine how many staff were required to support people safely. We observed staff were present in communal areas and saw people were supported when required. One person told us, "There's always somebody about, if I press my buzzer in five minutes someone would be here it's the same at night. Sometimes they are a bit short when staff go off sick." However some people told us they thought there was not enough staff on duty. Another person said, "There's not enough staff both weekends and during the week. Staff are good at night. But they [the staff] forget to give me my buzzer." When we spoke with the person they did not have access to the buzzer. They also said, "Sometimes I have to wait it makes you wonder if they have enough staff. I have waited an hour although the worst is usually 20 to 30 minutes." We did not see evidence of people waiting for assistance during our inspection and staff we spoke with said there was enough staff on duty to meet people's need. They said, "We only struggle if we are short, if a staff member is off sick and we are unable to get cover."

Relatives we spoke with all said there seemed to be enough staff when they visited. One relative said, "There is definitely enough staff. I have never seen a problem they are always there if you need them."

Staff understood the need to raise concerns, record incidents and report them appropriately. we also found the registered provider had systems in place to monitor incidents and accidents and investigate when things went wrong. However, we found some incidents had not been reported properly and the management were not aware of all the safeguarding alerts that had been reported to the local authority. For example we found an incident recorded of an un-witnessed fall where the person had sustained an injury this had not been reported following procedures.

Inadequate

Is the service effective?

Our findings

People told us the care staff were good and looked after them. People told us they were given choices and given time to make decisions.

People's needs were assessed and care plans were in place. However these did not always reflect people's current needs and didn't always follow best practice guidance and advice.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were not knowledgeable about this subject to ensure people received support in line with the MCA. We found people's best interests were not always documented, did not always involve all relevant people and the outcome was not documented. Decisions being made were sometimes very general and not specific. For example, one person used a specialist chair throughout the day, but there were no evidence to indicate that the person's best interests had been considered. This person's care plan indicated that they lacked capacity, however, a mental capacity assessment, specific to this interaction, had not been completed.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Staff told us they felt supported and had received supervision. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Staff also received an annual appraisal of their work. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time. Staff also received training that enabled them to fulfil their roles and responsibilities. Staff told us the training was good. However from our observations we identified that training was not always effective. For example we were given information that all staff had received moving and handling training, yet throughout the inspection we observed all staff moved people following unsafe practices. we discussed this with the registered provider who has since the inspection confirmed this has been addressed.

We observed lunch in the dining room downstairs and found tables were nicely set and the meal looked appetising. However, staff were task focused and did not always ensure individual needs were being met. For example, one care worker said to the care worker serving the dessert, "Are we asking them what they want again." This implied that people were not always offered a choice. One person was given an ice cream dessert and told the care work they didn't want it. The care worker said, "It's there in front of you." No choice was offered as an alternative.

We also observed the lunch time meal on the upstairs unit which supported people living with dementia. Four people were sitting at the dining table. Two people were being supported to have their meal in their room and one person was supported to eat by their family. The dining room was small with no windows which felt a little oppressive. The wall mounted television was on and the volume was quite loud throughout the meal service. During the food service a staff member remarked, "The Tele's a bit loud", but did not do anything about it. The loud volume did not promote a calm atmosphere for people to enjoy their meal.

The tables had had no tablecloth or mats, there were no condiments. Meals arrived in the Bain Marie already plated and covered in Clingfilm. Orange squash was given to the people sitting at the table although blackcurrant was available it was not offered. We asked a staff member how they decided what people would like to eat as no one was asked what they would like to eat. They said, "Staff decide, we tell the kitchen, I tend to know what they like." They also told us, "There are lists of preferences in the kitchen downstairs." We did not see staff refer to the list of people's preferences and people were not given a choice.

There was no assistive technology seen, we observed one person was struggling to eat their meal as it was falling off the plate. This person would have found a plate guard helpful.

One person was being supported to eat by staff member. While the staff member was assisting the person they were chatting with others at the table and at one point they put down the spoon and fed another person at the table. The conversation by the staff member was not appropriate as they talked about their upcoming holiday, they said, "Are you coming with me?" which they repeated a couple of times. People were living with dementia and would not understand they were not able to go on holiday. This could cause confusion and distress.

This member of staff then left the room while they were in the middle of supporting a person with their meal. Another staff member eventually took over supporting the lady to eat; the delay meant the food was cold and not appetising.

Both staff members who were in the dining room were called away during the meal service leaving five people eating their meal with no supervision, this was for at least two minutes. People that were in the dining room were at risk of choking so required observation and support during their meals.

When people had finished their main course we observed the Bain Marie did not contain puddings. A staff member had to go down a couple of floor to collect the puddings from the kitchen. Staff did ask people prior to going down to the kitchen whether they would like bananas and custard or ice cream; most people were unable to express their view. We asked the member of staff how they were going to manage this, they said, "We guess what they want for pudding 'cos they can't talk."

We observed over a 15 minute wait between some people finishing their main meal and receiving their dessert. People left the dining room before the dessert was served as they though the meal was finished. This meant people did not receive the appropriate support to ensure they had enough to eat and drink.

People accessed health care services; we saw people had been referred to dieticians and speech and language therapists. However, advice from health care professionals was not always followed. For example, The registered provider had referred the person to the speech and language therapist (SALT) team on October 2017 following a period of weight loss. The advice given by the team was for staff to ensure the person received a normal diet, but softer options, using gravy and sauces to moisten food. The also advised that the person should be encouraged to drink small amounts between eat mouthful of food. We saw this person was given a fried fishcake with mushy peas and a small amount of sauce which was served at the side. Therefore the fishcake was not moistened. Staff did not offer any support to the person throughout the meal. However, another person offered a drink to the person and this was accepted. Before the person had completed their meal a care worker approached the person saying, "Have you finished," then took the meal before the person had chance to respond. It was clear that the person had not finished her meal. This did not promote the advice given from the SALT team and put the person at risk of losing more weight.

We saw from the MUST that the person had continued to lose weight and no further referral had been made to healthcare professionals.

The cooks we spoke with confirmed that it was the care staff that ordered food for people on the dementia unit. They said although they have a book of preferences only [named one member of staff] looks at it. They told us they plated the meals up and they were all the same. They were unable to show us a record of any discussions with people about what they would like to eat. They told us that fortified meals were done by the care staff adding 'powder' to meals they also said there was cream available.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional needs and hydration.

We found people's needs were not always met by the adaptation, design and decoration of the home. The registered provider had not considered the needs of people living with dementia. For example the dining room had no natural light there were no windows, which meant people would not know what time of day it was to understand what meal was being served. There was also no consideration to providing picture menus of people to be able to understand what was on offer and be able to make choices.

The service provided care for people who required support and rehabilitation following discharged form hospital. People were assessed and reviewed at the service by health care professionals to determine when they were well enough to go back home. The service worked with the health care professionals to provide coordinated care and support.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us most staff were kind. One person said, "The staff are lovely." A relative said, "All the staff are kind I have not seen anything wrong they treat [relative] well."

However, we received mixed views from people we spoke with on how they were treated. One person said, "Staff are kind some are kinder than others, I try not to grumble. But some are abrupt it hurts inwardly."

Another person said, "We have a joke with staff sometimes, but they [the staff] have their favourites. When waiting to go to bed there are those they always take first, I feel really down about it some days."

People were not always happy with the support they received. One person said, "I haven't had a shower for a while, over a week, I have had a sponge down I would prefer to have a shower." Another person said, "I don't get a bath or shower they wash me on the commode, I would like a shower."

We observed care workers interacting with people who used the service and found that whilst they were predominantly kind they were task focused, only communicating with them to perform a task.

We observed staff moved people in wheelchairs without talking to them or telling them what they were doing. Staff were providing support with meals and did not talk with the person during the meal. This meant staff did not promote respectful and empathetic behaviour within the staff team.

Staff did not always respect people's preferences. One person we spoke with said, "I don't always have a bath and sometimes have to wait, they [the staff] prefer to give me a shower because it's easier for them, I prefer a bath. I only get that about every four weeks."

People told us some staff were not caring, some people we spoke with told us staff had their 'favourites'. One person said, "Staff let it show who they like better."

We also found during the tour of the service that continence wear was stored communally in bathrooms and we also saw it stored in corridors and outside people's rooms. This did not promote person centred care.

We also witnessed a couple of occasions where staff did not treat people as individuals. During our mealtime observations, we heard a care worker shout down the corridor, "Can someone give me a hand to toilet her." This was not personalised and individualised.

We also observed people only had socks on when staff stood them on a stand aid this caused the person to slip and nearly fall. Staff did not ensure people were dressed appropriately to meet their needs. We also found some care plans did not detail people's preferences or choices. They lack detail on how the person liked to be supported and card for.

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

Person centred care.

We saw staff did promote people's privacy and dignity staff closed bedroom and toilet doors went hey were supporting people. However, we observed one occasion where staff did not promote privacy and dignity. For example, we observed staff supporting a person to use the stand aid in the lounge. The person had on a skirt that was too big and as they stood the skirt fell down revealing their underwear. Staff had not checked the persons clothing was secure before they stood them and ensure their dignity was maintained. We discussed this with the registered provider who agreed to look into this.

Staff told us there was access to advocacy services if required. Independent advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives. We saw there were advocacy notices throughout the home.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that met their needs. People told us they had to wait for support and did not always receive care that was their choice. People's plans of care did not give sufficient detail to fully reflect their needs. They did not detail individual preferences, interests or aspirations.

The service provided care and support for people at end of life. We saw there was information in care plans regarding the decision to not resuscitate (DNAR). These had been drawn up by the person's GP and included the person where relevant and their families. There were end of life care plans in place. However, these only referred to DNAR and funeral directors. The plans did not show consultation with the person to ascertain their wishes, choices or beliefs to ensure these were documented for staff to be able to follow in the event that their health deteriorated.

We looked at care records and found they lacked detail and were not responsive to people's individual needs. For example, one person had been seen by a healthcare professional and specific advice had been given to staff on how to support the person. This advice was not contained within the person's care plan and we observed that care workers were not supporting the person in the way they had been advised.

Another person's care plan we looked at contained only very brief details and did not give staff adequate information to be able to meet their needs. for example, We looked at one person's care plan and it stated that they required a safety gate or a door guard on their bedroom door. However, the care plan had not been regularly reviewed, so may have been out of date as we didn't see a safety gate or door guard in use on the persons bedroom door, when we checked. The records were not clear to ensure staff provided care that met the persons individual needs.

There was no evidence people were involved in the planning of their care. Which meant peoples choices and decisions were no incorporated into their plans.

People's communication needs were not clearly documented in care plans. Care plans we looked at detailed conflicting information in each care need. From reading care plans it was not clear what people's communication needs were. Care plans we saw gave no detail to staff to enable effective communication.

The service had not always considered the Accessible Information Standard (AIS). The AIS applies to people using the service who have information and communication needs relating to a disability, impairment or sensory loss. People had access to a call system and could use this to alert staff that they required support. However, care plans we looked at lacked detail on how to meet people's needs who had a sensory loss.

This is a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Person centred care.

The registered provider informed us that the activity co-ordinator had been promoted within the company and a new activity coordinator had been employed and was waiting for recruitment checks to be

completed. The registered provider said that in the meantime the old activity coordinator and care workers were providing social stimulation within their roles. However, on the day of our inspection we saw limited activities taking place.

People we spoke with confirmed that activities did not take place. One person said, "We don't do any activities." Another said, "There are no activities."

Some people told us there were some activities. One said, "We had concerts a few times a year. Some play card games but it's not for me. I asked for a quiz, it happened just once."

Staff we spoke with told us they were meant to provide activities, but said there was not always time, one staff member said, "The care has to come first, there is not time for activities."

We did observe after lunch there was an activity on the unit for people living with dementia. Staff had instigated a game with printed sayings. The idea of the game was to complete the famous saying. Only one person was involved in this activity. We saw one person's chair had only been turned to join the activity after we arrived.

The registered provider had a complaints procedure which was displayed in the entrance of the home. The management team kept a log of complaints received and information relevant to each one. We saw two concerns had been logged in January 2018 and were logged as being resolved. The complainant had been happy with the outcome. However, the complaint record could have been more specific as to what actions had been taken to reach this outcome.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the home had 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.

However, the registered manager did not manage the home on a day to day basis. They informed us they had stepped down and were working as the clinical lead nurse. The deputy manager told us she intended to register as the registered manager with the Care Quality Commission. There was also a support manager in post who told us they had been recruited to support the service concentrating on the governance. We found from talking with staff this led to confusion about who was in charge. We identified lack of leadership and oversight.

The registered provider also had a governance team which consisted of two compliance managers and a head of service. We saw they had visited and identified issues and had provided an action plan. However these had not been addressed to ensure actions were completed. When we spoke with the registered manager, the deputy and the support manager, no one was able to give clear answers to questions and it was not clear who was overseeing what. This meant many issues were not addressed as there was no clear lines of responsibility.

The registered provider had systems in place to monitor the quality of the service; however, these were not being implemented effectively. Some audits completed raised concerns which were not actioned effectively. For example, the infection control audit completed on 26 January 2018, had not identified the issues we found on inspection such as the state of the laundry, store rooms and the cleanliness of the home. The pressure ulcer audit had not clearly identified all people who required pressure area care. When we spoke with the management team they told us this was because the audit was completed at the end of the month. However, the pressure ulcers we identified in care plans should have therefore appeared on the January 2018 audit.

We spoke with the head of service and were informed they completed a provider visit every three months. We saw this covered an overview of the home, care plans, environment, medicine management and staffing issues. The last provider visit was completed in January 2018 and following this concerns were added to the home's overarching action plan. The action plan dated 2 February 2018, identified concerns with care planning, risk assessments, medicine management and the implementation of the Mental Capacity Act 2005. For example, one issue raised was that care plans did not contain enough detail around moving and handling people correctly. There was no size or type of sling identified and no loop configuration. During our inspection we could not evidence that any action had been taken to address these concerns and found these concerns continued. This meant they had not been addressed in a timely manner which put people at risk.

Quality questionnaires were sent out to relatives on a frequent basis and collated by the administrator. One

recent issue that had been raised was that meal times could be improved. In response we saw the registered provider had commenced audits around the mealtime experience. However, we observed lunch on the day of our inspection on both units and found the mealtime experience did not provide a positive experience for people to enjoy their meals, and still could be improved. This meant the action the provider had taken was not effective.

The registered provider did not always learn and improve the service. We found that quality monitoring was not effective, there was a management team in place but there were no clear lines of responsibilities and roles. Therefore staff were confused who was managing the service. The management team did not develop staff to drive improvements. For example, we observed staff were task orientated and did not follow safe practices of working, the management team did not identify this and ensure improvements were made.

Incidents, accidents and safeguarding's were monitored; however, the information we were shown did not tally with the information we were provided with from the local authority. It was not clear if the registered provider had identified incidents that required safeguarding referrals, therefore they had not been notified correctly and appropriate action had not been taken. We discussed this with the registered provider who agreed to contact the local authority and ensure all information was accurate.

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

The registered provider had recognised that systems required standardising throughout the company and had allowed a year from November 2017 to embed these processes. For example, the head of service told us that care plans would be electronic and this process was due to commence in March 2018. The registered provider felt this would improve care records.

We found that meetings took place with staff, people who used the service and their relatives. This gave people a forum to discuss any issues or to be involved in service developments. Meetings had been scheduled at different times to ensure everyone had the opportunity to attend.

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
Treatment of disease, disorder or injury	The registered provider failed to ensure people received care that was person centred and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider failed to ensure that staff acted in accordance with the legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected as risks to their health and welfare were not effectively reviewed or managed. Medicines were not managed to ensure people received their medication as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not receive adequate support to be able to meet their nutritional needs. People's preferences were also not considered.

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
Treatment of disease, disorder or injury	The registered provider had failed to ensure systems of governance were robust and effective.

The enforcement action we took:

We have issued a warning notice.