Mauricare Limited

Ashview House Residential Care Home

Inspection report

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Date of inspection visit:
15 January 2018
16 January 2018

Date of publication:
27 March 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 15 and 16 January 2018. This was an unannounced inspection. Our last inspection took place on 4 September 2017. At that inspection, we identified some Regulatory breaches and we told the provider that improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and remained 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.

As a result of previous enforcement action, a condition was placed on the provider's registration with us that prevented them from admitting and re-admitting people to the service without our authorisation. This condition was made to promote people's safety and remains in place.

At this inspection, we identified continued and new Regulatory breaches. The overall rating for this service remains 'Inadequate' and the service therefore remains in 'Special measures' whilst we continue our enforcement action.

Ashview Residential Care Home 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.

The service is registered to provide accommodation and personal care for up to 22 people. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our

inspection six people were using the service.

There was a registered manager at the home. 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 and associated Regulations about how the service is run.

Systems were not always effective at identifying quality concerns. Medicines audits were taking place but they were not always finding issues that were present. Other audits were taking place such as environmental, kitchen and infection control audits which did not always identify issues. Timely action had not always been taken to resolve actions if they had been identified. These shortfalls posed a significant risk to the people living in the home.

Quality assurance records were not always up to date, such as the training matrix which had a member of staff missing from it, despite them receiving training months before our inspection.

Medicines were not managed safely. Stock levels did not always balance meaning we could not be sure whether people were always having the correct amount of their prescribed medicine. Some medicines were out of date, guidance for 'as and when required' medicines was not always been followed and recording of the administration of medicines was not always accurate.

People's health care plans were not always followed which meant there was a risk to people's long term health associated with their condition.

People with specific dietary requirements were not always supported in a way that met their needs. Health conditions were not always effectively monitored. People were supported to access other health professionals however guidance from health professionals was not always followed.

Staff knew how to recognise potential abuse and how to report it. Staff felt more supported. However, other staff training was not effective as people were not always being supported appropriately.

A notifiable safety incident was not reported to us, which meant that we could not accurately monitor safety at the service.

Improvements were noted about the provider complying with the Mental Capacity Act 2005 (MCA) however further improvements were required to ensure people's ability to make decisions and any decisions taken on a person's behalf were clearly recorded.

An action plan was in place based on feedback from previous inspections and from feedback from an external consultant who was working with the home. We found some improvements had been made but some of the actions were still on-going or were not fully embedded, so continued improvements were required.

People and relatives felt there were enough staff so people did not have to wait for support. Recruitment of staff had improved although further improvement were required.

The home was generally clean and infection control measures were in place.

People and relatives felt staff were caring and that they were treated with respect. People were encouraged

to be independent where possible.

Relatives felt able to complain. Complaints were being recorded, although the outcome was not always available. The complaints policy was not up to date and had missing information.

The home environment was tidy however some décor needed updating to ensure it was suitable for people with dementia. Future plans were in place to make improvements to the home.

People and relatives were involved in developing their plans of care and staff had the opportunity to read these plans.

People had the opportunity to partake in activities and leave the home on trips.

The provider had considered people's end of life choices and plans had been put in place with basic information.

There was an Equality Policy in place, which took account of the protected characteristics such as gender, sexuality, race, and religion, for example. The provider and manager were able to provide us examples where they had been supportive of some of the protected characteristics.

People, relatives and staff were complimentary of the acting manager.

The provider was continuing to display their inspection rating as required.

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.

Medicines were not always managed safely.

People were not always supported appropriately with their health conditions.

Recruitment processes had improved but further improvements were necessary.

There were sufficient staff in place to ensure people had timely support, although staff could sometimes be rushed due to other duties.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported appropriately with their dietary requirements and there were mixed views about the food.

Staff felt more supported however training was not always effective.

People's health needs were not effectively monitored and managed and professional advice was not always sought or followed to promote people's health, safety and wellbeing.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure people's ability to consent to their care was assessed however improvements had been made from the last inspection.

Is the service caring?

Requires Improvement

We could not improve the rating for caring from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The service was not always consistently caring. People's right to

choose was not always respected.

People and relatives told us the staff were kind and caring and people were encouraged to be independent. Staff knew people well.

People could access private areas of the home when they wished to do so.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A system was in place to ensure all complaints were recorded, people told us they felt they could complain however the policy required updating.

Reviews of plans were not always effective.

Activities were available for people to partake in and trips out of the home were taking place.

People and relatives were involved in planning of care.

Is the service well-led?

Inadequate

The service was not well led.

New systems were being introduced to monitor and improve the quality of care and support, however these were not effective.

The registered manager and provider did not always report notifiable incidents to us as required.

People, relatives and staff found the acting manager approachable.

Ashview House Residential Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced inspection of Ashview House Residential Care Home on 15 and 16 January 2018. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed the information we had received from the public and the local authority. We checked if Healthwatch had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and carry out 'enter and view' visits to service and provides feedback to commissioners and regulators about those services.

We spoke with two people who used the service, three relatives, four members of care staff, the acting manager and the registered manager who was also the provider. We did this to gain people's views about the care and to check that standards of care were being met.

We made observations in communal areas and we looked at the care records of five people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people consistently received their care in a safe manner. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that these improvements had not been made and people remained at risk of harm to their health, safety and wellbeing.

Medicines were not always managed safely and we could not always be sure that people were receiving their medicines as prescribed. For example, we could not always verify if people had received the right amount of medicine as stock levels were not always being recorded on the Medicine Administration Records (MARs) or anywhere else. For some medicines that did have stock levels recorded the amounts left did not always match the records. For example, one person should have ten tablets left in stock, based on how many were delivered and how many staff had signed as administered, however only 7 were left in stock. This meant three tablets were unaccounted for, so we could not be sure if the person had the correct amount of prescribed medicine. Staff used their initials to document when a medicine has been administered in line with the prescription. A code is used if a medicine has not been given for any reason. Codes were being used that were not denoted on the MAR key so there was no explanation as to why the medicine had not been given and no notes had been made by staff on the back of the MAR. There were also gaps in recordings so no code had been entered and no staff initial had been recorded. Therefore we could not always be sure that people were receiving their medicines.

One person had a medicine prescribed for their eyes. However this was not being recorded on a MAR so we could not be sure if it was being used in line with the prescription instructions. When we raised this with the manager, they looked and could not find a MAR and told us they would find it. This was not made available for us to see so we could not be sure that the person was receiving this medicine and that their health and wellbeing were being protected.

One person was having eye drops administered. The instructions stated it should be discarded after being open for 28 days. The drops in use had been open for longer than 28 days. We raised this with the manager and they told us they arranged for more drops by the second day of our visit. The risks of using expired eye drops can include ineffective treatment of vision or other eye problems, inflammation and irritation of the eyes and, in the worst cases, infection. This meant the person's health and wellbeing were not always protected.

The recording of some medicine did not always follow the guidance of the prescription label or the 'as and when required' guidance (also known as a PRN medicine). For example, one person had a PRN medicine and the prescription label instructions stated it should be administered after each time the person experienced a symptom of their condition, up to the maximum daily dose. The MAR chart did not state how many tablets were being administered on each occasion. The MAR also did not make it clear whether the medicine was given at the time the person experienced symptoms (which is what the prescription label stated) or whether the person was given the medicine at the same time as the usual medicine round by senior staff. Therefore we could not verify that this person was receiving their PRN medicine in line with the

prescription instructions as it was not clear that they had their medicine at the right time or in the right quantities. Other people had PRN protocols in place however they were not always personalised to identify when each person may require them. This could present a risk to the person's health and wellbeing. When we spoke to the manager about this they told us they were going to review these protocols.

There was not always evidence that people with diabetes were being supported appropriately. At the last inspection we found that there was not always guidance in place for staff to follow and staff gave inconsistent accounts of some people's healthy blood sugar readings. At this inspection we found that clear guidance was now in place for staff to follow. This included when each person should have their blood sugars tested and what range the reading should be within. The guidance also detailed what action staff should take if the readings were outside of this range. However, we found that action had not always been taken and documented if someone was outside of their specified healthy range. This meant there was a risk to people's long term health associated with continually high blood sugars. There were also occasions where some people could not have their blood sugars tested as the stock of testing strips had run out. When we spoke with the acting manager about this they explained there had been an error with the prescription which they had tried to resolve. More testing strips were bought by the acting manager prior to the issue with the prescription being resolved; however there was a period of two days where these were unavailable. This left people at risk as their health condition could not be monitored and placed people at risk of long term damage to their health. The ineffective medicine management systems deployed by the provider exposed people to the risk of harm. Following our feedback systems were put in place to evidence that people's health and wellbeing was being protected in relation to their diabetes support.

Effective systems were not in place to ensure people consistently received their care in a safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our January 2017 inspection a recruitment file relating to staff member was unavailable so it could not be verified if that person had been safely recruited. At the September 2017 inspection we found that recruitment processes had improved but further work was required as references were not always appropriate. At both of these previous inspections there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there was no longer a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, however further improvements were required.

At this inspection we viewed the recruitment file that had been originally unavailable at the January 2017 inspection. We found that insufficient information had been gathered at the time of the staff member's employment and action had not been taken to ascertain this information since, such as their employment history and there was no evidence that the staff member had been interviewed. The provider's recruitment policy stated all staff would receive a structured interview with a member of management; however, however there was no evidence that this had taken place for the member of staff we reviewed. Two verified references were available however due to no employment history being recorded it was not possible to verify whether these were from the staff members most recent employer. We were shown another example of someone applying to be a member of staff but they were not employed by the acting manager as checks with their previous employer had highlighted concerns.

Checks had been made on staff member's criminal records, called Disclosure and Barring Service (DBS) checks. This is important as it helps to check if people are of a suitable character to work with people who live in the home. If a member of staff had a conviction on their DBS check then a risk assessment had been written to protect people. We found risk assessments in place that were being followed by the acting

manager.

The acting manager, along with the registered manager, provider and a consultant that had been engaged to assist the service to improve had developed an action plan to try to improve and reduce the risks when things went wrong, such as accidents or incidents and to learn from them. We found some improvements had been made, such as increased detail in some people's care plans however some of the actions were still ongoing or were not fully embedded, so continued improvements were required.

Infection control measures were in place. Staff told us and we saw that they received training in this area. One staff member said, "We have a cleaner but they're not here seven days a week so the carers do tidying as we go. We've had infection control training so know how to clean or dispose of things correctly." We observed staff wearing gloves and aprons whilst they were serving food to people. Infection control audits were in place which had not always identified some issues or timely action had not always been taken when issues were identified however we observed the home to be clean and tidy overall.

At our last inspection, we told the provider that improvements were needed to ensure staff were effectively deployed to promote people's safety and ensure people's needs were consistently met in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that improvements had been made so that they were no longer in breach of this regulation, but further improvements were required.

A relative we spoke with said, "There are always staff around. I think it is adequate" when they were asked about staffing levels in the home. Another relative said, "There's always a member of staff in the lounge, or at least 90% of the time there is." We observed that people received support in a timely manner. At the time of our inspection there were no kitchen staff employed, so care staff were expected to cook for people in addition to their caring duties. We saw that staff were sometimes rushed during meal times, however this did not impact upon people having to wait for support.

At the last inspection the risks associated with people's behaviours that challenged, such as aggression were not always assessed and planned for. However, at this inspection we found that plans were now in place which guided staff on how to support someone if they became agitated. Staff told us about how they supported some people to become less agitated. This meant action had been taken which helped people to become less agitated and guided staff.

Staff were able to describe different types of abuse, how to recognise them and how to respond to potential abuse. Since the last inspection there had been one safeguarding incident recorded and reported to the local safeguarding authority. This meant people were being protected from avoidable harm by staff who could recognise abuse and taken action. We will continue to monitor the provider's compliance in this area of care.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to effective systems not being in place to ensure people's health, safety and wellbeing needs were monitored and managed in a safe and effective manner. At this inspection we found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people about the food was mixed although we saw people were offered choices. One person said, "Some of the food is ok but some of it I don't care for." A relative said, "I've raised concerns about the food before as it's the cheap version." A member of staff said, "I don't think the food is good quality but they get choices. The puddings are atrocious." We did observe people having choices and alternatives were available if they did not want the meals on offer. Some people had specific dietary requirements due to their health conditions. We saw that they were not always supported with these dietary requirements. For example, one person needed specialist food, which we saw was available in the home. However, the way it was stored and prepared meant it was potentially contaminated with food that was not appropriate for their needs. They were also sometimes provided with food that did not meet their dietary requirements and they were not always given the choice as to whether they wanted this or not. For example, they were given a choice of meals at lunch time and the staff did not prepare their lunch any differently to other people who did not have the same dietary requirements. We observed that this person was provided with a diet that they were intolerant to resulting in them being exposed to harm. When we asked the member of staff who prepared lunch about the food for this person, they told us they used the same ingredients for every person, despite some of the ingredients being inappropriate for the person. The member of staff was unaware that these items were not suitable and the person was provided with their meal without them being made aware of this. The charts that staff recorded the person's food and drinks on also did not clearly indicate whether food was suitable for the person's dietary needs so we could not be sure that it was always appropriate. According to the person's risk assessment, this left them at risk of long term damage to their health and their symptoms worsening if they were not consistently supported effectively. On the second day of our visit we were informed that different equipment had been purchased in order to avoid future contamination of the person's specialist food. In addition to this, improved recording was introduced following feedback given at end of the inspection.

Some other people in the service had diabetes and their plans of care stated they were to have a diet low in salt, sugar and fat. If people choose not to maintain a diet low in salt, sugar and fat then that is their choice. However, we did not observe staff offering people the choice to observe a healthier diet as snacks and meals offered were not always low in salt, sugar and fat and there were not always alternatives available. For example, biscuits were offered to people, however no 'low sugar' alternatives were available or being recorded as offered, even if those people decided not to choose the healthier alternative.

We found that some health conditions were not always monitored effectively. For example, one person experienced regular symptoms of their health condition. A GP had advised that a monitoring charts be used to record and monitor these symptoms. We saw that symptoms were recorded in the person's daily notes

however the recording was not always consistent and in detail. There was no evidence that the daily records had been checked or compared to other records about the person to ensure their health condition was monitored effectively. Using a recognised monitoring tool would assist staff to record a person's symptoms consistently and in detail. This meant the person was at risk of continuing to experience symptoms and their health condition was not being effectively monitored.

Some people were identified within their care plans as needing monthly checks on their weight to ensure they were not unintentionally losing weight, which could indicate they were becoming unwell. The people who required weighing had not been weighed since November 2017 up to the dates of our inspection, a period of just over seven weeks. This meant there these individuals health was not monitored effectively which could put their health and wellbeing at risk.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that effective systems were not in place to ensure staff were suitably skilled to meet people's needs in a safe and effective manner. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, some improvements had been made however there was still a breach of this regulation.

There was evidence that staff had undertaken training. We observed that when staff supported people to move, they used the correct techniques and this matched people's care plans. Staff were also aware of safeguarding procedures. We saw evidence of training such as training certificates and a training matrix. However, not all training was effective... Relevant staff had received medicines training however concerns were not always noticed and there were administration and recording errors which put people at continued risk. Staff had training in food hygiene however we found shortfalls in the way in which some people's food was stored and prepared. Guidance the acting manager told us was being used by the home was supplied to us following the inspection. The guidance was from an organisation which specialises in a specific health condition stated staff could access free training in relation to this health condition and associated best practice. However, there was no evidence that staff had undertaken this training, or equivalent. We also found out of date food in the kitchen fridge which had not been disposed of in a timely manner, which out people at risk of receiving inappropriate food. This highlighted that the training care staff had received had not been effective at providing them with the skills, knowledge and competencies they required to consistently care for people safely.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt more supported. Staff told us they felt more supported and that they had supervisions. One staff member said, "I feel more supported. I've had a talk with the acting manager." We saw evidence of supervisions being carried out. This meant staff had the opportunity to discuss their role and what support they needed to effective care for people.

People told us and care records showed that they were supported to see health care professionals when necessary. One relative we spoke with said, "The district nurse and chiropodist have been in to see [relative's name]" and they went on to say, "The home are excellent at arranging hospital appointments as they arrange ambulance transport too." Another relative said, "Staff are good at contacting the doctor if my relative is unwell." We observed a GP visiting during our inspection and we saw visits from other health professionals were recorded, such as the diabetes team, dieticians, district nurses and opticians. We saw

that some plans contained more detail than on previous inspections, such as diabetes plans and diet plans; however, this guidance was not always being followed. For example, one person had advice from the diabetes service that they should have their blood sugars monitored at night for one week, which was in addition to their usual blood sugars tests. However, there was no evidence these additional readings took place. This included the monitoring of the symptoms of a health condition, guidance about how diet-specific food should be stored and prepared, a lack of evidence that action had been taken as a result of blood sugar readings being out of their designated safe range. The frequency people were being weighed to ensure they remained healthy was also not in line with guidance. This placed people at continued risk of harm to their health, safety and wellbeing.

We saw people had assessments before they moved into the home to determine the level of support they needed and whether the provider felt they could support people. This meant the provider had taken into consideration whether they could support each person's level of need. However, other assessments that had taken place since people had started living in the home were not always clear what they were trying to assess and whether people's needs were low or high. This meant systems were not clear in what they were trying to achieve.

At our last three inspections, we told the provider that improvements were needed to ensure effective systems were in place to gain and review people's ability to consent to their care. At our last inspection, we judged that there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made so that the provider was no longer in breach of this regulation, but more improvements were required.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. Relatives told us they had provided copies of LPOA documents to the home and we saw evidence of this for people who had an LPOA in place and efforts were being made to get copies of LPOAs from relatives who had not yet supplied them.

One relative we spoke with said, "[Relative's name] doesn't have capacity. I don't think they'd be able to consent to care, they'd just agree to whatever the staff said but I do feel the home try to support my relative." We looked at this person's care plan file and could not see that an assessment of the person's ability to consent to aspects of their care had been undertaken, despite relative's noticing the person's decision-making capabilities changing. It was explained to us that the acting manager had not been made aware that there were any changes in the person's decision-making capability. We saw other decision-specific mental capacity assessments had been completed for other people in the home.

A best interest decision had been considered for a person in relation to their personal care. However, the decision did not include details of who else was involved in the decision other than the person who completed the form. Best interest decisions should incorporate, where possible, feedback from relatives and other professionals when appropriate. This best interest decision needed developing to ensure it encompassed feedback from all appropriate people involved. We saw that one person had signed their consent to care form whereas a relative had signed some of their care plans. It was unclear why the relative had signed the care plans as there was no evidence that that person was unable to sign these. When we asked the acting manager about this, they told us that the person wanted their relative to sign things on

their behalf, however this was not evidenced anywhere. We also observed a form was provided to relatives, which asked them for their consent to photographs being taken of people living in the home however some people in the home had capacity so they would be able to consent to this themselves. It was not clear why relatives were being asked for this permission.

At our last inspection, we found that improvements were necessary to ensure the requirements in relation to Deprivation of Liberty Safeguards (DoLS) were consistently met; however the provider was not in breach of Regulation 13. At this inspection, we found that improvements had been made.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS referrals had been made and followed up with the local authority when a response had not been received and staff were able to tell us about DoLS.

The environment was tidy as the acting manager had recently undertaken an activity with people to sort and dispose of items no longer required which removed clutter. Important rooms had labels such as bathrooms, toilets and bedrooms had names on them to assist people in getting to the place they wanted to go. We saw new displays of pictures and posters had been installed to improve the environment. However, some of the décor required updating and the carpet was patterned in the hallway which can cause people with dementia to become disorientated.. One relative said, "It's not the best home in the world [in relation to the environment]." Another relative said, "It's not the poshest place in the world but my relative is happy there." The registered manager explained there were future plans in place to undertake environmental improvements to the home.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people were consistently treated with dignity and respect. This was not identified as a breach of Regulation. At this inspection, we found that some improvements had been made. However, further improvements were still required to ensure that people had appropriate caring support. We could not improve the rating for caring from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

We saw that some people had choices offered about their day-to-day care. For example, we saw staff offered to help a person cut up their food, which they declined, and the member of staff respected this. We saw the registered manager noticed another person was not eating and they assisted the person to cut their food up after checking with them first. We also saw people were offered choices of food. However, there was one person who had a dietary need. Food appropriate to their needs was available in the home and we saw them being offered these alternatives. However, there were occasions they were offered food that was not appropriate to their needs and they were not made aware of this so they could not make an informed decision. Other people who had dietary needs were not always offered alternative options for them to choose from.

People and their relatives told us that the staff were kind and caring. One person said, "I don't mind it here. I get on well with everyone." One relative said, "The personal care and attention is there." Another relative commented, "[Relative's name] likes the staff. They haven't got a bad word to say about the staff." We saw staff checking people were ok and were kind and encouraging when a person became confused.

Staff were able to give us examples about how they ensured people were treated with dignity such as ensured people were as covered as possible during personal care. Staff also explained to us they encouraged people to be independent, one staff member said, "We let them live as independently as possible, with support obviously." Care plans also recorded the level of support people required with their personal care and indicated what people were capable of independently. This meant the home had considered people's ability to remain as independent as possible.

All people in the home were able to communicate verbally, however some people had sensory loss. Communication plans were in place to assist staff in knowing the level of support people needed with communication or whether people wore items such as hearing aids or glasses. We observed staff interacting appropriately with people and in a way people could respond to. This meant people were able to express their views and be involved in their care.

We saw people could access private areas of the home when they wished to do so. For example, we saw people spending time in the main lounge with relatives but also saw relatives spending time in quieter areas such as the dining room in between meal times. We also saw that when visitors arrived staff greeted them and staff knew who people's relatives were.

People and relatives told us that the staff knew their preferences. One relative said, "Staff know my relative well, they knew my relative's idiosyncrasies, their habits and they notice changes in my relative." We also saw staff offer a person a particular mug that the person liked to drink from which meant staff had considered the person's preferences. The manager also told us about the music a person liked and we heard them listening to that music.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relations to complaints. At this inspection, we found that the service was no longer in breach of this regulation, although further improvements were required.

A relative we spoke with confirmed their complaint had been dealt with, they said, "I have voiced concerns to the manager and they dealt with them straight away." We saw people and visitors could easily view the complaints procedure as it was on display in a communal area. However, the complaints policy did not contain details of alternative organisations people could complain to if they did not want to complain directly to the home or if they were unsatisfied with the response to their complaint. When we mentioned this to the manager, they explained that policies and procedures were going to be reviewed. We found that systems were in place to record complaints but only one complaint had been received and we were unable to verify if the complainant was happy with the outcome, as they were no longer residing in the home. The outcome was unclear as this had not been recorded along with the complaint. Therefore, we will continue to monitor the provider in this area of care.

At our last five inspections, we found that improvements were required to ensure care was consistently provided in accordance with people's preferences and individual needs. At the last inspection a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made so there was no longer a breach of regulation, but further improvements were still required.

If people's needs had changed then their plan was not always updated to reflect this, such as the monitoring of some health conditions and guidance from professionals. If a person had a fall their care plan had not always been updated to provide details about this. Reviews of people's care files were taking place however these reviews had failed to identify omissions in the guidance and that some plans were not always being followed. For example, one person had a plan in place which stated they could use a frame or sometimes they needed a wheelchair. We saw staff following this plan. A moving and handling audit plan was in place which stated the person used a frame only; this had been reviewed four times and it had not been identified that the wheelchair information had been omitted. This meant there was a risk people may receive inconsistent care or care that was not appropriate for their changed needs.

People and relatives told us they felt involved in developing people's plans of care. One relative said, "I feel involved in [relative's name] care." Another relative said, "I've seen [relative's] care plan but I don't feel the need to see it all the time." Staff also told us they had time to read people's care plans to get to know people. One staff member said, "Yeah we look at the care plans, there's opportunity to read them and new staff can too." Another member of staff said, "I've read all of the care plans and when they are updated I read them again. You get to know people though." We saw that preferences were recorded, such as how people liked to be supported with their personal care.

People and relatives told us they were supported to partake in trips and activities. One relative said,

"[Relative's name] plays dominoes, they've played darts, bingo and we've been asked to bring in photos of our relative's from when they were younger. There were some trips before Christmas and there has been a musical night and exercises." Another relative said, "Residents went out for lunch before Christmas. It would be good if they could keep it up, they need to." We observed staff doing activities with people, such as a quiz and reading magazines and staff had one-to-one time with some people. We also observed new displays were on walls with photos, posters and reminiscence items that people could look at and use when they chose to. This meant people were now encouraged and able to partake in their hobbies and there was more opportunity to leave the home.

The home had considered people's end of life choices. One relative we spoke with said, "I know about [relative's] end of life choices." When they explained to us what the person wanted, this matched the person's end of life plan written by staff. No one living at the service was receiving end of life care however people's end of life plans had basic details about what people wanted following their death recorded which meant the service had taken people's preferences into account in this area of their care.

There was an Equality Policy in place, which took account of the protected characteristics such as gender, sexuality, race, and religion, for example. The provider and manager were able to provide us examples where they had been supportive of some of the protected characteristics. This meant the service had considered people's and staff member's choice whether to discuss if they felt they had a protected characteristic or not.

Inadequate

Is the service well-led?

Our findings

At our last six inspections, we found that improvements were needed to ensure the home was well-led. At our last two inspections, we found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance and how the home was managed. At this inspection, we found the required improvements had not been fully made and we could not be sure all concerns or changes would be identified and that processes were sufficiently embedded. This placed people at risk of on-going harm to their health and wellbeing.

Systems were not yet fully in place to ensure the quality of care was effectively assessed and monitored. We found that care plans had all been updated since the last inspection, and often there was more detail available than found during previous inspections. However, we found that these plans were not always being followed or updated following professional advice. For example, regarding steps to take to help support a person's health condition, monitoring of a health condition and taking action in relation to blood sugar readings. There was no evidence that people's daily records were being checked, which is where staff recorded how a person is or what they have been doing each day. Checks on these records can indicate if a person's needs have changed according to their current care plan. These shortfalls posed a significant risk to the people living in the home.

Effective systems were not in place to ensure people's medicines were being managed effectively. Medicines audits had been undertaken however, these had not always been effective at identifying all concerns or at rectifying concerns if they were found. For example concerns had not been identified such as stock levels not being recorded, stock levels not always matching records, codes being used by staff and there not always an explanation why the code was used, a medicine being used passed the manufacturer's instructions and that some records were missing for one particular medicine for one person. Some people who no longer lived in the home still had their medicines present in the medicines trolley, which was used on a daily basis however; they were no longer living in the home. This could cause problems if they were to get mixed up with other medicines of people who currently lived in the home. It was explained to us that a member of staff had put these into the medicines trolley recently; however we were unable to verify this and it was unclear why they would have been moved rather than returned to the pharmacy. A medicines audit had taken place in December 2017 which identified that the medicine fridge temperatures were not always being recorded. This meant that the provider could not be sure whether temperature-sensitive medicines were being stored correctly on the days when the temperature was not checked. Upon review of the fridge temperature recording following this audit, we found that there continued gaps in checks.

'Walkabout' audits carried out by the acting manager had taken place around the home which included checking the environment and issues had been identified, such as dining room tables being sticky, crumbs on the floor and a lounge being untidy and action was noted as being taken in response to this. However, one person's room had a strong malodour of urine. None of the walkabout audits, bedroom audits or environment audits had identified this.

Infection control and kitchen audits had been carried out; however prompt action had not been taken when

an action had been identified. During a kitchen audit in September 2017 it was noted that the freezers had not been defrosted, and this was identified as an action to take and that a member of staff had been spoken to. During another kitchen audit in October 2017 it was noted that one of the freezers had still not been defrosted. Also, guidance supplied to us following the inspection by the acting manager in relation to a specific health condition recommended that internal audits take place. The guidance suggested audits should look at how the service was following processes; however there was no evidence that these suggested internal audits were taking place or had been incorporated into existing audits. Therefore timely action had not been taken following actions being identified and best practice guidelines had not always been followed.

The acting manager also told us of an incident they had been made aware of involving a member of staff. The acting manager explained what action they had taken, such as speaking to other staff and it was felt the allegation was false. We were unable to verify the action we were told had been taken as there was no evidence of this. Since the alleged incident we were told the member of staff had not worked at the home. This meant that timely action was not taken, such as reporting and documenting of an allegation, against a member of staff. Following the inspection the investigation report was sent to us verifying the appropriate action taken by the acting manager.

The training matrix, which tracks when staff have had training and when they were due to have their training refreshed was not always accurate as a member of staff had not been included on it, despite them receiving training up to nine months before our inspection. We were supplied a printed copy of the training matrix which the acting manager explained was out of date, however they had an up to date one available electronically which they sent to us via email during the inspection. The up to date version did not have the current member of staff noted. The provider was also not following their recruitment policy to ensure all staff had appropriate interviews. This meant we could not be sure that systems were consistently effective to ensure that staff would remain up to date with training to support people safely. Following the inspection we were made aware that this has now been rectified and the missing member of staff has now been included on the training matrix.

Multiple documents which were requested as part of the inspection were not always available or not presented to us to view, which were subsequently supplied as part of the report review process. This is despite being offered the opportunity to provide anything additional following the visit to the home to allow the opportunity for managers to think once inspectors had left. This meant effective systems were not in place to ensure information was readily available.

The provider had consistently failed to make improvements to ensure effective systems were in place to identify poor care and take timely action in response to keep people safe. People had been exposed to the on-going risk of harm as their dietary requirements were not being consistently supported which could affect people's long term health. People's health conditions were not always monitored effectively and action to protect people not always evident which left people at risk of continuing to experience symptoms and becoming unwell. People's medicines were not always safely managed and this had not been identified despite checks taking place; therefore we could not be sure that people were receiving their prescribed medicines to help keep them healthy which put people at risk. The provider had failed to achieve a good rating in the previous six inspections when we would have expected significant improvements within this period.

The above evidence shows effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always notified CQC about significant events that they are required to notify us of by law. We use this information to monitor the service and ensure they responded appropriately to keep people safe. For example, we had received a notification of safeguarding allegation however an incident involving a serious injury had not been notified to us. The person's injury had since healed. However, this meant we could not always be assured they were dealing with incidents and issues in an appropriate way.

This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

People, relatives and staff were complimentary of the acting manager. The acting manager in post was applying to become a registered manager. They would replace the current registered manager. A relative said, "The acting manager is very nice. They are doing a good job in difficult circumstances." Another relative described the acting manager as 'approachable'. A staff member told us, "The leadership is good with the acting manager, they're bob on and always at the end of a phone." Another staff member said, "If I have concerns I can go to the acting manager. They're [the acting manager] is trying to put things right, they're brilliant" and they went on to say about the acting manager, "They're trying. It'll take some time but they've been putting things in place." Other comments included, "The acting manager is good."

Staff told us staff meetings were taking place and staff were having their competency checked. One staff member said, "If you've done something that you could improve upon, the manager lets you know professionally, not in front of everyone." Relatives meetings were not currently taking place, however due to there being only six people living in the service. The acting manager felt they were able to see relatives on an individual basis when they came to visit. One relative said, "The acting manager called me the other week and we had a chat. You can see them in the office any time." Another relative said, "The staff update me when I visit." There were also newsletters available for relatives by the signing in book so they could be kept up to date.

The correct rating from the last inspection was being displayed in an accessible communal area for people and visitors to see.