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Alton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Alton House is a care home, providing accommodation and support for 23 older adults including people who may have a diagnosis of dementia. At the time we inspected, there were 17 people living at the service.

People's experience of using this service and what we found:
The service had failed to ensure that people were supported in a safe way. Risk assessments did not identify and mitigate individual risks; medicines were not being managed safely; recruitment practices did not ensure staff were suitable to support vulnerable people and there was no recording or analysis of accidents and incidents. However, people told us they felt safe and there were systems in place to protect people from abuse.

There were shortfalls regarding the induction procedures for new members of staff. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems did not support this practice. The service had not been adapted to meet the needs of people living in the home. However, people were supported to receive holistic health care and to have a healthy and balanced diet.

People felt staff were kind and caring. The service ensured people and their relatives were involved in the care and support they received, and the service promoted a culture of equality and diversity. People were supported to remain independent and felt they were treated with dignity and respect.

Care plans were detailed and guided staff to provide person-centred care. People were supported to engage in activities; however, a recommendation was made to ensure activities were tailored to meet the needs of people living at the service. Complaints were appropriately responded to, although information on how to make a complaint was not always provided in an accessible format; a recommendation was made for this to be reviewed. End of life care was provided in line with best practice.

The quality assurance systems were not always sufficient as they had not identified the shortfalls we found during our inspection and did not ensure people were always kept safe. However; people, relatives and staff spoke positively about the registered managers and trusted the service to look after them.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
At the last inspection the service was rated Inadequate (Published 15 October 2018) and there were eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found two breaches of the Registration Regulations Act 2009. Since this rating was awarded the registered provider of the service has changed. We have used the previous rating and enforcement action taken to inform our planning and decisions about the rating at this inspection.

This service has been in Special Measures since 15 October 2018. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as Inadequate overall.

Why we inspected:
This inspection was carried out to follow up action we told the provider to take at the last inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alton House on our website at www.cqc.org.uk.

Enforcement:
We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were related to Safe care and treatment; Staffing; Premises and Equipment; Need for consent and Good governance.

Please see the action we have told the provider to take at the end of this report.

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

Follow up:
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Alton House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two Inspectors and an Expert by Experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was 'older people'.

Service and service type:
Alton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced and took place on 21 and 22 May 2019.

What we did before the inspection:
Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We spoke with the local authority commissioners and other health and social care providers.

Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. This is known as a Provider Information

Return (PIR). The provider had completed a PIR.

During the inspection we spoke with five people using the service, and seven relatives. We also spoke with six members of staff including the two registered managers. Furthermore, we spoke with two health and social care professionals.

It was not always possible to speak to everyone and ask direct questions about the service they received because some people living with dementia were unable to understand. However, people could express how they felt about where they were, the care they received and the staff who supported them through non-verbal communication. We observed interactions between staff and all the people using the service as we wanted to see if the service communicated and supported people in a way that had a positive effect on their wellbeing.

We reviewed six people's personal care records, three staff records, staff rotas, medicine administration records and other records relating to the management of the service such as health and safety records and training records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:
At our last inspection on 30 August and 4 September 2018, the provider had failed to assess the risks relating to the health safety and welfare of people including moving and handling, manage medicines safely and review accidents and incidents. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient improvement had not been made in each of these areas and the provider was still in breach of Regulation 12.

- We found risk assessments were not always in place for specific medical conditions. One person with diabetes did not have a risk assessment completed and there was no information provided for staff regarding signs and symptoms of blood sugar levels and what actions to take. A second person was known to demonstrate behaviours that may challenge and within their risk assessment there were no details of potential triggers and de-escalation techniques. This meant people's safety could not be ensured. A third person had a pressure sore and the registered manager told us this had been affected by their diet; however, there was no risk assessment in place for skin integrity or nutritional needs. This meant that there was a risk of re-occurrence of skin complications and possibly other complications relating to poor nutrition.
- Where risk assessments had been completed there was not always an analysis of the identified risk to ensure people were kept safe. For example, one person's weight chart identified they had lost weight and then gained weight, but there was no further information provided. It was therefore not clear if this person was at risk of harm due to changes in their weight and staff were not guided on what action to take.
- Records confirmed that all staff were up to date with their moving and handling training; there had been no injuries caused to people because of moving and handling techniques and health and social care professionals did not raise any concerns. The service had multiple size slings to ensure people were supported to move in a safe way.
- However, we found continued concerns with moving and handling. We observed one person being supported to move throughout the home in their wheelchair; however, they were not supported to put their feet onto the foot pads which meant they were dragging on the floor. This could put the person at risk of infection and cause further pain and damage to their skin. We also observed one person left in a wheelchair that was not their own for some time before being supported to sit in a comfortable chair. This could put the person at risk of harm due to not having their own wheelchair that had been adapted to meet their needs. Neither of these people had received an occupational health assessment and staff were not guided on how to move them around the home in a safe manner. We discussed the importance of this with the registered manager. This evidence demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- However, people and relatives told us they trusted staff to keep them safe and manage their risks. One relative said, "Yes I do without a doubt." Furthermore, staff demonstrated an understanding of individual health conditions and how to keep people safe. When discussing Parkinson's one staff member said, "[Person] can be stiff, shaking, swallowing can [be affected]."

Using medicines safely:
● PRN medicines are medicines that are needed as and when required. There was a PRN protocol in place. However, for people that received PRN medicines we found that there were no protocols to safely administer these medicines. Furthermore, when PRN medicines had been administered, there were no records kept that detailed the effects they had on the person.This meant medicines were not being used appropriately to ensure people were safe.
● One person received covert medicines, which meant they were crushed on to their food without their knowledge. A mental capacity assessment had not been carried out to determine if the person had capacity to refuse their medicines, so it was unclear if they were being administered in their best interests.
● We found that room and fridge temperatures where medicines were kept were being monitored. The temperature was within acceptable ranges in most cases; on two occasions the temperature went above an acceptable range. However, there were no records to show what action, if any had been taken. This meant there was not an adequate system in place to ensure medicines were stored safely and people had received the full benefits of their medicine. Furthermore, records show that only two out of 12 staff had a recent medication competency assessment. This meant the registered managers could not be sure staff were suitably skilled to provide medicines to people safely. This demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded after the inspection. We received records to confirm that nine out of 12 staff had a competency assessment completed; the remaining three staff had not yet completed their medicines training. We also received updated PRN protocols and a blank template to assess the effects for people on PRN medicines. This shows the provider is responsive to feedback to ensure people receive their medicines safely.
● People told us they trusted staff to support them with their medicines. One person told us, "No trouble at all [with my medicines]." Staff told us they felt confident about managing medicines safety; "Oh yes, we do the long-distance training, the medication one is good." They understood when people needed PRN medicines; one staff member said, "[People] that can tell us, will tell us, and the ones that can't we know when they are in pain we can tell by their face."
● We checked medicine management records for nine people and found they received their medicines as prescribed. There were no gaps in records. There was a medicine profile for each person with a photo of the person that included details of any allergies, pain management and medicine on admission. We counted medicines against the Medicine Administration Records (MAR) and found that this was accurate. We checked the blister packs for all people and found that medicines were administered when they were supposed to. Medicines were stored securely and there were arrangements in place to return and order medicines.
● Controlled drugs (CD) had been administered as prescribed and the controlled drugs book was accurate. Controlled drugs are medicines that are at risk of being misused. The second staff member also signed the book as a witness of CD's being administered, and they had been stored in line with guidance. We counted the medicine stock against the medicine that was administered and found this was accurate.

Learning lessons when things go wrong:
● Records confirmed that accidents and incidents had been recorded on forms with details of the incident and the immediate action taken. The form allowed for a review to take place to ensure the well-being of the person.
● However, reviews were inconsistent as out of 24 forms since January 2019, 12 reviews had not been completed to ensure the person was safe after the incident.
● There were seven occasions whereby an incident had occurred involving the same person. This had not been identified and action had not been taken to minimise the risk of re-occurrence.
● There was an overview of accidents and incidents that occurred since January 2019 to April 2019 that listed the number of incidents and the action required to prevent the risk of re-occurrence. Records showed

the actions were not always acted upon. Furthermore, the number of incidents listed on this form was incorrect and not an accurate reflection of the incidents that had occurred.
● After the inspection, we received an updated analysis, but no assurances the identified risks had been acted upon. This meant there was a risk the incident may re-occur, and preventative action may not have been taken to ensure people were safe. This demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The above evidence shows the service had failed to ensure risk assessments are sufficient; medicines are managed in a safe way; people are supported to move in a safe manner and accidents and incidents are properly analysed. This demonstrates a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:
At our last inspection on 30 August and 4 September 2018 the provider had failed to ensure people were protected from the risk of infection. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had not been made and the provider was still in breach of Regulation 15.
● Records showed there were inconsistencies with the cleaning schedule. There were two different forms in place for upstairs and downstairs and the forms being completed did not reflect what had been done, which means the areas that needed cleaning were not being done. We also found some gaps on the cleaning schedule; therefore, the home may not have been cleaned regularly.
● We observed carpets were stained and needed hoovering; some people's bedroom walls were cracked, and the wallpaper was peeling off. Some window seals had cracks on them. We also found moving and handling equipment was unclean.
● Furthermore, the washing machine was used to clean both soiled and unsoiled items; the registered manager told us it was cleaned in between washes. However, there were no records to evidence this was being done. This meant the service could not demonstrate that people were protected from the risk of infection. This demonstrates a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● However, people and relatives told us the home was clean; one person said, "It is spotless clean." A relative told us, "Yes, it always smells clean." Staff were aware of infection control practices; they wore protective clothing and had access to personal protective equipment including gloves and aprons.
● The kitchen contained opened food which had been labelled correctly. The service had been awarded a 5-star food hygiene rating with no actions.
● All personal emergency evacuation plans were up to date. Maintenance checks were in place to ensure the service was free from potential hazards and all identified risks had been resolved.

Staffing and recruitment:
At our last inspection the provider had failed to ensure there were enough staff to meet people's needs and they were not recruiting staff in a safe manner. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had not been made and the provider was still in breach of Regulation 18.
● Relatives and visiting health professionals felt there were not enough staff. One relative said, "Sometimes there are not enough staff. They could do with more." A health professional told us, "At times carers are not around."
● We observed a lack of engagement with people; people were left alone for long periods of time. We found that staff were either busy with tasks or just not engaging with people.
● Assessments were carried out for each person that evidenced their dependency levels, categorised by

code of high, medium or low. Two people were assessed as 'high' which means they needed two members of staff for support with transfers and personal care.

● Records confirmed that during the week the staffing arrangements were adequate as there were two managers and three care staff on shift. However, the rota showed that during weekends the managers were not on duty and only three staff were on duty. This meant if both people who required two staff needed help, there were not enough staff available to provide support. We were informed managers alternated shifts every Saturday, however the rota showed this was not the case on 4, 18 and 23 May 2019. There was no management cover on Sundays. This demonstrated people were not provided with care and support to meet their needs and keep them safe from harm.

● The recruitment policy was not being adhered to. This stated an interview panel would always consist of two members of staff. However, notes indicated that for one staff member there was no interview. For a second staff member it was not clear who conducted the interview, the person's name was incorrect, and it was not clear when the interview was held or what questions were asked. We found there were gaps in a recruitment history for one staff member, and another staff member's recruitment history was blank. For two staff members there was only one form of identification available, rather than two.

● The recruitment policy was out of date and referenced incorrect legislation. This meant recruitment procedures were not robust and the service could not be sure they were recruiting staff in a manner that ensured they were safe and suitable to provide care and support to people. This demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:

At our last inspection the provider had failed to ensure people were protected from abuse. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had been made and the provider was no longer in breach of Regulation 13.

● People told us they felt safe living at the service. One person said, "Nothing to be scared of here." Another person told, "I feel perfectly safe."

● Staff were able to list the different categories of abuse and told us they would respond appropriately if they had any concerns. One staff member said, "Speak to the manager, record everything in the care plan, the communication book."

● There was a safeguarding policy in place that included the types of abuse to be aware of and who to report concerns to. There was a list of external contacts such as the CQC or the local authority, but their contact details had not been included. The registered manager told us they would update this following the inspection. Records showed that appropriate referrals had been sent to safeguarding teams and the CQC.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience:
At our last inspection the provider had failed to ensure staff received an adequate induction and had access to ongoing training, supervisions and a yearly appraisal to ensure they could provide effective care and support to people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had not been made and the provider was still in breach of Regulation 18.

- We found that the induction processes in place for all staff were not relevant to the service and role they were undertaking. We were advised by the consultant that the induction forms had been printed off the internet with no regard to the roles of staff who had been recruited. The registered manager told us they would look to change this following the inspection.
- Furthermore, the recruitment policy said the induction period for a new member of should be 12 weeks. This was not evidenced in staff files and the registered manager was not aware of this timeframe. Therefore, the induction process was still not robust, and staff were not supported to ensure they had the suitable skills and knowledge to deliver effective care and support to people. This demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- People and relatives felt staff were knowledgeable and well trained. One relative said the staff are, "Very skilled." Staff felt the training had improved and they were now doing more training. One staff member said, "We have in house training. We had medication recently. It's good to have a refresher. We have all done our dementia training, it is fascinating."
- There was a training matrix in place which identified what training had been completed but not when it expired or was next due. We spoke with the registered manager about this who advised they would update this following the inspection to allow them to have better oversight of staff training needs.
- We found supervisions were in place which were more detailed, and appraisals where relevant had been completed. This showed some systems had improved in the service to ensure staff were provided with the appropriate skills and support to support people in an effective manner.

Adapting service, design, decoration to meet people's needs:

- At our last inspection on 30 August and 4 September 2018 the provider had failed to ensure the service was appropriately designed and decorated to meet the needs of people living there. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had not been made and the provider was still in breach of Regulation 15.
- We found the décor and space was not dementia friendly; there were no specific sensory activities available for people throughout the home and the signs to direct people were not always in place and clear.

● We observed one person become extremely distressed when seeing people arrive and leave through the front door; this person was not supported to understand the layout of the home and where they could go to feel safer.
● Access for people using a wheelchair was through the back door because the front door was not wheelchair accessible. We observed that each time a person in a wheelchair went to the bathroom, they were asked to keep their arms in, to prevent them being knocked on the door frame. It was a very narrow place to manoeuvre in a wheelchair which put people at risk of injury.
This demonstrates a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● However, staff told us they had consulted people and their relatives about the décor; "[People] like it as it feels like their home, even the [relatives agree]. It isn't institutionalised. We can only go by [people] and their feedback. It's aimed to feel like their home."

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● Mental Capacity Assessments were inconsistent; two people who were identified as not having capacity to make decisions regarding their care and support did not have mental capacity assessments in place.
● There was a DoLs matrix in place, but it could not evidence that all DoLS had been applied for in line with best practice.
● This shows the service was not always providing care and support in line with the MCA. As a result, people were at risk of having decisions made without their consent and not in line with their best interests. This demonstrates a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staff had received relevant training and knew about capacity and how to support people in line with their best interests; one staff member said, "Where people haven't got the ability to make decisions themselves we do what is best for them. We make sure care is person centred."
● Observations confirmed people were being consulted before receiving care and support; relatives also confirmed they had observed staff talking to people and explaining what they were going to do before they did it.
● Records showed that people, where appropriate, had consented to the care and support provided. Where people were not able to consent, we saw these consent forms had been signed by health and social care professionals.

Supporting people to eat and drink enough to maintain a balanced diet:
● At our last inspection on 30 August and 4 September 2018 we found lunchtime experiences were not positive. There were long waiting times, people had mixed feelings about the food and staff did not always know about nutritional risks or how to support people to eat in a safe way. During this inspection we found improvements had been made.
● People and their relatives were positive about the food and confirmed people had a choice of meals. One person said, "Yes, it is good, if you want more you can get it" One relative told us, "Yes [person] gets a

choice." Another relative said, "[Person] loves the food."
● Staff knew which people needed support to eat and what people liked. The chef told us about one person who had diabetes and said, "We have sweeteners, [person] has own biscuits and normally has a sugar free yoghurt." A staff member told us, "There is on [person] who will often ask me for soup if [person] isn't feeling too well, we have a good selection."
● Our observations confirmed food was provided in a timely manner and people were offered a choice of food. The chef showed people a picture of both options when taking orders. The menu was provided on a 4-weekly cycle and options included a variety of vegetables, meat and fish. People were given a choice of drink and condiments were available. This demonstrates people were supported to have balanced and enjoyable diet and to stay healthy and well.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support:
● At our last inspection on 30 August and 4 September 2018 we found multi-agency work was not being well managed. During this inspection we found improvements had been made.
● People and their relatives told us the service worked well with other professionals to ensure people received care and support to keep them safe and well. One person said, "[Staff] will immediately see to it if you need the doctor." One relative told us, "[Person] has a catheter, last Sunday it got blocked and they called the district nurse."
● A health and social care professional confirmed, "[Staff] are co-operative" Another told us about a person receiving specific care, "All measures are in place, everything I would advise has been done. They have done everything they should do." Staff told us they had positive relationships with other professionals.
● Records confirmed that people were being supported to receive care from other health and social care professionals, including GP visits, dieticians and dentists.
● This showed that the service worked well with other organisations to enable people to stay healthy.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● The service completed pre-admission assessments to identify people's support needs and determine if they can support people effectively. These pre-admission assessments looked at people's mobility, preferences around care and likes and dislikes around food and activities. This showed that the service was assessing people's needs and choices to ensure they could deliver effective care and support.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
At our last inspection the provider had failed to respect people's dignity and people did not feel cared for. People were not supported to be as independent as possible. People's privacy was not always maintained. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had been made and the provider was no longer in breach of Regulation 10.

- People told us they felt well cared for. One person said, "The staff are helpful and kind." Another person told us, "[Staff] do it from the heart." Relatives confirmed, "[Staff] could not be better. They really care about residents."
- Staff appeared to be caring and respectful. They acknowledged that all people are different and should be treated in a person-centred way. One staff member told us of one person who is from a specific area. They said, "[Person] likes a bit of banter and is happier when you talk to [person] like that, they light up when you speak to them in the manner they like to be spoken." Another staff member spoke about specifically supporting people living with dementia and said, "We keep our voice calm, ask them how they are feeling, we make sure they are safe."
- A health and social care professional confirmed, "People seem to be fairly looked after. You can see the smiles on [people's] faces."
- When staff were providing care and support to people, we observed this was done in a kind and manner and staff ensured people were well.
- Care plans confirmed people were given a choice about the gender of the staff they received care and support from.
- The service had an equality and diversity policy in place that said, 'We will empower people to recognise and counter discrimination and be supportive in doing so.' This shows the service was working in line with best practice to ensure people were treated with respect and compassion.

Respecting and promoting people's privacy, dignity and independence

- People told us, "Oh yes the staff are very good" when we asked if they felt they were treated with respect. Relatives confirmed this; "Certainly what I have seen over the years."
- Staff respected people's privacy and dignity and treated them with respect. One staff member told us, "We close the door, covering them up, when doing personal care, talking to them at their own level." Another staff member said, "We call them by the name they like to be called, we make eye contact. I want to talk to people how I want people to talk to my mum." Care plans confirmed the service worked to support people to maintain their dignity. One person's care plan said, '[Person] has a commode in room, [person] has requested in case [person] doesn't make it to the toilet in time."
- Staff told us how they supported people to be independent, "You help [people] do things, but if they can

do things for themselves you let them." They gave an example of one person, "We encourage [person] to always walk to the toilet and each day we give [person] a chance, some days [person] can and other days [person] will use the frame." Care plans confirmed the service worked to support people to be independent. One person's care plan said, 'To be encouraged to walk as much as I can to remain independent.'

● Staff understood the importance of confidentiality and they only discussed people's support needs in private areas. One staff member told us, "We don't have conversations in front of the other [people], we make sure the books are locked away." All confidential documents were locked away.

● This showed that the service knew how to support people to be as independent as possible, respect their privacy and dignity and improve their wellbeing.

Supporting people to express their views and be involved in making decisions about their care

● Relatives confirmed they were involved in reviewing their loved one's care. One relative said, "I have been to a couple [of reviews], I feel happy with speaking up." Another relative told us they were unable to attend but knew care plans were reviewed, "[Staff] send us the minutes."

● Records confirmed people, relatives and professionals were involved in reviewing care packages where possible. One staff member said, when discussing care plan reviews, "We always involve the family, we go through the care plan, we keep them updated on any change. If any problems arise, we discuss with the family as soon as we can. Its normally been resolved but if not, we get their guidance."

● This showed that people and other relevant professionals were supported to be involved in making decisions about the care people received.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control: At our last inspection the provider had failed to ensure people's care plans reflected their personal preferences and staff were not providing person centred care. We also found people were not being encouraged to engage in activities. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had been made and the provider was no longer in breach of Regulation 9.

- Relatives told us they felt staff were responsive. One relative said, "Very well, [person] tells me [staff] can't do enough. They are all lovely." One staff member said, "Care plans and risk assessments are a lot easier to follow and a lot more organised. The paperwork is more informative."
- We found that care plans were more person-centred and contained information on people's support needs, background and religion. We also found that in each person's care plan there was a 'This is Me' section that detailed which carers knew people the most and information on people's previous occupation. People's individual preferences were recorded including areas such as sleeping, and support. A food and nutrition questionnaire had also been completed. This showed the service had worked to improve records and ensure staff are guided on how to provide care that is person-centred.
- During this inspection we saw evidence that the service encouraged people to engage in various activities. Photographs showed events including pet therapy, musical nights and reminiscing activities were provided for people, and people were seen to be smiling and laughing in the photographs.
- However, during our two days of inspection we did not see any evidence of staff supporting people to engage in activities and we observed people sitting in the same position for long periods of time without any engagement or interaction. There was an activity timetable in place that was not being followed. We also observed that people were not encouraged to access the garden.
- We saw that care plans had been updated further to reflect what activities people enjoyed doing but we could not always find evidence of this being implemented. For example, one person's care plan said they enjoyed public transport including buses and trains, but we could not find any relevant activities being provided for this person.
- When we spoke with staff about activities; one staff member said, "We have loads of activities. [People] love reminiscing though, and the pets. We have to do what they like. A lot of people genuinely refuse, sometimes [people] just walk away or they fell asleep." However, people continued to tell us they did not feel they were supported to engage in activities of their choice. One person told us, "I wish there was someone to take me out for a walk." Another person said, "I like to read The Times. They have the Sun and Mirror here." A relative told us, "We suggested that they do more activities." We recommend the provider seeks guidance from specialists to explore suitable activities for people living with dementia and r similar conditions, to ensure their wellbeing was maximised.

Improving care quality in response to complaints or concerns:

At our last inspection on 30 August and 4 September 2018 we found that the service was not working in line with the Accessible Information Standards (AIS). Organisations that provide NHS or adult social care must follow the AIS by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information will tell them how to keep themselves safe and how to report any issues of concern or raise a complaint as well as explain their care and support.

● During this inspection we found this had not been addressed; there was still no easy read version of a complaints form available for people to access. This meant people who may have wanted to make a complaint or raise a concern about the service would not know how to and therefore not feel safe or supported.

● We recommend the provider follows best practice guidance on implementing the AIS.

● People and relatives we spoke with did not wish to raise any complaints. One person told us, "It is alright here, no complaints." One relative said, "We have no complaints about anything."

● A complaints policy was in place. We checked complaints that had been received since the last inspection. There had been one from a family member and we found it had been recorded on a complaint form and appropriate action had been taken, to the satisfaction of the complainant.

End of life care and support:

● At our last inspection on 30 August and 4 September 2018 we found the end of life processes were not sufficient. Not all staff had received end of life training and care plans did not evidence end of life care being provided. During this inspection we found that end of life care processes had improved.

● One relative told us, "They really need commending, from explaining the end of life process to me and getting a mattress within a few days, they have explained everything and done everything, and I couldn't recommend them enough." Another relative said, "I filled in an end of life plan of what [person] would have wanted."

● We looked at individual care plans for people at end of life and found relevant risk assessments were in place including ones for skin integrity and moving and handling. There was evidence of re-positioning and regular monitoring of wounds.

●There were records in place for the 'last days of life'; this included details of the person's family members and GP and their end of life care wishes and spiritual needs. For example, one person's care plan said, 'A priest should be called.'

● The registered manager showed us a matrix that was in place. People who were assessed by the registered manager and medical professionals as near end of life were monitored more closely and the service reported on their progress and notified the relevant professionals and relatives, so the appropriate care and support could be provided.

● There was an end of life policy in place that had been developed with the relevant professionals. Records confirmed all staff were up to date with end of life training. One staff member said, "We just did a refresher course. The hospice nurse says we do end of life care well, they are impressed." This shows the service was working well to ensure end of life care and support for people kept them safe and met their preferences.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.
Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
At our last inspection on 30 August and 4 September 2018 the provider had failed to ensure there were robust quality assurance systems in place which placed people at risk of not receiving safe, effective and responsive care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had not been made and the provider was still in breach of Regulation 17.

- The registered managers and provider did not have a robust system in place to oversee the running of the service and they had not identified the concerns we found during our inspection.
- The service has a continued breach of Regulation 12 relating to the safe care and treatment of people. Risk assessments continued to be inadequate; medicines were not being managed effectively; people were at continued risk of infection; accidents and incidents were not analysed to reduce the risk of harm to people; and recruitment and staffing was not being managed in a safe way. We found a continued breach of Regulation 15, Premises and Equipment as the service had not ensured it was appropriate for people living with dementia or similar conditions. The service had failed to ensure staffing levels were sufficient or that new members of staff received a thorough induction into the service to allow them to provide effective care and support to people. This was a continued breach of Regulation 18, Staffing. Furthermore, we found the service was still not working within the principles of the MCA which demonstrates a continued breach of Regulation 11, Consent to Care and Treatment.
- Monthly provider reviews looking at the environment and people's safety and welfare had not identified the concerns we found. No changes had been made to the service because of these reviews which demonstrates they were ineffective.
- Records confirmed that monthly care plan audits were in place; these ensured people's changing needs were reflected. However, they did not identify the shortfalls we found with regards to risk management. This means the staff were still not sufficiently guided to provide safe care and support to people with specific health needs and people may still be at risk of harm.
- Unannounced spot checks were being done by the registered managers; since January 2019 there had been 15. These looked at infection control and people's wellbeing. However, they had failed to identify the concerns we found and therefore were not effective. This demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- However, people and their relatives spoke positively about the new registered managers. One relative told us, "The management has improved over the last year, [person] is safe and well cared for. We can see the difference with the new manager." Another relative said, "I really like [registered managers], no complaints. Quite a lot has changed for the better, they have upped the game." Staff also told us the service had improved since our last inspection and they spoke positively about the registered managers. One staff

member said, "They are both brilliant managers, they have good communication with each other, and with us. You can tell them anything, you get praised, they thank us for our work. We all have worked so hard and it is better."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
At our last inspection on 30 August and 4 September 2018 the provider had failed to provide the CQC with an up to date statement of purpose. This was a breach of Regulation 12 of the (Registration) Regulations 2009. At this inspection, we found this breach had been addressed.
● The provider's statement of purpose was up to date and reflected the running and set up of the service. This had been sent to the CQC.
At our last inspection on 30 August and 4 September 2018 the provider had failed to notify the CQC, where appropriate, about the running of the service and incidents relating to people in receipt of a regulated activity. This was a breach of Regulation 18 of the (Registration) Regulations 2009. At this inspection, we found this breach had been addressed.
● Relevant notifications were being submitted in a timely manner to ensure the CQC can effectively monitor the running of the service and incidents relating to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● At our last inspection on 30 August and 4 September 2018 we found there were no surveys or meetings provided for people, relatives or staff to give their feedback about the service for improvements to be made. During this inspection we found this had been addressed.
● The service sought feedback through surveys and meetings with people, relatives and staff. One relative told us, "I have been to a couple of relatives' meetings." Staff confirmed, "[We have] family meetings and resident meetings, they are more regular and helpful."
● We reviewed surveys and found that feedback was mostly positive. Comments included, '[Service is] clean and tidy,' and, 'All residents appeared well looked after.' However, some relatives said, 'I have never seen any activities take place,' and 'My suggestion is for residents to participate in activities to stimulate them.' The registered managers told us they had worked on this feedback to increase activities and would follow our recommendation to improve people's experience.
● Staff told us, and records confirmed they attended monthly team meetings. One staff member said, "We have team meetings more now. The team get on so well, we all work together." Another staff member told us, "We have a meeting every morning, we discuss everything."
● This showed that the service involved all people receiving care and those delivering care to ensure high quality care is provided.
Continuous learning and improving care. Working in partnership with others
● At our last inspection on 30 August and 4 September 2018 we found the registered manager was not working in partnership with other health and social care professionals or overseeing their professional development. During this inspection we found this had been addressed.
● We received feedback from health and social care professionals prior to our inspection who told us they had no concerns about the running of the service.
● Records confirmed that the registered managers kept up to date with their professional development by completing relevant training. We were advised of plans for the registered manager to attend a local authority event where they could share best practice and ask for advice. They were unable to attend the first event due to our inspection but assured us they would attend the next one.
● This showed that the service worked well with other organisations to ensure the service was well-led and people received support that was informed by best practice and up to date guidance.

● The registered managers demonstrated their commitment to learning lessons from our previous inspection and improving the service to ensure people received safe care and support.

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 11 HSCA RA Regulations 2014 Need for consent The service had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice to support people who lack mental capacity to make an informed decision or give consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service had failed to ensure the premises where care and treatment is being delivered is clean, suitable for the intended purpose and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to ensure there were effective governance systems and processes in place to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to assess the risks to health and safety of people and to do all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had failed to ensure there were enough staff who were suitably qualified,competent, skilled and experienced to make sure they can meet people's care and treatment needs.

The enforcement action we took:

Warning Notice