Appletree House Care Home

Appletree House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 November 2017 and was unannounced. At the last inspection in July 2015, concerns were identified in relation to the oversight that the provider had of the service and how they could be assured of the quality of care delivered. A recommendation was made in relation to this that supervision methods should be put in place to support the registered manager. At this inspection, whilst the registered manager received support and supervisions from an ex-colleague, these were not sufficient in maintaining the quality of the service provision.

Appletree House Residential Care Home provides accommodation and residential care for up to 15 people living with dementia, mental health needs and frailty of old age. Communal facilities include a sitting room with dining area and access to outside space. All rooms are of single occupancy, except for one room, which is shared by two people. Appletree House Residential Care Home 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.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people had not always been identified or assessed appropriately. Some care plans lacked detail or guidance for staff. One person had sustained a number of falls during the year, but no referral had been made to the local authority's falls team for advice and support. Premises were not always managed to ensure people's safety. The lift was out of commission and a stair lift had been installed for people to access the first floor. However, the stairs were steep and some people were too nervous or unable to use the stair lift which meant they could not come downstairs. A commode chair was used to transport one person, which was unsafe. Some topical creams and bath lotions had been left on the windowsill of a communal bathroom and not stored safely. The provider had failed to ensure that risks to people, the use of equipment and premises were managed appropriately.

Staffing levels were not sufficient to ensure people were supported safely. For 15 people who lived at the home, care was provided by two care staff, although the registered manager and cook occasionally helped out during the week if required. The provider had failed to ensure there were sufficient numbers of staff to meet people's care and support needs safely.

People's preferences were not always identified or taken account of in relation to the care they received. One person persistently told staff they did not like vegetables, but every day they were served with them. People and/or their relatives were not involved in reviewing their care. Activities in the home were limited and did not relate to people's likes or interests. There was a lack of meaningful activities for people to

engage with and no outings into the community.

There were no systems in place to measure and monitor the overall quality of the service and no means of identifying areas that required improvement. The culture of the home did not promote person-centred, open or inclusive care. Issues we identified at this inspection had not been picked up through the audits we looked at. Relatives were not asked for their feedback about the service. The provider had failed to establish systems or processes that operated effectively to assess, monitor and improve the quality of the service. The registered manager was unaware of the new Key Lines of Enquiry which the Care Quality Commission introduced from 1 November 2017.

People's identified needs were not specifically catered for in relation to the adaptation and design of the home. There was only one bathroom, located on the first floor, for up to 14 people. The majority of people had a bath once a week. People who were unable to access the first floor via the stair lift were unable to have a bath. Some parts of the home were not well lit and could pose a risk to people as they navigated around the home. Opportunities had been missed in relation to the use of signage to assist people. We have made a recommendation to the provider in relation to this.

Generally, medicines were managed safely. However, two medicines for two people had not been administered over the last couple of days as stocks had run out. The registered manager immediately followed this up with the medical practice to ensure these medicines were delivered on the day of the inspection.

People were supported to have sufficient to eat and drink. Choices for meals were limited, although people generally were happy with the meals on offer. Drinks were freely available. People had access to a range of healthcare professionals and services. The registered manager understood the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation and put this into practice. People's consent was gained lawfully.

People were looked after by kind and caring staff who knew them well. Staff were warm and friendly and genuine relationships had been developed. People were able to express their views in relation to their day-to-day care needs and they were treated with dignity and respect by staff.

Staff completed a range of on-line training to meet people's care and support needs. Moving and handling training and dementia care training was delivered face to face.

Care plans were in the process of being reviewed and updated by the registered manager and this was work in progress. No complaints had been logged with the new registered manager since they commenced employment.

Systems were in place to ensure the safe recruitment and vetting of new staff. Staff understood how to protect people from potential abuse and knew what action to take. They had completed training in adults at risk.

Staff spoke positively about the registered manager and felt supported by her. Staff were asked for their feedback about the home and results overall were positive. People too were happy to live at the home and spoke of the caring attitude of staff.

We found Appletree House Residential Care Home in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take

at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risks in relation to people and the use of equipment were not always managed safely.

Staffing levels were insufficient to ensure that people were safe.

New staff were recruited appropriately and checks completed to ensure they were safe to work in a care setting.

Generally medicines were managed safely. Two medicines had not been received for two people and this was followed up with the medical practice at the time of inspection.

Systems were in place to safeguard people from abuse and staff had completed training in safeguarding adults at risk.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The home had not been adapted or designed to meet people's individual needs. There was a lack of signage around the home.

Staff had not received supervision since the registered manager came into post, although staff meetings took place which could be used as group supervisions.

People had sufficient to eat and drink, although some people felt there was a lack of choice.

Staff completed a range of training to update their skills and knowledge.

People had access to a range of healthcare professionals and services.

Staff had a good understanding of the legislation relating to mental capacity and deprivation of liberty safeguards and put this into practice.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well.

People were supported to express their views and made day-to-day decisions about their care and treatment.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities organised for people were limited and did not take account of people's preferences or interests. There was a lack of outings into the community unless relatives or friends took people out.

Care was not person-centred as people's preferences were not always recognised and acted upon. People and/or their relatives were not involved in reviewing their care.

No complaints had been recorded since the latest registered manager came into post.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There was no clear vision or strategy in place in relation to the governance of the service.

The registered manager had regular contact with the provider, but since the provider lived overseas, they could not be assured of the quality of the service provided at the home.

Overall systems were not in place to monitor and measure the quality of the service or ways to identified drive continuous improvement.

The registered manager was unaware of the new Key Lines of Enquiry which the Commission had introduced in November 2017.

Staff were encouraged to be involved in developing the service and their views were sought. Staff spoke positively about the

registered manager and said she was working hard to sort things out.

People were asked for their feedback through residents' meetings and satisfaction surveys. There were no systems in place to ascertain relatives' views.

Appletree 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 14 November 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in dementia and the care of older people.

Prior to the inspection we reviewed the information we held about the service. This included statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we spoke with seven people who lived at the home and a friend of one person who was visiting. We spoke with the registered manager, the deputy manager, a senior care assistant and the cook. We spent time observing the care and support that people received during the inspection.

We reviewed a range of records relating to people's care and how the home was managed. These included three people's care records. We also looked at medicines records and observed staff giving people their medicines. We looked at staff training, support and employment records, audits, minutes of meetings with people and staff, policies and procedures and accident and incident reports.

Requires Improvement

Is the service safe?

Our findings

Risks to people were identified and assessed but, in some instances, care plans lacked detail or guidance for staff. Risk assessments were in place relating to people's skin integrity, nutrition and weight monitoring, personal evacuation plans and mobility. However, one person with a specific health condition was at high risk of falls. Each fall they had sustained was recorded and over 20 falls had taken place during 2017. We discussed this issue with the registered manager who explained that the person had a high incidence of falls because of their health condition, but that no serious injuries had occurred. We asked whether a referral had been made to the local authority's falls team for advice and guidance, but the registered manager was not aware of their existence. We discussed the need to ensure that people's risks were identified, fully assessed and action taken to mitigate any risks. One staff member said, "We usually make sure risk assessments are up to date. The manager does these, she types them up and puts them in place".

Premises were not always managed to ensure people's safety. The registered manager told us that the lift was broken and that people, who were able, could use a stair lift. She went on to say that the provider was in the process of obtaining estimates to repair or replace the lift, but was unable to provide us with any timeframe as to when or whether the lift would be operational again. We saw that the stair lift in situ was located on a very steep staircase with narrow step treads. Two people who were accommodated on the first floor expressed their concerns. One person said, "I daren't go downstairs. I need two people to help me. One member of staff got trapped in the lift and no-one came and it really scared me. I wish they had a safe lift because what they've got there [referring to the stair lift] isn't suitable". A second person told us, "I'm petrified of the stair lift. I went to a birthday party downstairs and made myself, so I'm trying to get used to it".

We observed one person being hoisted by two care staff and that the procedure was done safely. However, the wheelchair used was not suitable, and put the person at risk, as it was a commode chair on wheels. This commode chair was not designed for moving people as it had no brakes, no foot rests and no proper support for the person. We also noticed that the cushion on the commode chair was torn which meant it could not be cleaned effectively.

In the bathroom, we saw some emollients and lotions had been left on the windowsill and not stored safely. In the afternoon on the day of inspection we saw someone freely enter the building through a side door, walk through the staff room and into the home. The side door was unlocked. We spoke to the person later who was visiting their friend, a person who lived at the home. The visitor said, "I used to go to the front door and ring the bell, but staff told me to just use the side door and let myself in". This put people at risk as anyone could have come into, or exited the home, without being checked.

There were no formal arrangements in place for reviewing and investigating safety and safeguarding incidents and events. This is an area that needs improvement.

The above evidence demonstrates that the provider had failed to ensure people were safe because risks to people were not managed appropriately, including ensuring that equipment and premises were safe. This is

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

Following the inspection, the registered manager informed us that the two people who were unable to easily access the ground floor had been relocated to ground floor bedrooms. Both were now able to access the communal areas on the ground floor and were happy with the new arrangements.

Some people were cared for in bed and at high risk of developing pressure areas. Care records showed the risk assessments had been drawn up and actions recorded. Staff were given instructions on how to care for each person including the use of topical creams and specialised equipment to prevent pressure ulcers from developing. In addition, in one care record, we saw the person had been regularly positioned throughout the day and night as staff had completed 'turning charts' to confirm this.

We looked at audits relating to the safety of the premises in relation to gas, electricity and other safety checks; these had been completed appropriately and were up to date.

The majority of people we spoke with felt that staffing levels were sufficient to meet their needs and that their call bells were answered promptly. However, one person said, "I was lying in bed last night in a soaking wet pad. It was a very bad night. I couldn't see my clock and I couldn't reach my call bell. It's like that sometimes. I don't know where the bell is and I wonder what would happen if I was having a heart attack". We discussed this issue with the registered manager who was aware of the concern and told us that the bell this person used was their own call bell which they had bought and that this had now been repaired.

The registered manager told us that staffing levels were assessed based on people's dependencies, although we did not see any records to corroborate this. At the time of the inspection, 15 people were living at the home. They were supported by two care staff in the morning, two in the afternoon and two at night. The registered manager told us they would also help out if needed during weekdays when they were on the premises. The cook was qualified to provide personal care and could provide additional support if an emergency arose. Out of the 15 people who lived at the home, we were told that five or six required two staff to provide care, for example, with hoisting or repositioning. This meant that, at night or weekends, when two care staff were on duty, staff might not be readily available to meet other people's needs promptly. We looked at the staffing rotas. These confirmed the above staffing levels. We asked staff whether they felt staffing levels were sufficient. One staff member said, "When the manager's here, yes. It would be nice to have a third person. We do have time to sit and chat with people. Sometimes in the morning it can be busy – two staff bathing someone for example. The cook can step in if needed and she is qualified". Whilst staff were used flexibly, people were put at risk because of insufficient staff. A staff member confirmed this and said, "Yes, I think people are at potential risk because of staffing levels. If someone falls downstairs and we're upstairs for example". We were told that staff spent additional time with people who were unable to come downstairs, but in our view this would have been difficult to manage with the current staffing levels. We were told that staff organised activities for people on a daily basis but an additional staff member would only be provided once a month to organise some additional entertainment.

The above evidence demonstrates that the provider had failed to ensure there were sufficient numbers of staff to meet people's care and support needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at two staff files and checked the systems for the recruitment of new staff. Checks were in place to ensure that staff were suitably vetted to confirm they were safe to work in a care setting. Staff files contained references that had been obtained and checks completed with the Disclosure and Barring Service (DBS). Where staff had 'spent' criminal convictions, these were historic, although there was no evidence to

show how these staff had been risk assessed by the previous registered manager(s). However, the current registered manager spoke highly of the staff in question and had no concerns as to their suitability to work at the home as they were valued and long-serving members of staff.

People told us that they received their medicines and any pain relief regularly and appropriately. One person said, "I have my six tablets each morning and that's as it should be. I think I should have dressings on my leg as it weeps and gets on my slipper, so I have to put them on the radiator to dry out. If I had my dressings on it would soak it up. I did have them, but they ran out". We asked the registered manager about this issue and she said that dressings were available, but that the person would not allow staff to change the dressings.

Staff completed training in the administration and management of medicines. We saw records relating to a person who had not been administered their medicine on two occasions and that this had been investigated and followed up appropriately. People's medicines were stored in separate plastic containers within a locked medicines room. All medicines, including medicines to be taken as needed (PRN), were prescribed. We saw that two people had not received two medicines for two days; these were an indigestion remedy and eye drops for sore eyes. We discussed this with the registered manager who showed us the faxes that had been sent to the medical practice to chase up these medicines. The registered manager rang the surgery on the day of our inspection and was promised that the medicines would be sent later that day. The registered manager told us they had arranged a meeting with this particular medical practice to discuss the concerns because prescriptions were not always managed in a timely way to ensure people received their medicines as needed. We observed a staff member administering medicines to people and that this was done safely. Medicines were stored, disposed of and managed safely.

A cleaner was employed for 12 hours per week and a cook on a daily basis. From our observations, the home was clean and tidy. Staff had completed training in infection control and food hygiene as required. The home was awarded a Food Hygiene Rating of 5 (very good) in August 2017.

Systems were in place to safeguard people from abuse. We asked people whether they felt safe living at Appletree House Residential Care Home. One person said, "I do feel safe here, yes, I do. Everyone is very nice". A second person told us, "No-one's nasty or abusive". A third person said, "I get on with everyone here; there's no trouble or anything like that". People were encouraged and empowered to raise any concerns. We spoke with two people who told us about a member of staff they were not happy with. They had raised their concerns with the registered manager and these had been addressed. One person said, "There's just one person [staff] recently that I didn't like. She pointed her finger at my nose and told me off, so I reported her. The lovely lady, head of care said if I didn't tell her she couldn't do anything about it, so I told her".

Staff had completed training in safeguarding adults at risk and understood how to keep people safe. One staff member explained, "If a resident's been abused in any way, it has to be reported to the manager and Social Services, even CQC. The professionals will investigate as needed". This demonstrated their understanding of their responsibilities under safeguarding policies and procedures and how they would raise a concern.

Requires Improvement

Is the service effective?

Our findings

People's individual needs were not specifically met by the adaptation and design of the home. Appletree House Residential Care Home was converted several years ago from a private residence into a care home. As a result, space was limited. For example, apart from one room that had an en-suite shower, there was one bathroom on the first floor which was shared by up to 14 people. We were told that people had a bath once a week and this was allocated on a rota system, although people could choose which day they wanted their bath. The deputy manager said, "We bath whoever is on the list in the morning. People can have a bath when needed and can have two baths a week if they want. If people can't get upstairs, it has to be a bed bath, which is not always appropriate. It would be nice to have a bathroom downstairs". All rooms had wash hand basins and two rooms had toilets en-suite. One room was shared by two people, so they also shared a wash hand basin. People told us they were happy with the bathing facilities.

Most people spoke consistently of being happy and comfortable in their rooms and had all they needed to hand. However, one person said, "I do find my room cold at night. I don't think they like to put the heating up. I go to bed at 6.00pm to keep warm". We saw the person had an extra thick cardigan over their shoulders. They added, "My light bulb shattered and I only had my side light for a week". We discussed this matter with the registered manager who told us they would look into this.

In our observations around the home we observed some parts of the corridors, the entrance hall and upstairs landing were quite dark which could put people at risk if they could not see where they were going. There was a lack of signage around the home. For example, there was a toilet situated at the end of the dining room, but no sign on the door to indicate this. There were several occasions when people checked with us that the door led to the toilet. Opportunities had been missed in the use of signs and colours to aid people in their orientation around the home.

We recommend that the provider obtains advice and guidance in relation to the adaptation, design and decoration of the premises to meet people's individual needs.

Staff completed a range of training to ensure they had the skills and knowledge they needed to provide effective care and support. Training, apart from moving and handling which was also delivered face to face, was via e-learning. Healthcare professionals had delivered training to staff on what it was like to live with dementia. Training followed the modules under Skills for Care guidance and was mandatory. Topics included moving and handling, medicines, infection control, food and hygiene, equality and diversity, deprivation of liberty and mental capacity and safeguarding. The deputy manager was also studying for their level 5 qualification in leadership skills, as well as end of life and supervision training. The registered manager told us, "Most of the staff have done the 10 units". The deputy manager told us about the training they had received in relation to dementia and said, "We've learned about the different types like vascular, Alzheimer's – people are still human. I like to sit and talk with people and do reminiscence with them". All staff had completed level 2 vocational training as a minimum and were encouraged to study for additional qualifications such as the diploma in health and social care. New staff would follow the Care Certificate , a vocational, work based qualification, although no new staff had been recruited recently. People told us they

had confidence and trust in the staff's capabilities. One person said, "They just get on well with the job". Another person told us, "They're quite capable of helping me have a bath. I had one today and it's a very relaxing time. I just sink into it and they pass me things I need like the flannel, but they don't delve, just allow me to enjoy it".

We asked the registered manager how often staff received supervision and checked the records relating to this. She told us that her aim was to organise six supervisions a year for staff, but had not yet put this into practice. The registered manager said, "I've been overwhelmed with the amount of work". Staff had completed some supervisions with the previous manager in 2017, but none with the current manager who registered with the Commission in August 2017. Three staff meetings had taken place since the new manager came into post which could be considered as group supervisions, but staff had not had individual meetings with the registered manager in recent months. This is an area that needs improvement.

People were supported to have sufficient to eat and drink and encouraged to maintain a balanced diet. We observed people having their lunchtime meal which consisted of minced beef, mixed vegetables and boiled potatoes, followed by fruit salad and cream. One person did not like the melon in their fruit salad so this was exchanged. The main meal was served at lunchtime with a light supper. Menus were planned over four weekly cycles and specialist diets were catered for. The menu for the day was displayed on a board in the dining room, but was not easy to read as the print was small. At lunchtime we observed the majority of people sat in the sitting room with an individual table laid up with a place mat, cutlery and napkin, plastic beaker and condiments were also available. Other people chose to sit in the dining area. We observed staff encouraging people to come and sit down for their lunch. One staff member said, "[Named person] do you want to come to the table today? It's up to you." Staff were polite with people as they served them their lunch and the mealtime was calm and unrushed. People told us that meals tended to be a set meal, but that on the whole they were happy with the food on offer. However, one person said, "They have too much tinned stuff. I don't like food that's been tampered with like corned beef, it's not proper meat. I get hungry a lot and they do me extra sandwiches. I like cheese, but not this tinned stuff and the other day they gave me jam, can you believe it? I like a hot chocolate to drink, but it's often cold and my food is luke warm by the time I get it up here and I like hot food". Choices of food did not appear to be readily available to people and the menus were not easy to read for people whose vision may be impaired. These are areas that need improvement.

Drinks were freely available and at the end of lunch, people were given a hot drink, which was what they usually had. Staff knew who preferred tea and who preferred coffee. People were asked if they had enjoyed their meal and they gave positive feedback. One person said, "Excellent dinner". A second person commented, "I'm loving it" and a third person told us, "Nice food, beautiful".

People's care and social needs were holistically assessed and, from our observations and conversations with staff, it was clear they knew people well and how they wished to be supported. Staff had completed training in equality and diversity. One staff member explained, "Everyone's an individual – different culture, age, religion and beliefs and we respect that".

The registered manager was unable to demonstrate how the service worked with other organisations to deliver care, support and treatment – this is a new KLOE that was introduced in November 2017 and the registered manager was unaware of this. However, healthcare professionals such as community matrons and district nurses did visit the service and provided support to people and staff as needed.

People had access to healthcare professionals and support when required. Care plans recorded when people saw healthcare professionals such as their GP, optician, district nurse, physiotherapist and

chiropodist. In addition, the service had access to a project that enabled staff to monitor people's health by asking people a set of questions and following a specific process in sharing this through a digital health programme. Information learned in relation to people's daily health needs and existing medical conditions could then be used to prompt staff when healthcare input from professionals was required. We asked people whether they had access to prompt medical attention when needed. One person said, "I used to have a very nice man, but the chiropodist doesn't come now". However, care records confirmed that people did have access to a visiting chiropodist. Another person told us, "I'm struggling with my sight now so I can't read any more or see the telly. Someone looked at my eyes and I should have an appointment at the eye hospital. That was six months ago, but I've not heard any more". We discussed this issue with the registered manager who said that they were looking at alternatives, such as large print books, whilst this person waited to be seen by a specialist. A third person said, "I can't think of needing a doctor, but one does come in from time to time".

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that when she commenced employment at the home, no DoLS had been applied for. As a result, she had completed mental capacity assessments for people, as needed, to determine whether they had the capacity to make specific decisions in relation to their care. The deputy manager told us about one person who did not have a DoLS in place and had walked out of the home freely earlier in the year, putting them at risk. The new manager had immediately completed a DoLS to ensure that this person was no longer able to leave the home on their own. The registered manager and staff had a good understanding of the legislation relating to mental capacity, and the importance of gaining people's consent, and put this into practice.

Good

Is the service caring?

Our findings

People were looked after by kind and caring staff and genuine relationships had been developed. We observed staff to be of a friendly and cheerful disposition and people were spoken with in a caring manner. Staff demonstrated kind and effective communication by bending down to people's level, holding their hands and listening to what people had to say. One person said, "They couldn't be nicer here". A second person told us, "No faults, they are all good and kind". A third person commented, "Oh, that girl there is so lovely, she makes me smile. I can't remember her name, but she sometimes brings us a cake in and she got me a punnet of grapes, they were delicious". We observed that care was person-centred and not task driven. People and staff were engaged in conversations and had a shared humour. One person explained, "[Named staff member] daughter is having a baby soon, so she's going to keep me informed when it's born". Staff demonstrated empathy and placed importance on people's comfort. For example, we saw that people had blankets over their laps. At lunchtime, we observed a staff member asking one person if they would like a cushion to prop them up in order to have their meal. This was done kindly and gently and the person's consent was sought. The staff member then checked that the person was comfortable and happy.

We observed people were supported to express their views by staff and were actively involved in making decisions about their care, treatment and support. We saw staff guiding people gently and calmly into the dining area at lunchtime and procuring walking frames to assist people where appropriate. One staff member helping one person and said, "It's okay, take your time, no need to rush". We saw a staff member noticed a person was looking sad and knelt down to the person's level, saying, "Are you all right?" The person said they did not feel too well to which the staff member responded, "Can I get you anything? Are you too warm? Would you like to go back to your room?" The person said, "No I'd like to try and eat my lunch here". The staff member held the person's hand and said, "That's fine, but let me know if you need me and after lunch, if you want to go back to your room, I'll take you. Is that all right?" The person was reassured and smiled, thanking the staff member for their thoughtful attention. Another staff member noticed a person was coughing and came to their assistance. The staff member stooped down to the person's level, stroked their back and asked them if they wanted a drink of water, which was promptly obtained for them.

We asked staff about their understanding of people's preferences, personal histories and backgrounds. One staff member said, "One lady goes to church every Sunday and there's Songs of Praise on the television which people like. Another lady plays hymns on the piano".

People were treated with dignity and respect by staff. One person said, "Staff know I'm quite private and my room is my private space, they know that". A member of staff commented, "It's about treating people with dignity and respect, to make sure the doors are closed, curtains are closed and everything is within reach".

Requires Improvement

Is the service responsive?

Our findings

We observed that staff did not always take account of people's preferences when providing support. For example, one person told us that they did not like vegetables and was angry that vegetables were always served to them, despite them asking staff not to. We saw a member of staff came into the room to ask the person for their lunchtime choice and made reference to the fact that the person did not like vegetables. The person said, "I don't want vegetables on my plate, you know I don't like them. It's a waste and there might be someone who's vegetarian here, so don't give them to me, I don't want them". The staff member responded, "So do you just want the boiled potatoes and casserole?" to which the person replied, "Yes please". We visited the person again at lunchtime and noticed that the person had vegetables on their plate. The person looked at us and said angrily, "This is what I get every day!" This person added, "I was in their bad books yesterday and I didn't get a pudding, that's the third time in a week". We discussed this issue with the registered manager who told us they were not aware of this happening and would follow it up. After the inspection we spoke with the registered manager who told us they had investigated this issue and that the person had been offered desserts on a daily basis.

We looked at one person's care plan which recorded that they had a particular health condition. However, within this person's medicines care plan there was no mention of their health condition or a separate care plan in relation to this, to advise and guide staff.

Within each care plan was a section entitled, 'My Review', but this had not been completed in the care plans we looked at. We asked the registered manager how people and/or their relatives were involved in planning and reviewing their care. She told us there was no involvement from people or their relatives currently and added, "I am hoping to get the keyworker involved with this".

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Care plans were not written in an accessible way to ensure that people could understand what had been written about them.

Just after 10am, we observed one person sitting in their chair. Their hair looked as though it needed a wash and the person had no clothing on their lower half other than their netting incontinence pants and pad. They did, however, have a blanket over their legs. This person was wearing a plastic apron and the table in front of them was sticky and had pools of liquid spilled along with food debris. At 12.45pm, we saw the person was eating their lunch in their room, but the blanket covering their lower half had slipped, exposing them, whilst eating their lunch. At 2.30pm, the person was in the same position in the chair with the lower half of their body exposed. Staff had not responded promptly to this person's needs.

We asked people about activities at the home and whether they felt there was enough to occupy them. People said they were able to exercise choice and independence in terms of where they wanted to be in the building. However, two people on the first floor stayed upstairs and one person said, "I do get a bit lonely up

here sometimes, but that lady over there passes the door and we wave. She says, 'If you can't be good, be careful'!" The second person told us, "There's nothing to go downstairs for. People just sit around falling asleep. I'm not interested in their quizzes, they bore me. I read instead. They never take us out. There's a park just over that way and I'd love some fresh air".

From our observations, no particular activity had been organised on the day of our inspection. Spontaneous singing broke out at one point in the lounge just before lunch. One person said they went out with their relative and told us, "I'm going to the pub later. My son will come. I like knitting". Another person told us, "I used to go to church, but I can't now, I can't get there". A third person said, "I don't mix very much and they let me be really".

Additional staff occasionally organised activities for people and external entertainers came into the home, but activities were not routinely on offer to people. One staff member told us that some people liked to help lay the tables at mealtimes. Some people went out with their relatives and others visited an over 60s club on a Thursday, which was organised locally. One staff member told us that activities such as reminiscence or board games were held for people during the afternoon. At the time of our inspection, the television was not working, so people were watching DVDs instead. People who lived on the first floor were at risk of social isolation. We asked the registered manager whether outings into the community were organised and were told that a trip to a garden centre was planned. From the records we looked at and our observations, no account was taken of what people's interests were or how they would like to spend their days. Overall there was a lack of meaningful activities that met people's social, emotional and intellectual needs.

The above evidence demonstrates that the provider had failed to ensure people received care and treatment that met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were half-way through completely revamping people's care plans and that this was work in progress since they commenced employment a few months before. Some care plans we looked at contained detailed information about people's care and support needs and guidance for staff. For example, one care plan included information about the person's continence, eating and drinking, emotional and mental health needs, falls, family/social needs, hygiene and personal care, medication and pain control, mobility, eye sight and sleeping. This care plan also recorded the person's life story, interests and their likes and dislikes with regard to food and drink. We read that personal care was very important to this person, that they liked their nails manicured and painted and to look smart. We talked with this person who told us, "I like my nails and I'll sue if anyone touches them!"

We looked at the provider's complaints policy which stated that complaints would be acknowledged within three days of receipt. We asked the registered manager if we could see a copy of the complaints log, but she informed us no complaints had been received since she came into post and there were no other records available to us.

Requires Improvement

Is the service well-led?

Our findings

From our observations, review of records and conversations with people and staff, there was no clear vision about how high quality care was delivered in a culture that promoted person-centred, open and inclusive care. In the provider's Statement of Purpose, it referred to, 'privacy, dignity, independence and choice'. It referred to giving people opportunities to select from a range of options, their human rights and philosophy of care. In our view, based on the evidence referred to within this report, the aims and objects of this Statement of Purpose were not met.

Staff spoke positively about the registered manager and felt they were supported to do their jobs well. However, the lack of supervisions meant that staff may not always understand what was expected of them and their competencies not being checked. Staff meetings were organised and provided opportunities for staff to discuss matters. The deputy manager said, "Meetings are quite regular. Everyone airs their views and are encouraged to voice their opinions". The registered manager told us that, "Care plans were a mess" and that they were in the process of organising them in a person-centred way. The registered manager told us they had regular contact with the provider by telephone and email or over the internet and that the owner was supportive. However, since the provider lived overseas, the registered manager received support from an ex-colleague who organised supervision meetings with her. At the last inspection carried out on 30 and 31 July 2015, we identified that the provider could not always be assured of the quality of the service provided at Appletree House and made a recommendation in relation to this. This is still an area of concern and at this inspection we identified more areas of concern in relation to quality and compliance which had not been addressed through the provider's quality assurance processes.

The deputy manager told us they worked alongside the registered manager to update records and that this was an area that had lapsed. The deputy manager said, "[Named registered manager] has changed a lot and she's really good for this home. It's a lot better and staff get on well, there's good teamwork. The manager is approachable and if anything arises, she nips it in the bud straight away". From our conversations with the registered manager, whilst much had been achieved, it was clear that more work was required. Good governance is intrinsic to ensuring quality is integral and that potential risks do not compromise the quality of care people receive. One staff member explained, "I just think [named registered manager] is doing a great job and she will continue to do that to meet the standards. I'd like things to go up. The hard work will pay off in the end".

There was no evidence to show strong links with the local community had been forged, other than for some people who visited a local pub or club. Except for when family and friends visited the home, there were no formal methods, such as relatives' meetings or surveys, to establish how relatives felt about the home as their views were not obtained.

We saw some audits in relation to premises. provided by external contractors, which were satisfactory. However, overall there were no systems in place to measure and monitor the quality of the service. There were no governance systems in place to drive improvement and no analysis of accidents and incidents, in order for lessons to be learned. Audits were not in place to recognise any areas for improvement and issues

we identified at this inspection had not been picked up through effective auditing. For example, the levels of staffing, management of risks, the lack of staff supervisions and care that was not person-centred.

The above evidence demonstrates that the provider had failed to establish systems or processes that operated effectively to assess, monitor and improve the quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2017, the Commission implemented some changes in the way services would be inspected and introduced a new 'Guidance for Providers' on its website. We discussed the implementation of the new Key Lines of Enquiry (KLOE) with the registered manager, but they were unaware of these changes. For example, they were unaware of the KLOE in relation to how lessons might be learned and improvements made when things go wrong. There were no formal arrangements in place for reviewing and investigating safety and safeguarding incidents and events.

Staff were encouraged to be involved in developing the service and a whistleblowing policy was in place. A staff satisfaction survey had been completed in September 2017 and of the 11 responses, the majority were positive. Residents' meetings occasionally took place and records confirmed that items discussed included menus and activities. People had completed a satisfaction survey which asked for their views on their personal care and choices, staff, any complaints, cleanliness, food and menu choices. Eight responses had been completed and all were positive.

People we spoke with were positive about the home. One person said, "I like it here". Another person told us, "What more could you ask for? I have nice food and a clean bed every night". A third person commented, "We're one big family here". People told us they knew who the registered manager was and that she was approachable and responsive. One person said, "She is a very good person. You can have a laugh with her, but she takes you seriously if you want to tell her anything. You can tell she's a kind person". Another person told us, "I can't think what it was about now, but whatever I need, I just tell her, well any staff actually and they sort it out".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The provider had failed to ensure that service users received care and treatment that was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (3)(a)(b)(c)(d)(e)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Service users were not protected against unsafe care and treatment because of the mismanagement of risks and unsafe equipment. Regulation 12 (1) (2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to ensure that systems were in place to assess, monitor and improve the quality of the services provided. Regulation 17 (1) (2)(a)(b)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure there were

sufficient numbers of suitably qualified and experienced staff to meet people's care and support needs.
Regulation 18 (1)