

Miss Sonya Wase

Rosier Home

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

Rosier Home is a care service for up to 16 older people who may be living with dementia. It does not provide nursing care.

There were 15 people living in the service when we inspected on the 26 October and 1 November 2017. This inspection was prompted in part due to information received from the local authority. This was an unannounced inspection.

There was a registered manager in post. The registered manager was also the provider. 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.

At our comprehensive inspection of 13 November 2015, we found that improvements were required around Deprivation of Liberty Safeguard (DoLS) applications and the environment and the service was rated as 'Requires improvement.'

At our comprehensive inspection of 03 and 12 May 2017, we found that improvements had been made around DoLS applications, however the environment still required development to ensure it was dementia friendly for the people who lived there. Additional improvements were required as environmental risks had not always been identified and managed and improvements were required around cleanliness. We also identified that improvements were needed to ensure that risks to people's health, safety and welfare were effectively assessed and that care plans provided clear guidance to staff of the support that people required. Improvements were required regarding the storage and administration of medicines to ensure that the process was safe. We found that policies and systems in relation to the Mental Capacity Act 2005 (MCA) were not up to date and capacity assessments had been completed incorrectly. There had been a lack of oversight of the service by the registered manager to ensure the service delivered was safe and effective and that it was up to date with best practice. The service was again rated 'Requires improvement.'

At this inspection, we found that improvements had not been made and we identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our

enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

Following this inspection, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do immediately to address them. An action plan was returned to us the following day. You can see what other 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?

Inadequate ●

The service was not consistently safe.

Environmental risks were not effectively managed and the cleanliness of the service needed improvement.

Staffing levels were not adequate to meet the needs of those living at the service.

Not all risks to people had been identified and risk assessments were not detailed enough.

Medicines were stored safely.

Is the service effective?

Inadequate ●

The service was not effective.

Training and development was not sufficient to assist staff in the delivery of safe and effective care.

People were not supported effectively with their nutritional needs.

People were not always supported in line with the Mental Capacity Act.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People's privacy was not always respected.

People's preferences were not always documented to ensure that support was provided according to their wishes.

People's independence was promoted.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

Care plans lacked detail and contained conflicting information.

There was a lack of meaningful activity and stimulation for people to ensure their well-being.

A complaints policy was in place.

Is the service well-led?

Inadequate 

The service was not well-led.

A lack of progress had been made to make the required improvements identified through previous inspections.

Robust audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

There was a failure to recognise, identify and effectively act on failings which impacted on the quality of service provision.

Rosier 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.

This unannounced inspection took place on the 26 October and 1 November 2017. The first day was undertaken by two inspectors and the second day was undertaken by one inspector.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and the safeguarding team.

During our inspection, we looked at the care records of nine people, recruitment records of five staff members and records relating to the management of the service and quality monitoring. We spoke with three people living at the service and two relatives. We observed the support provided to those who were unable to talk with us due to their complex needs. We spoke with five staff including the registered manager and assistant manager.

Is the service safe?

Our findings

At our last inspection, we found that improvements were needed regarding the management of environmental risk and cleanliness. At this inspection, we found that further improvement was still required.

Robust systems were not in place to ensure the cleanliness and maintenance of the building. The carpet in the front lounge was stained, the arms of the chairs in the second lounge were grubby and the side tables were dirty with the tops of the tables peeling off. This was an infection control concern as they were unable to be cleaned properly. There was a broken end bath panel in the upstairs bathroom and there were missing tiles in the downstairs bathroom and this still required decoration as identified at the previous inspection.

Environmental risks had not always been identified or addressed effectively. Where a risk of scalding had been identified from a hot tap in the upstairs bathroom, the registered manager had put a handwritten sign up to request that people used the tap in the bathroom next door. They had not recognised that people may not read the sign and could continue to use the tap placing them at risk. The registered manager had not considered other options to reduce the risk more effectively such as closing off the bathroom and requesting that people use the bathroom next door. The registered manager assured us that action would be taken. After the inspection, we were told that the tap had been covered so that it could not be used until the temperature had been reduced to a safe level.

The registered manager had completed an audit of window restrictors. Window restrictors are required to reduce the risk of people falling out of windows. This audit did not include the window in the upstairs hallway or in the upstairs bathroom and both of these windows did not have restrictors in place. The registered manager confirmed they had not checked these windows and they had not been recorded as checked on the audit.

The stairs between the ground floor and the first floor were open and accessible to four people who were mobile and had their bedrooms upstairs. Two of these people would usually use the lift to move between floors but that the lift had stopped working for five days resulting in people using the stairs. The registered manager had asked each person to use a call bell to request assistance to be supported to use the stairs. However, they confirmed that sometimes people still used the stairs on their own without staff support. This meant that the measures in place to mitigate the risk were not effective and this continued to put people at the potential risk of falling down the stairs.

These issues were previously identified as a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment. However, due to continued concerns, this puts people at increased risk of receiving unsafe care and treatment and is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and treatment.

Improvements were required as there continued to be risks to people's personal safety that had not been assessed. Where there had been a concern that one person could be smoking in their bedroom, it had not been identified that a risk assessment was needed to provide guidance to staff on how to reduce the risks to

that person and to others in the home from the potential risk of fire. Where people were having their bowel movements monitored, there was no guidance in place to tell staff what action to take if the person did not have a bowel movement for a prolonged period of time. Some assessments did not contain enough detail or guidance on the action for staff to take to reduce the risk. For example, where one person could become anxious and upset, there was limited guidance to inform staff on the best way to support the person.

There was inconsistency in pressure care records and in the knowledge of the management team regarding pressure care. People who were at high risk of developing pressure ulcers due to being cared for in bed had been recorded as being at low risk. Where risk had been identified, not all measures for reducing the risk had been recorded for staff to follow. The registered manager and deputy manager told us that where people were at risk they had an airflow mattress in place. They had not recognised that other measures such as repositioning, regular fluids and effective continence management were required to prevent pressure ulcers developing and that all measures needed to be recorded to provide guidance to staff despite this being raised at the inspection in May 2017.

It was documented on one person's repositioning chart that they required two hourly turns in the day and four hourly turns at night. On 23 October 2017 there were no turns recorded from 7pm until 9am the following day. On 25 October, there were no turns recorded between 1am and 10am. On the first day of inspection, no turns had been recorded since 5am when the record was checked at 1.15pm. This put the person at risk of developing pressure ulcers as the guidance was not being followed.

We found that moving and handling practices were not managed safely and people were at potential risk of harm. One person was being supported to stand in the lounge using a handling belt. The person did not look comfortable and the belt was right up under their arms which indicated that it was either the wrong size or had not been put on properly. The person did not appear to understand what staff were trying to do and staff did not explain to the person what they were doing or reassure them. The handover book stated that staff were to use a frame and belt to support the person but this was not recorded in the person's mobility assessment or care plan. A frame was not used to support the person. The falls prevention assessment referred to staff using a 'lifting belt'. The use of a handling belt to lift someone places them and the staff member at risk of injury to their backs or shoulders. There was no guidance provided to staff in the care plan, assessment or handover book about how to use the handling belt, the frame or how to support the person to stand. This put the person at risk of falling due to the use of inappropriate equipment and from staff not having the correct guidance to safely support the person.

One person needed to be transferred from one place to another. The registered manager and assistant manager were planning on moving the person using a sling and hoist. The person had not been moved using a sling or hoist before. The registered manager said that based on the person's weight, the sling should be suitable and were unaware that they needed to consider the type of transfer they wanted to make, the person's height and whether they had trunk control or needed support with their head. The person had not been assessed to ensure that the sling and hoist were suitable and that they would be moved safely. This could place the person at potential risk of falling from a sling. The inspectors intervened to ensure that the person was not moved using a hoist. This lack of up to date knowledge placed people at potential risk of the use of inappropriate equipment which could place them at risk of injury.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

At our last inspection, we found that staffing levels required review. The registered manager had made changes so that two staff were now doing an awake night. They had worked out a dependency level for each

person but had not determined how many staff were needed as a result and whether staffing numbers needed to be increased to ensure that people were supported safely and effectively. This meant that they could not be sure if staffing levels were meeting people's needs.

We observed that at times the staff were rushed and were running around and calling out to advise each other of where they were in the building. This had an impact on the atmosphere as it was not always relaxed. One staff member said, "We have been short staffed the last couple of months as three people left. The night staff are doing all the personal care before 7.30am. I am on the rotas constantly so am tired." One staff member said, "We have been short staffed as people have left." Another staff member said, "We do need more staff as sometimes we are a little bit stretched." One person said, "We still need more carers. Really and truly nothing has changed since the last inspection. They [staff] are still rushing around and there is definitely not enough staff when there are three people to feed upstairs and two downstairs." One relative told us, "They seem short staffed."

People using the service, staff and relatives told us that there needed to be more for people to do. The registered manager had not identified or explored how they could manage, deploy or support staff to make sure people could have their individual needs and interests met through discussion and time spent with people on a one to one basis.

We checked the rotas between 23 September and 20 October 2017 and found that the rotas were incomplete. The registered manager was not recorded on the rota and there were gaps where shifts were not recorded so we were not able to check the staffing levels that had been provided.

There was a lack of staff available at lunchtime to ensure that people were supported to eat and had an enjoyable lunchtime experience. There was a note on the fridge stating that staff must stay with one person to encourage them to eat. On the second day of inspection, we saw that person was left to eat unsupervised. This was because staff were supporting other people. The person was heard asking for help on numerous occasions, was unsure what cutlery to use and was using the tablecloth to wipe their mouth on. There were five people who required support with eating in their bedrooms. An hour after the lunch had first been served, three people who required assistance had still not been supported with their meal. There was a lack of staff to provide any support that was required to other people and those who were having lunch in their bedrooms had to wait until a staff member was available to support them.

People did not receive their medicines at the prescribed time as there were not enough staff. One person was due to have anti-biotics at 8am as documented on the MAR (Medicines Administration Chart). These were given at 9am. This person was also due a pain relieving medicine at 8am and said that they were in pain. This medication was also given at 9am. This caused the person anxiety and they were seeking reassurance that the rest of the medication would be given at the right times.

The medication was still being administered at 10am when according to the MAR chart it should have been administered at 8am. The assistant manager was being disturbed throughout as there were not enough staff for them to focus on the task. For example, the registered manager needed to clarify information with the assistant manager. The assistant manager had to wait for the registered manager to observe the controlled drugs being administered. This further delayed the administration of the medicine. The assistant manager told the inspector that the delay was due to disturbances and a lack of staffing. The interruptions also put people at risk of mistakes being made.

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

The service did not always follow safe recruitment practices. The registered manager had told the inspector that they sometimes had family members help out when they were short of staff and records showed that full recruitment checks were not always made on family members or new staff before they were employed by the service. One staff member was recorded as having a start date of 6 November 2017; however, the rota showed that they had worked at the service in October 2017. There was no work history or references on the person's file although they did have a criminal record check in place. A lack of appropriate checks meant there was a risk that staff could be employed who were not of a sound character, competent or experienced to fulfil their role. The registered manager said that the person did not work unsupervised, however due to there being a lack of staff, we could not be sure that this actually happened in practice. The registered manager told us that the references for this member of staff these had been requested and that they would chase these up urgently.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and told us they felt comfortable reporting concerns to the management team. However, staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

At our last inspection, we found that improvements were needed regarding the safe management of medicines. At this inspection, we found that improvements had been made but that further improvement was required to ensure that people received their prescribed medicines on time.

Fridge and room temperatures were now recorded and staff were no longer directly touching the tablets. There was clear guidance in place for 'As and when required' (PRN) medicines for staff to follow.

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last two inspections, we found that improvements were needed regarding the understanding and application of the MCA. At this inspection, we saw that improvements were still required.

At the last inspection, we found that mental capacity assessments had not been completed correctly. At this inspection, we found they were still not correct. The assessments covered numerous decisions rather than the specific decision that was to be made. There was no assessment of capacity in place to determine if one person could give consent to having bed rails. It was documented on the person's risk assessment that the person's relative had given consent, however it was not clear if this decision had been made in the person's best interests or if the relative had Lasting Power of Attorney (LPA). A LPA is a legal document that allows a person to appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

The registered manager had signed some consent forms and told us that this was following discussion with the person's family. These discussions were not documented and it was not clear if people had capacity to sign their own consent forms as capacity assessments had not been completed. The registered manager was unsure if family members who had signed to give consent for people had LPA and did not have any evidence of this. This meant that the person was at risk of having decisions made for them unlawfully.

This demonstrated a continued lack of understanding of the MCA and consent and additional training had not been sourced to improve knowledge and understanding despite this being a recommendation from last inspection.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

The registered manager could not demonstrate that people were receiving effective care and support from staff who had the knowledge, skills and competency to carry out their roles and responsibilities.

We observed poor moving and handling practice. The assistant manager was providing training to the staff team in moving and handling, however the training certificate on their file was out of date and our observations around moving and handling did not evidence that they were confident and competent in this area. Staff did not recognise poor practice or understand the impact this had for individuals they cared for. For example, the unsafe use of moving and handling equipment and injuries that could be caused due to poor moving and handling techniques.

Training for staff was not managed effectively. The training matrix that was sent to us had gaps and no date was recorded for the assistant manager or seven additional staff to evidence that moving and handling training had been completed. The registered manager told us that not a lot of training had been done recently and recognised that some additional training was still required.

There were shortfalls in mandatory training and not all staff had received training in subject areas relevant to their role. For example, staff prepared food for people but not all had received training in food hygiene. There were people in the service who were diagnosed with dysphagia (difficulty swallowing) and were at risk of choking and aspiration (where food or fluid enters the lungs). The staff team had not received training in this subject. This meant that they may not understand the best way to support this condition or recognise signs that may require additional medical support. This put people at risk of being supported by staff who were not competent or skilled to support them.

This is a breach of Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

People's dietary needs were not always assessed and met when their needs changed. One person was nearing the end of their life and recently had a chest infection. It had not been identified in the care plan or risk assessment that there could be an increased risk of that person aspirating (where food or fluid enters the lungs) or choking due to their frailty or due to the chest infection. The failure to recognise changes in the person's health needs placed the person at risk. The nutritional care plan stated that the person required 'soft food only', however old information regarding the person's food choices had not been removed which could be confusing for staff and result in the person being given foods that were not suitable.

We observed one person whose food was out of reach and was cold. The inspector alerted a staff member that the person appeared in discomfort and the staff member tried to encourage the person to eat. The person refused the food and so was given a sandwich but no further encouragement was given to them to eat and the person did not appear to know the food was there. The person was assisted to the toilet and sat in a different room on their return but their food was not moved to where they were. The cook took the sandwich away thinking the person had returned to their bedroom. A staff member noticed the sandwich and only offered the sandwich to the person when the inspector intervened. The person was not encouraged to eat the sandwich and was not sufficiently supported by staff to ensure that they had enough to eat.

Consideration had not been given to ensuring that foods were suitable for individuals. At lunchtime, one person was struggling to chew the turkey that they were eating and their food was not cut up small enough making it difficult for the person to eat. The person kept repeating that the food was not hot enough and kept sitting with their head in their hands. This person had been identified as requiring a staff member to sit with them to encourage them to eat, however this did not happen. The inspector alerted the registered manager that the person required support and this was provided. The importance of ensuring that food was kept hot for the duration of the meal had been discussed at the previous inspection, however despite this; action had not been taken to improve this. The registered manager said that they were looking at how to

address this.

These issues were previously a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting national and hydration needs. However, due to continued concerns, this puts people at increased risk of receiving unsafe care and treatment which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and treatment.

At our inspections of 13 November 2015 and 03 and 12 May 2017, we found that the service required development to ensure that it was suited to people with dementia and we made a recommendation at each inspection to support improvement in this area.

At this inspection, we found this still required development. There was a lack of visual prompts to provide information to people and to promote independence within the service. Only one bedroom door had a photograph on it to personalise it and provide an extra prompt to help people recognise their bedrooms. The lunchtime menu was written on a chalkboard which was in a corner of the dining room and was not very visible to people. Sensory and comfort items such as musical instruments and dolls were tucked away behind a chair and not accessible to people. Access to sensory and comfort items are important when caring for people with dementia as they provide stimulation and evoke memories. People were not provided with time from the staff team to ensure that all aspects of their physical, emotional and psychological needs were met.

Following recent safeguarding concerns and following our last inspection, there had been a significant amount of support provided to the service from the local authority with the aim of improving outcomes for people, particularly in identifying and addressing their health needs. Where changes in people's wellbeing were identified, action had been taken to seek guidance and treatment from health professionals. One person told us, "I have been referred to the dietary nurse and they are coming to see me soon." The community matron visited the service on a regular basis.

Is the service caring?

Our findings

At our last inspection, we found that people's privacy was not always respected by staff. At this inspection, we found that improvements were still required.

People's preferences were not always documented. We observed that the radio in the bedroom of two people was on a radio station of modern dance music at quite a loud volume. The two people in the bedroom were sleeping. We did not see that their preference was recorded and we did not know if this was the person's choice. At the previous inspection, people's bedroom doors had been wedged open. The registered manager told us they would document each person's preference; however we did not see evidence of this. While not all bedroom doors were wedged open at this inspection, those that were did not have their preference documented and as a result we did not know if this was the person's choice.

Handover books and activity records were stored on the desk in the hallway which was used as an office area. These contained personal information about people. This meant that information could be read by people who did not have a right to see it. The registered manager had told us at the previous inspection that this would be addressed; however we did not see evidence of this.

People were not always treated with dignity and respect. We observed staff members discussing one person in the doorway of their bedroom where the conversation could be overheard by other people in the service. We also observed on two occasions, staff member's entered people's bedrooms without knocking.

We observed that one person had dirty fingernails and their hair had not been brushed. One relative said, "[Person] is in bad need of a shower or bath but the staff say [person] is awkward and might say they don't want one. We have concerns with hygiene which we have raised with [registered manager] but it hasn't improved yet." This was discussed with the registered manager who said that the person would often refuse personal care but that they would look into how best to provide support to address this concern.

Despite our findings, people told us that the staff were caring. One person said, "I live here because I like it. It's a lovely little home." Another person said, "I like living here. The staff are very good and helpful. They are always there for you." We saw a compliment which said, "The staff are attentive, friendly and I am most grateful for the regular updates that I receive on the person's health."

There was a friendly atmosphere in the service and there was lots of laughter. Staff spoke fondly of the people they cared for. One staff member said, "We are like a big happy family." One relative said, "The staff are very friendly and welcoming. The cook is lovely and down to earth." However, we saw that interactions were sometimes rushed and we did not see staff spending time sitting and chatting with people and encouraging conversation.

People were supported to maintain their independence by staff. Where one person was being supported to mobilise, they were encouraged to do as much as possible for themselves and the staff member was heard saying, "Watch that little step there." One care plan said, "Keep giving me my independence by letting me

make choices that suit my needs."

People's bedrooms were personalised and reflected their choice and individuality. People had the opportunity to include personal items of decoration and furnishings to personalise their space.

People's relationships with their families and friends were respected. Relatives and friends could visit at any time and we saw people entertaining their visitors who were welcomed by staff. One relative said, "One of the family visits every other day. The service is very accommodating."

Is the service responsive?

Our findings

At our last inspection, we found that the service was not always responsive to people's needs. Care plans lacked detail, contained conflicting information and had not been consistently updated when people's needs changed. At this inspection, we found that while some improvement had been made, further improvement was still required.

Despite the registered manager updating the care plans, some plans continued to lack sufficient detail particularly in relation to supporting people with moving and handling, pressure care, anxiety and bowel monitoring. There was conflicting information in records and where new information had been added, the old information had not always been removed. Information was not always recorded in the most appropriate place making it difficult to find. For example, how to support one person when they became anxious was covered in their washing and dressing care plan and another person's mental health and behaviour plan stated that the person was on an airflow mattress.

Where people had bowel monitoring in place, there was no information provided to staff within the care plans of the action to take if a person did not have a bowel movement. For example, one person had a bowel monitoring chart in place and their care plan stated that bowel movements were to be monitored but there was no other information recorded. Another person had two bowel monitoring charts in place for the same month which was confusing. This meant that staff might not realise if the person had not been to the toilet for a prolonged period of time and they may not respond as needed to seek additional medical advice.

There was a lack of clear guidance for staff to enable them to support people with their emotional needs to ensure their wellbeing. Where people could become anxious and upset, there was limited information regarding what this meant for the person and how they could best be supported. Care plans for social and emotional care did not cover how to engage and provide stimulation for the person to ensure their wellbeing. For example, one person's social and emotional care plan said that staff check on them half hourly. There was no detail about what the person enjoys or subjects to talk about.

There was a lack of activities, stimulation and engagement observed or recorded to reduce the risks of boredom and isolation for people. We checked activity records for people which had limited entries recorded. One person had three entries recorded for September 2017 which included 'Creamed hands, listening to music and family visited.' Another person had two entries for 2017 which were 'Chat with staff and chiropodist care.' The activities care plan for one person stated 'Staff to sit and talk to me every day.' However, we could not see evidence that this had happened. One staff member said, "There hasn't been enough activities or stimulation as there has not been enough staff. We are very rushed." Another staff member commented, "There is TV and music. There is not enough to do." One person said, "I read now and again and we might do something like look at a film. I just sit which is not good." A relative said, "They don't have a lot of entertainment here and people are lacking in something to do. They still need stimulation as it's not nice to just sit and do nothing which happens a lot."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care

Since the last inspection, the registered manager had been updating and re-writing all of the care plans and these were reviewed monthly. They were planning to provide some training to the staff team on how to review the care plans going forward and ensure that people and their families were involved. People were involved in developing their care plans and staff listened to people when they wanted changes made or were not happy.

The service had a complaints policy and this was distributed in the service user guide. Since the last inspection, a log of complaints was in place. The manager had received three complaints which were investigated and the action that had been taken was recorded.

Is the service well-led?

Our findings

At our two previous inspections, we found that the service required improvement. These improvements had not been made which places people at continued risk of receiving care that is not of a good quality.

At our last inspection of 03 and 12 May 2017, we found that the service did not have an effective quality assurance process, there was a lack of oversight and feedback was not used to ensure continuous improvement. Despite an action plan from the registered manager stating that improvements would be made, we did not see that this had happened in practice.

At this inspection, we found continued shortfalls in the way the service was managed and regulations continued to not be met despite our previous concerns. The registered manager continued to fail to make the required improvements to ensure that there were effective systems in place to provide oversight and governance and to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively. Lack of effective oversight meant people were at continued risk of receiving care which was not of a good standard.

The registered manager had begun to complete audits within the service, for example, medicines and the external environment. However, as audits were not in place for all aspects of service delivery, the issues we found during our inspection had not been identified independently by the registered manager. This included shortfalls relating to staffing levels, risk assessment, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. There was a failure to recognise the breaches of regulation within this report and to identify failings impacting on the quality of service provision.

The absence of effective monitoring or auditing meant that issues relating to people's care and treatment were missed and risks of potential harm were not being mitigated as far as possible as identified in this report. A broken bath panel in the upstairs bathroom had not been mended and the downstairs bathroom still required decoration and had missing tiles. These concerns had not been identified by the registered manager. The inspector discussed the concerns with the registered manager to determine when these concerns would be addressed. The manager told the inspector that they would be addressed but there was no formal plan of when action would be taken.

The registered manager did not demonstrate competence in their understanding of aspects of service management. For example, effective risk assessment, legislative requirements regarding legionella and the legal requirements regarding window restrictors.

The registered manager was not up to date with their responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, on the first day of inspection, we saw that the ratings of the previous inspection were not displayed in the service. The registered manager was not aware that this should be in place. Notifications had not always been received for significant incidents such as when external agencies raised safeguarding concerns. Notifications are required by law to ensure that the

commission can monitor the service and ensure that people are receiving safe care.

The management team lacked effective systems for keeping up to date with best practice in the care industry independently. For example, in relation to the current guidance for pressure care, effective care planning and risk assessment, MCA 2005 and guidance in providing appropriate support specific to the needs of people living with dementia.

At our last inspection, we saw that the policies not been updated since 2011 and at this inspection, we saw that this continued to be the case. This meant that where changes in best practice and guidance had occurred, the policies would not reflect these changes. For example, there was no policy in relation to Regulation 20: Duty of Candour. The registered manager continued to be unaware of their responsibilities under this regulation.

We saw feedback had been received from questionnaires that had been sent out to relatives in July 2017. One response said that they had not seen an activity programme and two responses stated that they were not happy with the activity programme. The lack of activities had also been discussed at a relatives and residents meeting. As a result, a trip to the theatre had been booked but we could not see evidence of any other action taken in response to this feedback. Three responses had stated that there was 'sometimes' sufficient numbers of staff on duty. Again, we could not see any evidence of the action taken in response to these comments. The registered manager said that they had discussed the staffing levels informally with relatives; however, we could not see how this feedback had been used to continuously improve the service and ensure that adequate staffing levels were in place.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations: Good Governance

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 There was a lack of activities, stimulation and engagement observed or recorded to reduce the risks of boredom and isolation for people. 9(3) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments had not been completed correctly and there was a lack of understanding regarding the Mental Capacity Act (MCA) 11(1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Monitoring and audit systems were not effective in highlighting issues within the service. The service did not use the feedback it received to ensure that it continually improved. The registered manager was not up to date with current best practice to ensure that they were competent to manage and run the service. 17(2) (a) (b) (e)

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 9 HSCA RA Regulations 2014 Person-centred care Care plans contained conflicting information and did not provide sufficient guidance to staff. 9(3) (b)

The enforcement action we took:

Issued a Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Environmental and individual risks had not been assessed or action taken to mitigate the risks. Some individual risks had not been identified, assessed or addressed effectively. Some areas of the environment were not clean or well maintained and posed a risk to people. Moving and handling practices were not safe. Training for staff had not been managed effectively to ensure that those providing training and receiving training were skilled and competent. Dietary needs were not assessed or addressed effectively to ensure the way they were supported to not put them at risk. 12(2) (a) (b) (c) (d)

The enforcement action we took:

Issued a Notice of Proposal

Regulated activity	Regulation
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Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing levels did not meet people's needs and staff were not effectively deployed.

18(1)

The enforcement action we took:

Issued a Notice of Proposal