Gastank Limited

Ailwyn Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5, 7 and 13 February 2018. The first and third days were unannounced.

During our last inspection in May 2017, we found five breaches of Regulations. These had been in respect of Regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because risks to people's safety had not always been managed well or safeguarding incidents reported or investigated appropriately. There was also a lack of staff to meet people's needs and the provider's governance systems had not been effective at assessing and monitoring the quality of care people received. Furthermore, the provider had failed to ensure that the Care Quality Commission (CQC) had been notified of certain incidents as is required by law.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Responsive and Well Led to at least Good which was received from them. However, the actions the provider said they would make had not all been implemented.

At this inspection, we found that the provider remained in breach of Regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Furthermore, two new breaches of Regulations 11 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent and the premises and equipment people used were also found.

We have also made a recommendation regarding the manager and provider familiarising themselves with the Accessible Information Standard. This standard was put in place in 2012 to ensure that people had access to appropriate information to meet their individual communication needs.

Following the first two visits to the home on 5 and 7 February 2018, we wrote to the provider and told them they needed to take urgent action to protect people from the risk of harm. They responded to us and said what they had done to comply with this direction. However, when we revisited them on 13 February 2018 we found that sufficient action had not been taken in all areas to protect people. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and therefore we are placing the service in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
This is the second time that this service has been placed into 'special measures'. The previous occasion was as a result of an inspection in November 2016. Consequently, we have serious concerns about the provider's ability to achieve or sustain compliance with the Regulations.

Ailwyn Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 39 people within two units, one called Honingham and the other Mattishall. Most people living in the home are living with dementia from early to advanced stage. At the time of the inspection, there were 34 people living in the home.

There was a manager was working at the home. At the time of the inspection, they were the registered manager at another of the provider's homes and had applied to CQC to register as the manager of Ailwyn Hall which is currently being assessed. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had again failed to ensure that robust systems were in place to monitor the quality of care people received. This included the monitoring of staff practice and the safety of some areas of the premises. The manager and provider lacked knowledge in some crucial areas such as safeguarding and health and safety. This had resulted in some people experiencing harm or being exposed to the risk of avoidable harm. Furthermore, people and/or their relatives had not always been consulted about the quality of care they were receiving to help the provider improve the quality of care received. This included not consulting them on a significant change within the home regarding the preparation of their meals.

Risks to people's safety had not always been assessed or managed well. Incidents that had occurred such as falls or medicine errors had not always been recorded and where they had, had not been investigated in a timely way so they could be prevented or any risks associated with them reduced. This also meant that learning from these incidents could not occur.

Systems in place to reduce the risk of people experiencing abuse were not robust. Appropriate action had not always been taken when actual abuse had taken place or when allegations had been made. This included not reporting these incidents to relevant authorities such as CQC or the Local Authority for their investigation.

The number of staff the provider had deemed as being required to provide people with safe and effective care had regularly not been met meaning there was a risk that people's needs and preferences would not be adhered to. Furthermore, the staff working on each shift did not always have the relevant training or skills to ensure people's safety.

Some areas of the home and equipment people used was unclean. Staff were observed on occasions to use poor practice in certain areas which increased the risk of people being exposed to poor care. Some equipment was not always available in a timely way which resulted in staff not being able to be responsive to people's needs.

Consent had not always been sought from people in line with the relevant legislation. The practice in relation to people being offered choice and being involved in decisions about their care was variable.

Some areas of the premises were well decorated and pleasant but others, such as some people's rooms, required re-decoration. Safe, independent access was available to some people within the home. However, for others this was more difficult with the only means of leaving one unit independently involving having to negotiate a small step which was a trip hazard and made it more difficult for wheelchair users.

Although we found that some staff were kind and caring and treated people with dignity and respect, this was variable with some people's dignity and privacy not being respected.

People's care needs and preferences had been assessed. However, not all care was being delivered to meet these preferences. The care records required more information within them to provide staff with appropriate guidance on how to meet these needs. The manager was aware of this and was actively working to improve this area.

People had access to some activities that complimented their hobbies and interests and enhanced their wellbeing, but again this was variable. The manager was aware of this and was actively working to recruit a new member of staff to the team who could lead and drive improvement within this area.

People received enough to eat and drink to meet their needs and support to maintain their health. Their wishes at the end of their life had been sought and care was provided in line with these at this time. Any complaints or concerns raised were listened to and fully investigated.

Links with the local community had been established for the benefit of people living in the home and visitors such as relatives were encouraged to enhance their own wellbeing. The staff told us they were happy working in the home and felt supported in their work.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Individual risks to people's safety had not always been assessed or managed well. Also, not all risks in relation to the safety of the premises had been assessed. This placed people at the risk of harm.

The systems in place to protect people from the risk of abuse were not robust, placing people at risk of harm.

The provider had failed to ensure that the staffing numbers they had established were required to meet people's needs and to keep them safe were consistently met.

People's medicines were not managed safely.

Some of areas of the home were unclean as was some equipment people used. Staff did not always follow good infection control practice. These both placed people at risk from the spread of infection.

Incidents and accidents had not always been recorded or investigated in a timely way placing people at risk of harm and not enabling the provider to learn from previous events.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent had not always been sought from people in line with the relevant legislation.

Not all staff training was up to date and assessments of their competency to provide people with effective care had only recently been implemented.

People's needs had been assessed along with some of their choices about how they wanted to receive their care. However, not all care had been delivered in line with all relevant legislation.

People received enough to eat and drink to meet their needs and were supported with their healthcare needs.

Decoration in some areas of the premises required improving and some equipment was required to be changed or added to increase people's independence. Adequate storage areas for equipment were also required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff's approach to treating people with kindness, dignity and respect and encouraging their independence was variable.

Relatives were supported to express their views and be actively involved in decisions about the care of their family member where appropriate. The support given to people to make day to day decisions about their care was mixed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The meeting of people's individual needs and preferences was variable.

Care plans required further improvements as some lacked sufficient guidance for staff in how people wanted their care to be provided to them.

People did not consistently have the opportunity to participate in activities to support their hobbies or interests or to enhance their wellbeing. The manager was aware of this and a new staff member responsible for this area was being actively sought.

People's end of life wishes had been sought and were implemented and respected.

Is the service well-led?

Inadequate

The service was not well-led.

The systems in place to monitor the quality of care people received were inadequate and had either failed to identify areas for improvement or drive sufficient improvement.

The leadership within the service was not effective with some key leaders not having the relevant knowledge to ensure that people

received consistently good care.

People had not always formally been asked for their opinion on the quality of care they received although relatives, staff and outside agencies had and they had not been consulted about a significant change to how their meals were prepared that affected them.

Ailwyn Hall

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 inspection took place on 5, 7 and 13 February 2018. The first and third days were unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines management, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience's specific area of expertise was in older people's care.

Before the inspection, we requested the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the service does well and improvements they plan to make. However, this was not received from them. We therefore reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and sought the views regarding the home from the local authority quality assurance team and clinical commissioning group.

During the inspection visits, we spoke with seven people who lived in Ailwyn Hall and two visiting relatives. A number of people living in the home were not able to express their views to us. Therefore throughout our inspection visits, we also observed the care that people received and how this was delivered by staff. We spoke with four care staff, the deputy manager, the manager, the operations director who represented the provider and the provider.

We looked at five people's medicine records, ten people's care records, three staff recruitment files, staff training records and records in relation to the maintenance of the premises. We also looked at audits and other information relating to how the provider and manager monitored the quality of care people received.

Inadequate

Is the service safe?

Our findings

At our last inspection we rated Safe as Requires Improvement. At this inspection we have rated Safe as Inadequate.

At our last inspection in May 2017, we found that some risks to people's safety had not been identified or managed appropriately which placed them at risk of harm. This had resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the required improvements had not been made and therefore, the provider remained in breach of this regulation.

One person had been assessed by a speech and language therapist (SALT) as being at risk of choking if they consumed food or fluids of a normal consistency. To reduce this risk, they had prescribed that the person required two scoops of thickener in their drink and a fork mashable diet. On the first day of our inspection visit, we saw a staff member give the person a drink that had not been thickened. When we spoke to the staff member about this, they told us the person did not always require thickener in their drink. Another staff member told us the person did require thickener but only one or one and a half scoops in their drink. We also observed the person being given a diet of normal food consistency that was not in line with the SALT's prescription. This inconsistent and incorrect approach placed this person at serious risk of harm.

We alerted the manager to these incidents who immediately took action to correct this. On the second day of the inspection visit we saw this person received the correct consistency of drink and food. A risk assessment had also then been completed in relation to choking. This stated the person should avoid being given a drink from a spouted beaker as advised by SALT. However, we observed staff doing this which continued to place this person at unnecessary risk. We referred this concern to the local authority safeguarding team.

The manager told us that another person living in the home had been found in the past with a rubber glove in their mouth. Following this incident the manager said they had assessed that it was unsafe for the person to have access to gloves in case they choked on them. However, we found a box of gloves in the chest of drawers within the person's room that they were able to access. We brought this to the manager's attention who told us these would be removed from the person's room. However, on the third day of our inspection visit we found a single glove in the person's chest of draws. Gloves were also being kept in other people's rooms that this person could access independently. This demonstrated a failure to manage this risk adequately and placed this person at serious risk of harm.

Records showed that one person had experienced a total of 13 incidents where they had fallen or been found on the floor since November 2017. Eight of these had occurred in January 2018. None of these had been investigated by the manager or the provider at the time they had happened to ensure that actions were in place to reduce the risk of harm to the person as much as was practicable. Advice had been sought from a GP regarding these incidents only after the person had experienced 12 incidents, some of which had resulted in injury to the person. Furthermore, records showed that staff found this person with a large bruise

on the side of their head indicating a possible head injury but no medical attention was sought for this.

A staff member told us and the manager confirmed that one measure in place to try to reduce the risk of this person experiencing harm from having a fall, was for a sensor mat to be placed by their chair when they were sat in their room. When we visited the person with the manager, we found this sensor mat was not in place. Therefore, if the person tried to get up and walk the staff would not be alerted to their risk of falling. Failure to thoroughly investigate the incidents this person had experienced and not placing the sensor mat as required exposed the person to continued risk of harm. We referred this concern to the local authority safeguarding team.

As well as the incidents discussed above, the manager told us and we saw that other incidents such as falls that had occurred in January 2018, had not been investigated. This included medication incidents which the manager told us were not being recorded as incidents. We saw this had been the case since July 2017. The manager confirmed that this was of concern. This meant that people may have been placed at risk of harm as preventative measures had not been reviewed or considered. This also demonstrated a lack of learning at the service.

There was insufficient information within these people's care records regarding their risk of choking or falling. This meant that staff did not have clear guidance on what actions they needed to take to reduce the risk of these people receiving inappropriate or unsafe care. This risk was elevated due to the fact the provider used agency staff on occasions who may not have been familiar with people's needs.

One the first day of our inspection visit, we observed one person walking around a communal lounge in bare feet. Records showed that this person needed to wear appropriate footwear to reduce the risk of them falling. The staff we spoke with told us the person regularly kicked off their footwear however, we did not hear staff encourage the person to wear any footwear at all during our period of observation placing them at risk of falling. In the afternoon, the person was seen to be wearing anti-slip socks.

On the second day of our inspection visit, we saw that some drink had been spilt on the floor in a communal area near to where some people were sitting and walking. Staff were present in this area but made no attempt to clear the spillage. This increased the risk of people slipping and falling.

During our walk around the premises on the first day of our inspection visit, we found that a door to a person's room did not shut properly. This was important as their door was a fire door that must close in the event of a fire. We brought this to the attention of a senior carer who asked the maintenance person to fix it. They said they had done this but on the second day of our inspection visit it still did not close. This had placed the person at risk should a fire of occurred. On our third visit this had been fixed.

A communal toilet that staff told us people used independently did not have an emergency pull cord within reach. Therefore, should they fall or if staff wanted to alert other staff whilst attending to any incident that may have occurred within that area, they were not able to easily do so.

We found toiletries and items such as razors in some people's rooms which may have been a risk to people's safety. A cleaning spray was found unsecure within a communal bathroom that people could access independently. This stated that it could cause skin burns and eye damage if used inappropriately. The manager told us that razors should not have been in people's rooms and that cleaning products should be locked away. On the second day of our visit we found this to be the case. We also found some exposed pipework within the home that was very hot to the touch. There were people residing in this area who were mobile and at risk of falls. The provider told us they had not assessed the risk of hot pipes within the home

which placed people at risk of burns should they fall against them.

Staff were observed on occasions to use poor infection control practices that placed people at risk of the spread of infection. One staff member carried a bag of faeces into a bathroom without wearing gloves or an apron. Another staff member handed people biscuits directly without wearing gloves and assisted someone with personal care without wearing an apron. A further staff member handled chips when they were serving up a plate of food for someone. A staff member showed us a temperature probe that was used to test the temperature of the food before it was served to people. The box the probe was attached to was very dirty with ingrained dirt. We passed this to the manager who arranged for it to be cleaned.

The cabinet used to store controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) was not appropriately fitted to the wall in line with relevant legislation.

The above evidence demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the management of people's medicines required improvement. At this inspection we found that some improvements had been made but further improvements in some areas are required.

The records we looked at showed that people had received their medicines correctly as intended by the person who had prescribed them. Staff had received appropriate training and their competency to give medicines to people safely had been assessed. However, we identified that some records made when people had not taken their oral medicines were not sufficiently clear as to why this had occurred. For example, we could not see whether the person had refused their medicine and if so, whether medical advice had been sought regarding this.

We found that clear written directions or body maps were not always available to guide staff on where and how they should apply prescribed external creams and ointments to people. The records were not sufficient to enable us to ascertain whether creams were being applied as intended by the person who had prescribed them. For people, who were unable to tell staff about pain levels there was no recorded means of assessing their pain to establish if it was appropriate to give them their pain-relief medicines.

When people were prescribed medicines on a 'when required' basis, there was written information available to show staff how and when to give them to people for some medicines. However, for others where this was of particular importance, such as for sedative or mood-altering medicines, the information was insufficient to ensure staff gave them consistently and appropriately. Where these types of medicines had been given on a regular basis, there was no information to show that the use of the medicine had been justified or whether any other avenues such as distraction had been utilised first.

At our last inspection in May 2017, we found that the systems in place to protect people from the risk of abuse were not effective and that some incidents had not been reported to the local authority as is required. This had resulted in a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the required improvements had not been made and that therefore, the provider remained in breach of this regulation.

The people we spoke with told us they felt safe living in the home. However, we found that the systems in place to protect people from the risk of abuse were not sufficient exposing people to the risk of harm. The

staff we spoke with demonstrated they understood what constituted abuse. They were clear about when and to whom they needed to report any concerns to within the service and we found that staff were reporting these to senior staff when required. For example, staff were completing body maps when they found people with bruising. However, these had not always been passed onto the manager for investigation so it could be ascertained how and why these had occurred.

We also found that where allegations had been raised with the manager or provider about possible abusive practice by staff, sufficient action had not always been taken to protect people from the risk of abuse. This included not notifying the local authority. This meant the local authority had been unable to take action and provide support. We referred these concerns to the local authority safeguarding team.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2017, we found that staff had not been deployed effectively within the home to keep people safe. This had resulted in a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Prior to this February 2018 inspection, we had received a concern that there were not enough staff available to meet people's needs. We found this to be the case and therefore, the provider remained in breach of this Regulation.

We received mixed views from people regarding staffing levels. One person told us, "I ring my buzzer and even when they say they'll be back, they are before long." Another person said, "I have to say there are times when I need to talk to a carer in my room and no one is about." A further person told us, "The carers sometimes take more time than I would like to come and help me. It could certainly be 15 minutes."

All of the staff we spoke with told us they felt there were enough staff to keep people safe and to meet their needs. They did say that on occasions, they did not have time to engage people in activities or spend as much time with them as they wished to. They also said that sometimes people did have to wait for assistance but did not feel this was detrimental to them.

The manager told us that at the beginning of January 2018, they had calculated that the staffing levels within the home needed to be increased from five to six during the day to meet people's needs and to keep them safe. We therefore reviewed the staff rotas for the 21 days prior to our inspection visit to ensure the provider's requirements were being met. We found that on only two of the 21 days checked that these requirements had been fulfilled. On three occasions there had been only two staff available at night to support people when there should have been three. A number of people living in the home required two staff to support them with their care. Therefore, the provider had not ensured that the number of staff they had deemed were required was consistently being met.

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

The provider told us they were looking to conduct a further review of staffing levels within the home particularly in the late afternoon/early evening to ensure there were enough staff working to meet people's needs and to keep them safe.

Some areas of the home were unclean and not well maintained. Some equipment people used was also unclean. The crash mat and bed frame in one person's room was unclean. A mirror in another person's room was smeared and unclean and their headboard was stained. There was a large cobweb on the wall

beside the door and stains on the walls. There was a malodour in some communal areas and in some people's rooms. A valance on another person's bed had blood stains on it and had not been changed. Light switches in some communal areas were ingrained with dirt. A shower chair was unclean and remained the same during the three visits we made to the home. On the third day of our visit, a communal toilet seat had faeces on it for over an hour and a half before it was cleaned. A number of hoists were out of use and therefore, one had to be shared between both units which we saw caused a delay in one person receiving personal care in a timely way.

These concerns constitute a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Various checks had been made in relation to staff character and previous conduct in employment when they were recruited to work in the home. This included a Disclosure and Barring Service (DBS) check to ensure the staff member was safe to work in care and the gathering of references from past employees. Gaps in previous employment had also been explored to ascertain why staff may not have worked. However, we saw that two staff had commenced employment with the provider before their references had been received and one before their DBS had been received. The manager assured us that in these circumstances, these staff had only shadowed experienced staff and had not provided people with care. It is good practice however, to only employ staff once the necessary checks have been received to confirm they are of good character and safe to work within the care sector.

Tests in relation to the fire system had been conducted to ensure it worked correctly. The fire exits were kept clear so that in the event of an evacuation, people could leave safely. However, we saw that one designated fire exit led into an extension currently being built onto the home. The provider told us that the fire service had recently inspected the home and were happy that the fire exit was not in use. However, as the signage still pointed to this exit as a potential escape route this could be confusing for people.

The lifting equipment people used such as hoists had been serviced in line with relevant legislation to ensure it was safe. The risks associated with Legionella disease had been assessed and regular checks had been conducted to help mitigate this risk. Electrical and gas appliances had all been tested and serviced to ensure they were safe. People who could use their call bell had these within their reach.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated Effective as Requires Improvement. At this inspection we have continued to rate Effective as Requires Improvement.

There were a number of people living in the home who were not able to consent to some decisions about their care. Therefore the provider was required to act in accordance with the Mental Capacity Act 2005 (MCA). 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.

At our last inspection in May 2017, we found that the MCA had not always been followed when making decisions for people in their best interests and had judged that improvements were required within this area. At this inspection we found this had not improved. Although the manager and staff had considered and assessed some people's capacity to consent to various decisions about their care, we found this had not been consistently applied.

People's capacity to agree to move to different parts of the home and some other aspects of their care such as the administration of their medicines had been assessed. However when planning for the inspection, we found that the provider had a social media site that contained photographs of people living in the home being involved in various activities within the home. The social media site was open to the general public. The manager told us that consent had not been sought from these people to display their image on this site. This included people who may not have been able to consent to this. Some of these people may not have wished for their image and therefore their private life, to have been open to the public. This may have been a breach of their human rights.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with had a good understanding of the MCA and were clear about how they would support a person to make a decision. For example showing them different clothes they could wear to help them make a choice. They also understood that if they made any decisions for the person that this had to be in their best interests. However we saw that in practice, the application of this was mixed with staff not always supporting people to make a choice about what to eat or drink.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 was being met.

The manager told us they had assessed that some people were deprived of their liberty in their best interests and that therefore, they had applied for authorisation to so this from the local authority. They told us that as yet, none of these had been assessed by the local authority. During the inspection we saw that most people were able to move freely within the home and that least restrictive practices were in place. However, there were occasions where some staff were seen trying to persuade people to remain within communal areas so they could monitor them rather than allowing them to walk freely into other areas. This was therefore restricting their movements.

At our last inspection in May 2017, we found that new staff had not always completed training in key areas such as practical moving and handling, fire safety and first aid before they were included on the staff rota. We advised the provider that improvements were required within this area. At this inspection we found this remained the same and that staff had not all received sufficient training or supervision to provide people with effective care.

The staff we spoke with told us they felt the training they had received enabled them to provide people with effective care. They also said they were encouraged to participate in qualifications within health and social care. However, we found that some staff who had been working for the provider for more than three months had not completed all of their training or their training was not up to date. A total of 22 of the 29 staff had worked in the home for more than three months.

Four staff were required to complete health and safety training, seven some form of first aid (ie emergency or normal first aid) and three infection control. This included a staff member who we observed was working as a domestic on the third day of our inspection visit. Seven staff had not completed any fire training and six no first aid training, six still required to complete their food safety training. Although we saw that new staff had completed training in how to support people to move safely, six had not completed training in safeguarding, seven in first aid and six in fire safety even though they had been working for the provider since December 2017.

A number of incidents had been recorded where staff had been physically hurt when trying to support some people. One of these incidents had resulted in a person being injured when staff had had to forcibly remove the person's hand from pulling the staff member's hair. However, the staff told us and records showed that the provider had not sought any training for them in this area to help them support people effectively when they became agitated or distressed.

When we looked at the staff rotas from 15 January to 5 February 2018, we saw that on four occasions during the night shift that none of the staff on duty had completed any training in fire safety. On three occasions none of the staff on duty had completed training in first aid. This compromised people's safety and the ability of staff to provide them with effective care should a fire or the need for first aid have occurred.

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

During the inspection we saw some staff used poor care practice. We therefore asked the manager how staff competence was assessed. They told us that staff were observed informally in relation to their practice but that a system of formal observations had only recently been put into practice. They confirmed that so far, two staff had been subject to these observations. We saw that new staff when they had completed all of their induction training had been assessed by a senior member of staff to ascertain if they were ready to provide people with effective care.

At our last inspection in May 2017, we found that improvements were required to ensure that people received enough to eat and drink to meet their needs. At this inspection we found that necessary improvements had been made.

Where people were at risk of not eating or drinking enough to meet their needs this was being monitored. In most cases, a target for people to drink was in place and staff were totalling up the amount of fluid people drank each day so they could see if they needed to take any action to improve this. The fluid charts we looked at showed that people had a good fluid intake. People's risk of not eating enough was also being monitored effectively and for the people we looked at, we saw they were either gaining weight or their weight was steady. Relevant healthcare professionals had been involved such as a dietician where this was felt appropriate.

Prior to the inspection, we received a concern that the quality of the food provided had declined due to the provider taking a decision to transport the lunchtime meal from another of their homes rather than cooking it at Ailwyn Hall. The manager told us that breakfasts were prepared at the home but that lunches and teas were prepared at the provider's sister home. We therefore asked people for their thoughts regarding the quality and choice of food that was on offer.

All but one person told us that the quality of food they received was satisfactory. One person said, "The food is not too bad. I'm happy with things. They ask me half an hour before I eat and I can choose, but they would find something else if I didn't like it, but I always do." Another person told us, "The food is okay. I've had worse. I'll eat what they give me. I haven't had a bad meal." Other comments received included, "I have no problem with the food being delivered. It tastes good and I make a choice and am happy with that", "The food was A1 when we had a chef, but it now travels all the way from Attleborough. I don't like it anywhere near as much. It's not tasty and can be a bit mushy" and "The food is fine. I eat in the dining room." A relative said, "The lasagne was nice and the choice seems good."

Snacks were readily available and we saw people being offered these throughout the day. In one area of the home afternoon tea was served. We checked food stocks and saw that there was food available in the home so that people could have different options including a hot meal at any time if they wished for this.

On the first day of the inspection visit, we observed lunchtime in both units of the home. The manager told us that lunch was usually served between 12pm to 12.30pm. People started to arrive in the dining rooms from 12.10pm. Other people started to enquire at this time when the lunch would arrive. However, the lunch was delayed which meant that some people had to wait for 50 minutes for their lunch. The manager told us that the arrangement in relation to the main meal of the day coming from another home was a trial and that they were monitoring this carefully.

When the meal arrived it looked to be of good quality and people enjoyed the food. If people did not eat the main meal an alternative was offered. People had access to plenty of drink also during the day. People who required support to eat their meals received this. Where people had any cultural or diverse requirements in relation to their food this was respected.

People's care needs had been assessed and included a number of different areas that included their physical, mental and social needs. People's diverse needs had also been assessed as had some people's preferences and choices. However, care had not always been delivered in line with all relevant legislation. This included the Mental Capacity Act 2005, legislation in respect of the storage of controlled drugs and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Technology such as pressure mats were in place to help monitor that people were safe. The manager told us they were aware of best practice guidance such as that outlined by NICE (The National Institute for Health and Care Excellence) and that they regularly reviewed information from the CQC and certain care magazines. From this best practice, they had not yet implemented any changes. However, they said they did have plans to improve the garden area to encourage people to go outside more and socialise to avoid being at risk of social isolation and to improve the environment for the benefit of the people living there. The manager had also recently joined a peer support group run by the local authority for managers of care homes to facilitate the sharing of best practice.

Improvements are required to some areas of the premises to make them more accessible and pleasant. One communal area within the home had a sofa and a chair in it which was very low. These were used by some people living in the home and we observed some of them struggling to get up after they had sat in them. Raised toilet seats were in place within people's en-suites where required and some communal bathrooms however, in one communal toilet there were no grab rails to help people use the toilet independently. A broken chest of drawers was found in one person's room and in another bedroom part of the curtains were hanging off the railing.

Some people's rooms required re-decorating as there were stains on the walls. In the kitchen, plaster was coming off the walls in some places and one of the window sills had rotted. There was a lack of space to store equipment such as stand aids and hoists on one unit which meant this equipment was either left in people's rooms or the corridor presenting a trip hazard.

Upstairs in one part of the home, we found a number of hoists that had broken down were being stored within the communal bathroom and toilets. These areas had not been cordoned off and were still accessible to people. The manager told us that people living in that area had en-suite facilities so may not need to use these communal areas. However, there were some people residing on this floor who were living with dementia and who were independently mobile. This may therefore, have been a hazard to them if they tried to use the toilet due to the amount of equipment in them.

Hand rails were in place in communal areas for people to use to help them maintain their balance whilst walking. Most communal areas were nicely decorated and welcoming. For those people who had sensory impairments or could not remember their way around the home, there was signage on communal toilets and bathrooms in both words and pictures for their benefit. Most people's rooms had numbers on them and some but not all, had pictures on the doors to help people orientate themselves to their room. The manager told us that plans were in place to improve the environment for those that required assistance to orientate themselves around the home and also for there to be more communal areas for people to spend time in.

There was space for staff to manoeuvre equipment such as hoists and wheelchairs. The outside of the home was easily accessible to people from the Honingham unit. From the Mattishall unit there was a slightly raised threshold which could pose a trip hazard and make it difficult for wheelchair users. There was metal fencing in place to secure the garden area. The manager told us that this was temporary with a new fence shortly to be erected.

People told us they saw various healthcare professionals when they needed to. One person told us how they had experienced a fall and that the staff quickly got them a doctor. The management and staff within the home worked with other healthcare professionals to ensure that people received support with their healthcare needs. For the people whose care we looked at, we saw they had seen professionals such as the GP, chiropodist, optician or dentist when needed. However, professional guidance had not always been followed such as not following SALT guidance for one person who required a specialised diet and thickened

drinks to promote their welfare.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated Caring as Good. At this inspection we have rated Caring as Requires Improvement.

All of the people we spoke with told us they felt the staff were king and caring. One person told us, "They've been good to me, very good. They address me by name. Anything I want they will get me and if it's not there, they'll get it." Another person told us, "They are kind to me and everyone talks to me and that makes me feel wanted." Other comments received included, "The carers all treat me nicely. They are very respectful and treat me as if I really matter to them"; "All of the carers are lovely. We chat together now and again and it lifts my spirits" and "The carers are a friendly lot, thoughtful and decent." A relative told us, "The staff are very friendly and smiley. I can't find fault with them. They've got to know my family well. I get a welcome when I enter the building."

Information had been gathered on people's life history and the staff we spoke with were able to tell us about people's past and how they used this information to strike up conversations with people. These staff had a clear understanding about how to treat people with respect and how to uphold people's dignity and privacy. However, we observed variable practice from staff during our inspection visits in relation to consistently treating people with kindness, dignity and respect. Therefore improvements are required in this area.

For example, during our lunchtime observations we saw that staff were attentive and supportive to people. Gentle encouragement was given to support people to eat and drink. Staff were also observed in some communal areas holding people's hands. One person became anxious and in response, a staff member knelt beside them, held their hand and spoke in to them in a gentle tone and reassured them that all was well. A member of the domestic staff was observed to greet one person in a very jovial manner, asking them how they were and making the person smile and engaging with them in conversation.

However, on another occasion we saw a person crying out in pain. A staff member walked past them and did not acknowledge their distress. This person was sitting in a very unclean dressing gown that was stained with food. We had seen the person wearing the same dressing gown on our previous visits. We brought this to the attention of the manager and later, we saw the person wearing a clean dressing gown.

One staff member was heard to ask someone if they wanted 'a wee.' This was asked loudly in front of other staff and people in a communal area and therefore did not support this person's dignity. The same person was asked by a different member of staff later in the day 'Do you want a wee wee.' This was done in a tone that resembled talking to a child rather than to an adult. Another person was supported to come into the communal lounge after having been helped in their room to get dressed. Their trousers were not on straight as staff had not taken the time to dress the person properly.

At one point during the inspection, we had enquired how many people were still asleep in their rooms on one unit. Staff had advised us that two people were having a lie in. However, immediately after we were told

this the maintenance person started to fix a door to an unoccupied room. This included using loud machinery which would have woken anyone who was asleep. No effort had been made to check whether people were happy for this work to occur or whether it could have been completed at a more appropriate time.

We also observed mixed practice in relation to supporting people with independence. Some people were seen to be encouraged by staff to do as much as they could for themselves and the staff we spoke with demonstrated they were aware of the importance of this. Although not seen, staff told us how some people enjoyed being involved in tasks of daily living such as folding laundry or making their beds. However, people living in one area of the home were not able to access a communal toilet independently when they wanted to. This was because it was locked with a padlock. Therefore, we saw that people only used the toilet when accompanied by the staff. This was despite staff telling us that at least one person, who we saw them accompany to the toilet, was able to manage their personal care needs on their own. There was no facility in the toilet to allow this person to have privacy whilst staff were in there with them. Therefore, this compromised both this person's independence and privacy.

We found confidential information about some people on a cabinet within a communal area of the home which was accessible to visitors. This was in the form of a copy of a fax that had been sent to the GP surgery. This listed some people's names and the reasons for referral which were conditions such as 'anxiety', 'chesty' or 'urine cloudy.' Staff were not always present in this area to ensure that unauthorised people could not access this information and therefore, this compromised people's privacy.

People told us they felt involved in their care. They said they felt actively involved in making decisions about their own care and that these were respected. The relatives we spoke with agreed with this and said they were also involved. We again found the staff's approach to involving people in making decisions about their care was mixed. Some staff were observed to always offer people choice and to support them to make decisions. This included such as where to sit or reside within the home, asking them if they wanted to be in their room or sit in a communal lounge or providing them with a choice of drinks or food.

However, other staff did not always give people choices or options in these areas. For example, we observed one staff member hand people biscuits without first showing them the choice so they could help themselves. On another occasion, people were not offered a choice of drink and were all given the same. At lunchtime people who may not have been able to remember their choice of meal when they had been asked earlier in the day, were not visually shown the meals on offer which is good practice in dementia care to help people make a choice. Some of the staff told us they used to show people pictures of meals to help with this, but that this had stopped although they were not sure why.

We saw that people's communication needs had been assessed. Some people's care records contained good information in respect of this area and we saw that staff adopted this when speaking with people. However, other people's care records required more comprehensive information on how to meet these needs. The manager told us they were currently reviewing and updating people's care records and would include this information.

The manager was not aware of the Information Accessible Standard which is a standard that is in place to ensure that providers take steps to meet people's individual communication needs, specifically if they have a sensory impairment. We therefore recommend the manager and provider familiarise themselves with it to ensure it is consistently being complied with.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated Responsive as Requires Improvement. At this inspection we have continued to rate Responsive as Requires Improvement.

At our last inspection in May 2017, we found that improvements were required to ensure that people received care that was consistently responsive to their needs. At this inspection we found that the necessary improvements had not been made and that further improvements are required.

The people we spoke with told us they received the care they required and that their preferences were respected. One person said, "They understand me. Whatever I need, they've got. They give me a wash, help me with my clothes, get me up and to bed when I want." Another person said, "I have to get up early for my medicine and they are there to do it for me when I need it." The staff we spoke with told us they felt they could meet people's needs and preferences. A relative told us how staff had arranged for net curtains to be put up at one person's window on their request and another said that staff would read letters to their family member which they were not able to do themselves.

During our observations, we saw that the response by staff to people's needs and preferences was mixed. People were seen to be able to get up from bed when they wanted to with some enjoying a lay in as was their preference. Some staff were seen helping people in a timely way with personal care when they required this assistance and helping people to relax in areas they wished to do so. However, at lunchtime the meal was late being delivered from the provider's sister home. Due to this we heard some people saying they were hungry. Staff did not respond to this and did not offer these people any snacks or food in the interim until the meal arrived. One person was told the meal would arrive in 10 minutes, but it did not arrive until 50 minutes later.

On another occasion we saw a person request support from staff with their personal care needs. This person required a hoist to help them move. There was no hoist available on the unit and therefore the staff had to find one on the other unit. This caused a delay in the person receiving assistance for 15 minutes.

At least six people within one unit of the home did not have a television in their room. We asked one person about this. They told us they used to have a television which they enjoyed but that it had been taken away and that they did not know why. The manager was not aware why some people did not have access to a television and could not tell us whether this was their personal choice. They agreed to look into this.

For one person whose care we looked at, it had been recorded in their care record that they liked to have two baths a week. The bath on this unit was very unclean and looked as if it had not been used for some time. Staff confirmed that the bath was not used and that people only received a shower or daily wash. This was not in line with this person's preferences. One staff member told us they knew some people liked baths and could not explain why it was not used and the manager was also not aware of this.

The manager told us that all people's foods were fortified with extra calories where this was able to be done

for example, by adding cream or butter to mashed potato. Whilst this is appropriate for people who require this extra nutrition, for those that don't it may not be necessary and could cause people to put on weight when not needed. This was therefore not a person-centred approach.

Some records we looked at did not demonstrate that people were receiving personal care in line with their needs and preference. For example, the bathing records showed that one person was recorded as last having a bath or shower on 3 January 2018, another person as not having received either from 2 January to 1 February 2018. For another person, the records showed that their personal care requirements had not been checked for up to eight hours during the day on some occasions. One person's records showed they regularly declined personal care each day but there were no other written records to show that staff had gone back and re-offered personal care. We therefore spoke with the staff about this. They told us they did give people adequate personal care but that they did not always update the records regarding this.

People's care needs had been assessed and where they were able, people had contributed to this information as had their relatives. Various care plans had been put in place following this assessment and these had regularly been reviewed. We found the information in these plans was of variable quality. For example, there was clear information in one person's care record about how staff could recognise if the person was having a seizure and what they needed to do about this. For another person, the information about what strategies to use to encourage them to have personal care was good as was information regarding their interests and hobbies. However, for another person their behaviour care plan stated that they may be confused during personal care but no information was given to show how best to respond to this.

Some information staff gave us about how they supported a person when they became distressed was not included in the relevant care plan. Another person's care plan in respect of skin integrity just stated that their skin was in good condition but there was no guidance on how staff needed to maintain this. This meant staff did not always have sufficient written guidance to advise them how to meet people's needs. It also meant that new or agency staff did not have sufficient guidance to meet people's needs in the event that permanent staff were not available to ask. The manager told us they were aware that some people's care records required more information and we saw that they were currently working on improving this area.

We received mixed views from the people we spoke with regarding support with activities they enjoyed to support their wellbeing. Some told us they entertained themselves and were able to participate in things they enjoyed. However all said they felt they needed support to participate in more activities that they enjoyed. One person told us, "We have functions here and I've been out in the bus to various things. I sit and mix with people, that's it. I'm happy and content, but I suppose I'm the kind of person who doesn't get bored." Another person said, "I fill my time. The I'm not fussed about doing anything else"

However another person told us, "I've been on a trip to Norwich. I watch the birds outside and enjoy TV. I do get a bit bored because I sit a lot. The carers are around in the lounge, talking to people and helping out which is nice for us. I'd like the chance to do more things, like some walking. I enjoyed it when we had a dog visit." Another person said, "I read and knit. There needs to be more going on as some tend to sit doing not a lot. Yes, even I get bored as I'd like more to do" A further person told us, "Yes it would be nice if we had some things to do as lots of people just sit all day doing nothing." A relative said, "The residents do go on trips, like to have fish and chips. There's music and dancing. Nan enjoys chatting but there's not much else. She would love bingo and any memory games." Another relative told us, "We are here in the dementia unit and there is very little stimulation going on for them. [Family member] gets some input but the others don't get it."

The manager told us there was no dedicated activities staff member currently working in the home as they

had left in December 2017, but that they were advertising for a replacement. In the interim, they said that staff were responsible for providing people with activities and stimulation. We received mixed views from staff regarding their ability to do this. Some staff told us they had time to do this but others said that this was not always the case and expressed a desire to be able to spend more time with people.

During our observations we did see on occasions staff engaging people in conversation and in activities. During the morning on the first day of our inspection, one person was being supported to do exercises to music and another person was being encouraged to play the piano. At one point, a staff member played the piano for a short time which people enjoyed. Staff were seen to dance with some people and reminisce with them about the past which again, some people enjoyed. However, there were others times during the day where some people lacked any form of meaningful engagement. We saw that as found at the last inspection in May 2017, staff were not always pro-active in engaging with people when they had time to do so which may have enhanced some people's wellbeing.

There were some items of interest that people could pick up and engage with such as books and magazines. One person was seen enjoying caring for a doll but one of the units could benefit from more tactile objects for people to freely access, touch and manipulate to enhance their stimulation.

The manager told us that some people did participate in trips out which included to the local theatre which provided shows that were 'dementia' friendly. Coffee mornings were held that people could participate in along with a regular church service and external entertainers such as singers. Cheese and wine evenings were held and local children had visited the home to perform for people at Christmas. It was clear from our conversations with the manager that they had a drive to involve people in meaningful activities if they wished to participate. This included in areas such as cooking, cleaning and doing the washing.

Staff demonstrated they had an awareness of people who were at risk of social isolation and therefore, ensured they tried to spend some time each day speaking to them. They also told us how they encouraged some people to take part in activities such as looking after the birds in the aviary so they had something meaningful to do. Staff also said they encouraged visitors to the home to enhance people's wellbeing and the relatives we spoke with confirmed this.

People's complaints and concerns were listened and responded to. All of the people and relatives we spoke with said they felt confident to raise concerns if they wanted to. Records showed that any concerns or complaints raised had been investigated and dealt with appropriately.

Records showed that people's end of life wishes had been discussed with them or those close to them and that plans were in place to respect people's wishes. At the appropriate time relevant healthcare professionals were involved to ensure that people had the required equipment or medication in place to reduce pain and make them comfortable. We saw that staff had received some compliments from relatives in relation to the support and comfort they had provided at these difficult times.

Inadequate

Is the service well-led?

Our findings

At our last inspection we rated Well-Led as Requires Improvement. At this inspection we have rated Well-Led as Inadequate.

At our last inspection in May 2017, we found that the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care. They had also failed to maintain an accurate and complete record in respect of each person who used the service. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Furthermore, they had failed to notify CQC of specific incidents that are notifiable by law. This had resulted in a breach of Regulation 18 of the Care Quality Commission 2008 (Registration) Regulations 2009. At this inspection we found that the required improvements had not been made and that therefore, the provider remained in breach of both of these Regulations.

We spoke with the operations director about the oversight of the quality of care provided to people in the home. They told us that various audits were completed by the senior staff and that they also conducted a monthly audit. They also told us that an external consultant periodically visited to complete an audit. However, we found that the current governance systems in place had failed to effectively monitor the quality of care people received and therefore the improvements we found at our last inspection in May 2017 had not been sustained. Where audits had been conducted by the manager or provider, they were not always robust at identifying issues or driving improvement.

There was no effective system in place to ensure that incidents such as falls, bruising and medication errors had been reported and investigated in a timely manner to ensure that risks to people's safety were being mitigated as much as practicable. In respect of medicines, the provider's safeguarding policy stated, 'Ailwyn Hall (Ashley Care Group) should follow local safeguarding reporting procedures for medication errors and ensure that notifications are made to the CQC in line with statutory requirements. Ailwyn Hall (Ashley Care Group) should have an open and transparent approach to medication incidents and ensure that staff follow Ailwyn Hall (Ashley Care Group)'s Medication Errors and Near Misses policy and understand their Duty of Candour responsibilities.' However, as medicine errors were not being documented the provider had not ensured that their internal procedures were being followed. This also meant the provider could not effectively learn from incidents that had occurred. These areas had not been looked at by the provider in their last audit that had been conducted in January 2018.

Although premises had been looked at during the provider's last audit in January 2018, it had not identified that one communal toilet did not have an emergency pull cord within people's reach or that some equipment was not in place to enhance people's independence.

The issue in relation to there not being enough information within people's records regarding the application of prescribed creams had been identified as a concern by an external consultant in October 2017. However, we found this still to be an issue showing that sufficient action had not been taken to

improve the matter. Again, although medicines were looked at during the provider's audit in January 2018, they had not looked at the application of creams as part of this audit.

The manager told us the completion of staff training was monitored but we found that a number of staff had not completed their mandatory training even though they had worked for the provider for over three months. Furthermore, we found that some staff had been placed on the staff rota at night without having the necessary skills or knowledge which posed a risk to people's safety. This had not been identified as an issue by any audits that had been conducted in this area.

The manager told us they were aware that information within people's care records required updating to ensure they were accurate. An audit of two people's records had taken place in January 2018 although this had not been written up and there was no action plan currently in place to show what improvements were required. Although the manager had recognised this as an issue, we had already identified this to be an issue at our last inspection and therefore, the drive for improvement within this area had not been sufficient. Some records in relation to the support people had received with personal care had not been completed and this had not been identified as an issue during these audits. Consequently, the provider had not been able assure themselves that people's needs were being met. Daily notes were being completed by staff but there were blank lines between each written entry. This is poor practice as it enables staff to write in retrospective information. The provider's audit of January 2018 recorded that they had reviewed three people's care records but had not recorded the outcome of this.

The manager told us a dependency tool was being used to identify how many staff were required to provide people with safe care. However, we found the provider had not ensured that the numbers required had been consistently met which placed people at risk of receiving poor care and their needs not being med. Also, there was no system in place to ensure that these levels were reviewed when new people were admitted to the home to ensure the staffing levels were sufficient.

There was a lack of effective leadership regarding the monitoring of staff practice to ensure that people received the care they required to meet their needs and keep them safe. We observed a number of issues in relation to staff practice during this inspection that placed people at risk of harm. None of these had been picked up by the senior staff working on the floor at the time.

Following our second visit to the home during this inspection, the manager told us they had introduced a daily walk around by senior management in the home to ensure staff were following correct practice but when we visited again, we continued to find issues such as a glove in a person's room placing them at risk of choking. This shortfall also demonstrated that communication with staff was not always effective. This was further found where we saw that staff had been told during a team meeting in November 2017 that they must always wear aprons when providing people with personal care. We saw this was not being followed. We also found that this walkabout had not identified issues with the cleanliness of some issues of the home, equipment that some people used, that communal toilets had not been cordoned off when being used to store broken equipment and that records relating to people's private information had not been stored away to ensure they remained confidential.

We were concerned that the manager and operations director lacked knowledge in some fundamental areas which led to risks to some people's safety not being managed appropriately. For example, the manager and operations director told us they were not aware that allegations of abuse were required to be reported to the local authority safeguarding team. This included allegations made against staff within the home. Their failure to understand this could have compromised any investigation, including any possible criminal investigation into these matters.

Furthermore, this did not follow the provider's policy on safeguarding dated October 2017 which stated that, 'In all cases of alleged harm, there will be early consultation between the Manager, local authorities, and the Police to determine whether or not a joint investigation is required' and 'We will work in partnership with other agencies to ensure that concerns or allegations of abuse are appropriately referred for investigation to the most appropriate agency.'

A lack of risk assessments had been completed in some areas. For example, the provider told us that no assessment of risk had been completed in respect of exposed hot pipework within the home, placing people at risk of burns. This demonstrated a lack of knowledge in relation to key guidance in relation to health and safety within care homes such as that published by the Health and Safety Executive in 2014. The operations manager and manager was also not aware of this and therefore, had not looked at this as part of their audit process. They were not aware that certain medicines were required to be stored in a certain way to comply with controlled drugs legislation.

People had not always been consulted about changes being made within the home. The provider had not consulted people or their relatives about the fundamental change in how their or their family member's meals were to be prepared. Also, the manager told us that a questionnaire had been sent to relatives, staff and outside agencies in October 2017 for their view on the quality of care that was being provided. We saw these had been analysed but could see no action plan in place to drive improvements where issues had been identified. The manager told us they were not aware whether any changes had been made as they had not been working for the service at that time. We were concerned that people living in the home had not been asked for their views during this formal process, even though there had been some residing in the home at the time who may have been able to give their views and therefore, contribute to any improvements that were required.

The manager or provider through their existing systems had not identified that specific incidents that are required to be reported to CQC by law had not been. We found several incidents of alleged abuse that we had not been told about.

This resulted in continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The current manager had been working in the home since November 2017. They were registered at one of the provider's other homes and were therefore managing both services. They were supported by a deputy manager and a head of care, the latter having recently been promoted to this position. The manager, although well intentioned, had found it difficult to drive improvement within both homes that had been rated as needing improvement. During this period, the provider had not maintained sufficient oversight of this home and this was why the required level of care had failed to be reached.

The operations director told us that a new governance framework had recently been put in place. We reviewed this and saw that there was clear delegation of responsibilities across the senior management team regarding auditing of various areas. This included areas where we had found shortfalls during this inspection. However, although this is positive we were concerned that action had not been taken to continually improve the quality of care people received since our last inspection which had resulted in some people receiving poor quality care and others being exposed to significant risk of harm. Since the inspection, the provider had told us that the manager will now only be managing Ailwyn Hall and that they have sought more regular support from an external consultant.

We received mixed feedback from people regarding the current leadership at the home but all told us they were happy living there. We also received mixed feedback from them regarding the availability of management but they all said they felt supported and that the management were approachable. Team meetings had been regularly held with staff to discuss accountability and the care that people required.

The manager was enthusiastic about improving the quality of care people received in the home. They had developed a number of relationships with organisations within the local community such as schools for the benefit of people living there and they were continuing to develop these. They had a number of ideas they were looking to implement such as having raised beds within the gardens for people to utilise and decorating people's walking frames to help them identify then and reduce the number of falls people experienced.