Gastank Limited

Ailwyn Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2016, it was unannounced.

Ailwyn Hall provides accommodation and support to a maximum of 39 older people some of whom were living with dementia. It is not registered to provide nursing care. At the time of our inspection there were 34 people living in the home.

We last inspected this service on 16 and 23 October 2014 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider was in breach of the Regulation 10 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This was because there was no effective system in place to assess and monitor the information contained in the home's records. This included information contained in people's care records.

Following the inspection in October 2014, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations.

At our inspection in May 2016, we found 6 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 1 breach of the Care Quality Commission (Registration) Regulations 2009.. You can see what action we told the provider to take at the back of the full version of this report.

There was a manager in post who had been appointed in January 2016. At the time of our inspection, the manager had not submitted an application to the CQC to become a registered manager. 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.

We found that there were continuing issues regarding the governance and quality monitoring of the service. The provider's quality monitoring had failed to identify issues regarding the documentation of people's care needs. We found these were not always accurate or detailed enough. The manager did not have a full understanding of their responsibilities and had not always taken the required actions.

Staff were positive about the manager and the support they provided. Whilst not all issues within the home had been identified the manager had taken steps to address some issues and make some positive changes in the home.

People were not protected from avoidable harm and abuse because staff did not always identify and take action to manage situations that placed people at risk of this. Safeguarding incidents were not always reported to the relevant authorities.

Whilst the service identified some risks to people and took action to manage these, not all risks to people were adequately identified or managed. Staff did not always take action when they should to manage the risks associated with people who displayed challenging behaviour. There were frequently insufficient suitably skilled staff available to meet people's needs and keep people safe.

People living in the service were not always receiving their medicines as prescribed and prescribed external medication was not stored securely. Other practices around medicines were followed safely.

Not all staff had received the training they needed in order to meet people's needs. The manager did not have sufficient knowledge of the Deprivation of Liberty Safeguards (DoLS) and the home was not working within the requirements of the Mental Capacity Act 2005.

People and their relatives were complimentary about the quality of food provided. However, people were not always given the support they needed in order to eat and drink. Whilst some people were offered choice regarding their meals this was not always consistent.

The home ensured people had access to appropriate health care professionals when required.

Whilst staff knew people living in the home well and took steps to promote people's dignity and independent they did not always behave in a kind way. We observed occasions where people were not treated in a kind manner and staff did not always take action to respond or relieve people's distress.

There was not always enough stimulation and activities for people living in the home. There was mixed feedback regarding how much the service supported people to leave the home and access the local community. Relatives could visit when they wanted and the home welcomed engagement with relatives.

People received care that met their individual preferences. The home had identified a need to provide people and their relatives with formal opportunities to provide feedback and discuss their care, and were making arrangements to do so. People and their relatives told us they knew how to raise concerns and felt able to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Staff did not always take action to manage risks associated with people who displayed behaviour that challenged themselves and others. They had not received sufficient training in this area.

Not all risks to people, including risks associated with the premises, were adequately identified or managed.

People were at risk because some medicines were not stored securely or appropriately.

The service did not ensure sufficient numbers of staff were in place to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training to support them in meeting the needs of people living in the home.

The home was not working within the requirements of the MCA.

People were positive about the quality of food however, some people did not receive the support they needed during meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always appear to listen to people and take action to respond or relieve their distress.

Staff understood and promoted people's dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not always enough stimulation and activities for people living in the home.

The home encouraged contact with relatives and had started to make arrangements to provide people and their relatives with opportunities to provide feedback and discuss concerns.

The home took action to ensure people were provided with care that met their individual preferences.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring audits had failed to recognise the issues highlighted in this report. However, we saw the manager had been proactive in addressing some of the issues and in trying to improve the quality of care provided.

The home did not have in place accurate, complete, and contemporaneous records of people's care.

The manager did not always appear aware of their responsibilities and this meant certain actions and tasks had not been carried out.

Staff felt supported by the manager who encouraged and supported staff in a constructive and motivating manner.

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.

The inspection took place on 10 and 11 May 2016. The inspection was unannounced.

The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority quality assurance team and a quality lead for the local clinical commissioning group for their views on the service. We also looked at the action plan the provider had sent us after their last inspection in October 2014.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During our inspection we spoke with five people using the service and two relatives of people using the service. We spoke with ten members of staff. This included, the manager, deputy manager, three care staff, a senior member of care staff, a domestic member of staff, the activities co-ordinator, and another domestic member of staff responsible for meals on the day of inspection. We also spoke to a visiting health care professional and a hairdresser who visited regularly. A registered manager from another care home the provider owned was also present on the days of our inspection and we spoke with them.

Not everyone living at Ailwyn Hall was able to speak with us and tell us about their experiences of living in

the home. We observed how care and support was provided to people and how people were supported to eat their lunch time meals.

We looked at five people's care records, three staff recruitment files and staff training records. We checked the medicines records for four people. We looked at quality monitoring documents, accident and incident records, and records of compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

Most of the residents we spoke with told us they felt safe in the home, however one resident said, "Most of the time I like the other residents coming into my room, but I sometimes find it frightening with the one or two residents, I have to ring my bell." We also observed during our visits incidents occurring that made people feel unsafe.

The staff we spoke with could tell us how to recognise, prevent, and report harm to help ensure that people were protected from the risk of abuse. However, one member of staff told us they could do with updated training. Records showed a number of staff had not received training in this area.

There was a lack of systems in place to report and identify incidents that should be reported the local authority safeguarding team. During our inspection we saw records of incidents that should have been reported had not been reported to the appropriate agencies. This meant the local authority had been unable to take action and provide support. We were not confident that staff would report safeguarding concerns to the appropriate authorities.

The above information meant people were not protected from improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always identify and take action to manage situations that placed people at risk of avoidable harm. We observed one person in a lounge repeatedly calling out the same phrase. This caused other people nearby to become agitated with the person and shout at them. On another occasion we observed one person being verbally abusive towards other people. We saw that the people being shouted at and others in the vicinity became distressed by this. Although staff were present on both occasions they did not take action to address these situations.

People had risk assessments in place that identified measures to mitigate the risk and provided guidance to staff. Where necessary relevant referrals had been made to manage these risks. For example, we saw staff had sought the input from mental health professionals to manage a change in a person's needs. However, whilst people in the home had risk assessments in place they did not always identify risks or provide staff with sufficient guidance. We observed two people presenting with behaviour that put them at risk this was not identified in their care plans and risk assessments. Another person's risk assessment said they required hourly checks to keep them safe. A member of staff told us this was not happening. Records showed on the day of our inspection that these had not been completed. This meant not all risks to people were identified, staff did not receive the correct guidance and actions were not taken to manage risk.

Accidents that occurred in the service were reported. These were regularly analysed in order to identify any patterns or actions required. For example, we saw the manager had identified an increasing number of falls for one person and they had ensured additional actions were taken which included referring the person to a falls team. However, we saw there were a high number of incidents within the home which involved challenging behaviour. There was no system in place for the reporting and analysis of these types of

incidents. A lack of analysis meant it would be difficult for the manager to identify any patterns or escalating needs so that appropriate action could be taken in response to this.

During our inspection we saw that whilst some staff took action to manage people's behaviour that challenged themselves and others, this was not consistent with all staff. Not all staff identified situations which could increase the level of risk to people living in the home. For example, we saw on one occasion staff had created a situation where a person was restricted and unable to leave the area they were sitting in. We saw the person became distressed by this which created distress amongst other people near the person. Whilst staff were present they had not identified that action was needed to de-escalate the situation.

Some risks to people from the premises were not adequately managed or risk assessed. We saw there had not been any fire evacuation drills since January 2015. This meant that staff may not have known what to do in the event of a fire. Records showed that other required checks had not been carried out this included checks on fire extinguishers and checks to manage the risks from the legionella bacteria. Other routine maintenance such as maintenance and servicing on moving and handling equipment had been done.

Medicines prescribed for external application were kept non-securely in people's rooms placing them and others using the service at risk of accidental harm. We discussed this with the manager who confirmed they had identified this was a particular risk for one person and had ordered a lockable bathroom cabinet. However, this was not yet in place and did not remove the risk of creams being left out in other people's rooms.

The above concerns meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that other practices around medicines were followed safely. People were positive about the support they received regarding their medicines. One person said, "My meds? They are OK the staff look after them for me." Another person said "I seem to get my meds on time normally within half an hour each day." We observed a member of staff administrating medicines; they ensured that medicines were locked away when they left the trolley unattended to administer people's medicines. We saw the member of staff checked to see if a person was ready to take their medicines and provided support at the person's own pace.

Other prescribed medicines were stored securely. The temperature at which medicines were stored was checked regularly so that staff could be sure medicines remained effective to use. We checked three medicines and saw the stock count was accurate. A member of staff told us the manager undertook spot checks of medicines administration and weekly stock checks were carried out. We saw the provider undertook their own medicines audit as well as having an external medicines audit in place. Where issues had been identified staff minutes showed the manager had taken action to address these.

Prior to the inspection we received concerns regarding the staffing levels at the home. People we spoke with told us they would benefit from additional staff. One person said, "I always have to have help in the mornings so I ring my bell. Sometimes I have to wait for them." Another resident told us they felt at times more staff were needed in order to meet people's needs.

The staff we spoke with also raised concerns regarding the amount of staff the home felt were required to meet people's needs. One member of staff told us, "Sometimes people have to wait." They went on to say, "Staff sometimes don't get five minutes to get a drink." Another member of staff told us there was not enough staff when people in the home became agitated and displayed behaviour that challenged. They went on to say, "Some days we won't be able to finish our work." Another member of staff told us staffing

levels impacted on staff's ability to manage paper work and domestic tasks. Another two members of staff told us that at times it was hard to complete domestic tasks with the amount of staff they had.

A number of staff raised issues regarding the home being short of staff on occasion. All the members of staff we spoke with said they tried to work together to cover shifts. However, a number of staff told us on occasions shifts during the day and night were not always fully staffed. Staff rotas confirmed this. One member of staff said, "Sometimes when working a bit short it's hard to feel you are giving the highest level of care that you can." One member of staff told us an outing had been arranged for people living in the home on one of the days we visited. They said this had been cancelled because they had been short staffed and there were not enough staff to support the outing.

During the days of our visit we saw that a lack of staff and poor deployment of staff impacted on keeping people safe and meeting their needs. On one occasion we saw a number of residents sitting in the main lounge. Two residents were displaying behaviour that challenged themselves and others. A number of residents were becoming distressed by this. There were no staff in the main living room at the time and this resulted in another resident trying to intervene and manage the situation themselves. On another occasion a member of staff was on their own with 13 people in the large lounge. They left the room in order to attend to a ringing call bell. Once they left the room a person began to display behaviour that was challenging to themselves and others. We saw that other people became offended and distressed by this. The member of staff did not return for ten minutes and during this time the behaviour continued.

There was no formal tool or system in place to check that staffing levels met people's individual needs. In response to concerns raised regarding staffing prior to our inspection the manager had analysed people's needs in relation to staffing numbers. However, on the days of our inspection we saw that a number of people required periods of one to one care which had not been accounted for.

Sufficient staff were not deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff files showed safe recruitment practices were being followed. This included the required health and character checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the risk of employing unsuitable staff was minimised as far as possible.

Requires Improvement

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 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.

Records showed that people had assessments of capacity in place, however a number of these were regarding whether the person had capacity to decide to live at the home rather than in relation to their care. Other people had one assessment of capacity that covered both living in the home and their capacity regarding their care plan. People did not have separate capacity assessments to cover particular aspects of their care where required. One person's care plan stated they lacked the capacity to administer their medication however there was no mental capacity assessment recorded regarding this. Where people had been assessed as lacking in capacity there was no information recorded about the decision that had been made and how this had been made in their best interests. A number of people had capacity assessments that stated they lacked the capacity to decide where to live and applications under DoLs had been made for some people. However, there was no best interests documentation in place to demonstrate that relevant people had been consulted and the outcome. This information showed that the home was not following the guidance set out by the MCA and DoLS.

The above information in relation to MCA and DoLS meant there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we saw records that showed staff had not received training in the MCA during our discussions with staff they demonstrated a basic awareness of the MCA and how they would support people with decision making. We discussed with the manager their understanding and knowledge of DoLS. They explained that they were new in post and did not yet have the knowledge necessary in this area. This meant the manager might not identify when situations regarding the deprivation of people's liberty had occurred.

We received mixed feedback from staff regarding their training. Most staff told us they felt they had received the training they needed. One member of staff told us the home had arranged for additional training in order to meet the specific needs of some people in the home. A number of staff told us the provider had supported them to gain national qualifications in care. We saw that the manager was in the process of checking how many staff wanted to be supported to complete further qualifications. However, several other staff members raised some concerns in relation to training. Several members of staff told us that there

training was out of date. One member of staff told us training had been a, "Little bit slack." During our discussions with staff we saw not all staff felt confident about their knowledge in certain areas. One member of staff said they had training, "A while ago and could do with more updating."

Staff training records confirmed that some staff training was out of date and showed some staff had not received training in a number of areas. The manager told us they and the provider had identified there were issues regarding training. We saw the manager had written a training plan for the current year which addressed this.

A number of relatives raised concerns regarding the ability of the home to manage people living in the service who had behaviour that challenged. We looked at their records which showed on the day of our inspection that hourly checks had not been completed. One relative told us, "I think some of the staff are not trained or skilled to look after some of the residents with challenging behaviour." A member of staff we spoke with also raised concerns regarding staff's ability to manage this type of behaviour. They said, "I worry someone's going to get hurt." Records showed that although there were a number of people with behaviour that could appear challenging, staff had received no training in how to manage this. This meant we were not confident that staff had the skills and competence to keep people safe in relation to behaviour that challenged. The manager told us they had identified the lack of training in this area as an issue and prior to our inspection had been discussing the need for additional support with the provider. Following our inspection the provider contacted us to confirm this was being arranged.

The above information meant the provider had not taken steps to ensure staff had the knowledge and skills to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed new members of staff received an induction. The manager told us all staff who were completely new to working in a health and social environment completed the care certificate. The Care Certificate covers the minimum standards that should be covered as part of induction training for new staff. The manager said if staff already had experience of working in a similar environment they would complete the provider's own written induction. We saw that this covered topics such as fire safety, nutrition, moving and handling. This meant that new staff understood their role and basic information that new staff needed to know was covered.

The manager told us that staff supervisions had not been happening. However, all the staff we spoke with said they felt a lack of supervisions had not been an issue for them as they felt supported by the manager and were able to approach them for informal advice and guidance when required. One member of staff said, "If I had a problem I could go and talk to the manager or deputy." This meant that although there was a lack of formal supervision staff were still supported by the management team to carry out effective care.

We received mixed views regarding the amount of choice people had regarding their meals. One person told us, "There is a good choice here every day." We saw there were no written menus or pictures of the food to help the people decide beforehand what they would like to eat. Staff told us they showed both options for the meal to the person so this could help them choose. Whilst we saw this happening in some cases it was not consistent and we saw some people were not given a choice regarding what they wanted to eat.

During lunch times we observed people did not always get the help and support they needed to eat enough. We saw three people in a small lounge had been served their meals but required support to eat them. Five minutes later a member of staff came to assist one person. The member of staff tried to encourage and prompt the person to eat their meal. However, they only spent three minutes doing this and then took the

meal away. We saw they were not offered alternative options which they might have preferred and there were no further attempts to support the person to eat. By the time the staff member left the room the two other people had been sitting with their food in front of them and no support for ten minutes.

We saw one person had difficulty cutting their food up because their knife was upside down and they were not able to recognise this. There were no staff in the room to identify and support the person with this. This meant the person had difficulty eating their main meal throughout the whole of the lunch period and was not supported to use their cutlery until they were served their dessert.

In the main dining room we saw there were twenty people eating their lunch, a number of whom required support with their meals. There was one member of staff in the dining room. They told us they had been on their own providing support most of lunch time and this is why one person had fallen asleep in front of their meal without eating any of it. We saw that by the time the member of staff had attended to the person, the person's food was cold.

Where people were at risk of not eating or drinking enough this had been identified and a care plan had been put in place. We saw one person at risk of dehydration required the amount they drank to be recorded and monitored. However, when we looked at the records for this we saw the charts were not always completed and there were no amounts logged for several days. This meant the risk to this person could not be accurately monitored and it was not clear the person had received sufficient fluids.

The above concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dietary needs were catered for. People and their relatives were positive about the quality of food served. One person said, "The food here is very good and I always have seconds." Relatives told us the food was of good quality, one relative said, "The food is superb." We saw one person had a number of foods they could not eat and their care plan give clear detailed guidance in regards to this. We saw during lunchtimes staff were aware of what each person could or could not eat. The member of staff responsible for cooking meals on the day of our visit told us staff made sure people's nutritional care plans were followed.

People told us they were supported to access health care services. A visiting health care professional spoke positively about the home. They told us the home was good at highlighting concerns and working with them to meet people's needs. We saw evidence of frequent and clear communication between staff and people's doctors when required. Records showed that where necessary people were referred for input from a range of healthcare professionals. This included referrals such as for nursing support or specialist mental health support.

Requires Improvement

Is the service caring?

Our findings

During our visit we saw a number of incidents when staff did not act in a caring way. For example, on one occasion we observed one person in the path of a member of staff. We saw the staff member attempted to walk round the person without acknowledging them. We also saw at times staff did not take action to relieve people's distress and anxiety. For example, we saw on one occasion a person became very distressed and anxious however staff did not take any action to relieve their distress.

There were occasions when staff did not listen or respond to people regarding their care. We saw one person complained to a member of staff that their food had been served cold. The member of staff apologised but did not rectify the issue for the person. On another occasion we saw a person became upset when someone else was given some chocolate which wasn't offered to them. The member of staff explained to the person that this was because it had been brought privately and did not belong to the home. However, the person continued to be upset and we saw the member of staff did not offer them any alternative food or reassurance.

Care staff appeared task orientated and we did not always see all staff engaging with people on a more meaningful level. One member of staff told us they felt their colleagues were not always proactive in taking opportunities to engage with people.

Whilst there were concerns people spoke positively about the staff in the home and we observed some good practice. Some staff took the time to listen to people, ensuring they made eye contact with them and provided reassurance when necessary. One person told us the staff were, "Very kind, gentle and patient." One person told us they felt listened to and able to talk to staff. They said, "I can tell them when something is wrong." Relatives also spoke positively. One relative said, "The staff are good, I have no concerns" and another relative told us, "The staff are exceptional here."

Staff spoke in a positive and caring way about the people living in the home. Several staff members told us they loved the people living in the home. One member of staff said, "I try my best to care for people like I would my parents." Another member of staff said, "We make [the people living here] a priority." We observed a number of positive caring interactions between staff and people living in the home. For example, we saw some staff sharing a joke with a person and getting a blanket for another person when they said they were cold.

During our inspection we saw, and our conversations with staff demonstrated, that they knew the people living in the home well. We saw people's care records included information about people's lives. This meant staff were supported to understand and know the person rather than just the person's care needs. The activities co-ordinator told us how they explored people's histories, likes, and dislikes when planning activities. They said they had made memory books with some people in the home which documented their life history and interests. They gave us several examples which demonstrated they knew the people living in the home well.

Staff told us how they upheld people's dignity and promoted their independence in practice. We saw that staff ensured that doors were closed when intimate care was being given. We also observed people being encouraged to do things for themselves where possible. For example, we saw one member of staff assisting a person to walk independently and we observed a person helping staff set the tables for lunch. People had care plans in place that promoted respect and dignity for the person. For example, we saw one person had a care plan in place that asked staff to respect the person's choices in certain areas. We saw minutes of staff meetings which showed the manager reminded staff to be respectful of people's dignity. The manager gave staff practical suggestions to enable them to do this.

Requires Improvement

Is the service responsive?

Our findings

There was an activities co-coordinator in place at the home. However, we saw that the home was separated into two wings and each wing had their own lounge. As there was only one activities coordinator this meant that there was little for people to do if the activities coordinator was engaged in a different lounge. One member of staff told us that people living in the home had sometimes said they were bored at times. Another member of staff told us they felt there could be more stimulation for people. We also observed that staffing levels meant that sometimes the activities coordinator was engaged in care tasks which impacted on the amount of activities provided.

We saw that a high number of people living in the home required individual attention and stimulation in order to engage them in activities. We observed the activities co-ordinator engaged, where necessary, with people on a one to one basis. However, we observed that this also meant whilst the activities co-ordinator was engaged with one person, other people were left sitting on their own with little stimulation. One member of staff told us they felt activities were difficult because of the number of people with advanced dementia. The activities co-ordinator was recently new in post. They told us they had not received any additional training in providing activities for people living with dementia. However, we saw that they had spent a lot of time researching this and had tried out a number of different ideas in order to engage people in meaningful activity. On the day of our visit we saw the activities co-ordinator had made some sensory objects for people. We saw a number of people engaged with and enjoying these.

There was no planned time table of activities, however we saw records that showed a range of different activities had been offered. We saw pictures of people enjoying cooking sessions, gardening, and on the morning of one of our visits we saw people were engaged in playing a building game with wooden blocks. We saw that the activities co-ordinator tried to involve everyone in the game. Some people came over to move the wooden blocks and others counted to indicate which block the activity coordinator should remove for them.

There was mixed feedback regarding how much the service supported people to leave the home and access the local community. The activities co-ordinator told us they supported people to attend health care appointments and would make an outing of this. For example, by taking the person shopping or for coffee and cake afterwards. One person told us, "We sneak off to [local city] sometimes." However, one person said, "It's ok-ish here but I like access to the towns and the shops." The activities co-ordinator told us they had raised the issue of group outings for people and had requested the use of the provider's mini bus in order to put this in place.

Relatives could visit when they wanted and we observed relatives arriving at different times. One person told us, "Normally late in the afternoon one or two of my [relatives] comes to visit me." We also saw that the home was planning a number of events at the home in order to encourage relatives to visit. One relative told us, "There is a social evening with a garden party soon I will be attending."

People told us they received care that met their individual preferences. One person said "I am an early

person, they help me to wash when I want to get up then I have breakfast about 9 o'clock." Another resident said, "I go to bed at about 9:30. That's the time I wish to." In our conversations with staff they demonstrated they knew people's individual preferences and how they should be met. The home had paid attention to how each person wanted their care delivered. One member of staff told us staff made sure they asked people about their preferences. They said, "We make sure we ask people if they want to get up or stay in bed." The manager gave us an example where one person had queried if they still required a soft diet. The manager had listened to the person and requested an assessment from a health care specialist to check this. Care records we looked at showed people's individual preferences and were written from the person's perspective.

Care records did not always show that people who would have been able to participate had been given opportunities to discuss or be involved in decisions about their care needs. However, relatives we spoke with told us they felt staff involved and consulted them regarding how to best meet people's needs. One relative said, "If the care home has any concerns they ring me to let me know." Another relative told us, "A few months ago we reviewed [name's] care plan." The manager told us that they had recently changed their care plans. They were in the process of inviting people who use the service and their relatives to meet and discuss their care needs and how they should be met. This showed that the management team recognised the need to involve people and their representatives in order to ensure they provided personalised and responsive care.

We saw that prior to people arriving in the home the service had taken action to ensure they had information about the person and their needs. People had written care plans in place before moving into the home. A relative told us, "It was a smooth transition to this care home."

All the people we spoke with knew how to make a complaint and felt able to do so if required. We reviewed the compliments and complaints records. We saw the home had not received any complaints in the last year. There were no formal opportunities for people and their relatives to provide feedback such as resident or relatives meetings. However, we saw that the provider did conduct yearly questionnaires with relatives, which sought their views and opinions on the care provided. The provider had identified some actions they would take which would provide people and their relatives with additional opportunities to provide feedback. This included a plan to organise three monthly reviews meetings with relatives to review each person's care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 16 and 23 October 2014 we found the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).This was because improvement was required in the quality monitoring of the service. Following our inspection in October 2014, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us this would be completed by February 2015. This May 2016 inspection found that improvements in this area were still required.

The provider had put in place regular audits and the manager told us they met with them on a regular basis. However, we saw that they had not identified a number of issues that we had identified during our inspection.

Whilst we saw that the provider audited care records, issues relating to the absence of care plans to support people's needs had not been identified. The care records we looked at contained details about people's care needs but these were not always detailed enough and did not always contain key information. We looked at four people's medicines administration records. They did not show that medicines had been given as intended by prescribers, as there were gaps in the records. This meant the home did not have in place accurate, complete, and contemporaneous records of people's care.

Whilst the current manager had taken action to try to assess people's needs against staffing levels and had made some increases in staff during the night, it was a concern that significant issues regarding staffing levels had not been identified or addressed.

The manager did not have a full understanding of their responsibilities. For example, we saw that the required regular audits and checks on some equipment and the premises had not been completed by the manager. They told us they hadn't been aware they needed to do them. We saw one person was being funded for periods of one to one care, however their care records did not detail how much one to one care should be provided or when. The manager appeared unclear about how much one to one support the person should receive and told us they did not provide additional staffing but covered this within their own staffing numbers. This meant that they were not fulfilling their contractual responsibilities and could not demonstrate the agreed and funded level of care was provided.

The above information meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had carried out a quality survey in 2015 with relatives of people who live in the home. Comments were positive; however we saw the service had identified the need to regular resident and relative meetings. At the time of our inspection these had not yet started and we saw there were limited formal opportunities for people and their representatives to provide feedback and be involved in decisions regarding the home. We also saw there was no mechanism in place for the home to tell people and their representatives about

changes happening in the home, for example through regular residents and relatives meetings or regular written communications such as a newsletter.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. We saw that a number of safeguarding incidents had not been reported to us.

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

People and their relatives spoke positively about the home. One person said, "It's like home, but not my home." One relative called the home, "Breath taking" and another relative said "I can't think of anything the care home could improve on."

Staff told us they felt involved and listened to by the manager and provider regarding the home and how it was run. A number of staff told us they felt able to go to the manager with any issues and problems and felt confident the manager and provider would take action to resolve these. Staff told us they felt involved in the service and able to share ideas. One member of staff told us the manager, "Is open" and had taken time to get to know the staff and their areas of strength.

Several members of staff told us the manager encouraged change and provided feedback in a positive and constructive way. Staff told us they understood their role and what was expected of them. One member of staff said, "The manager is very fair, we know what they'd like us to do and they tell us in a nice way." Another member of staff said, "We know what we're doing."

The manager had started in post at the beginning of the year and we saw they had taken action to address some issues within the home. A relative told us, "[the manager] has been in at night and weekends when there has been problems." One member of staff told us there had been a settling in period and lots of changes. Another member of staff said, "For me they've been a breath of fresh air." All the staff we spoke with were positive about the amount of changes and impact the manager had in the home. Several members of staff gave us examples of this such as the manager had brought in more infection control, resolved issues with the laundry, and increased staffing on night shifts. Several staff told us the manager had tried to address issues with lunch times by changing the dining room so people could eat together and it would be easier to staff. We saw staff meetings which showed the manager addressed the quality of care provided and had encouraged staff to make improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered persons had failed to notify the Commission of adult safeguarding incidents that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent. How the regulation was not being met: The provider did not act in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way because risks were not always identified and mitigated, staff did not have sufficient competence and skills to manage situations safely. Regulation 12 (1)(2)(a)(b)(c)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment. How the regulation was not being met: People were not protected because staff did not take action to protect people from improper treatment. The provider had not ensured that safeguarding incidents were identified and acted upon appropriately. Regulation 13 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA (RA) Regulations 2014 How the regulation was not being met: People did not receive the support they required to eat and drink during meal times. Regualation 14 (1) (4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient and suitably skilled numbers of staff were not deployed to ensure people's needs were met. Regulation 18(1)(2)(a)

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 2014. Good Governance. How the regulation was not being met: The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17(1) and (2)(a)(b)(f) The service did not maintain an accurate and complete record in respect of each person who used the service. Regulation 17(2)(c)

The enforcement action we took:

We have sent the provider a warning notice and told them they must be compliant with this Regulation by 16 August 2016