J A Corney and Mrs J P Webb

Thistlegate House

Inspection report

Axminster Road, Charmouth, DT6 6BY
Tel: 01297 560569
Website: www.example.com

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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

Overall summary

The overall rating for this service remains as 'Inadequate'. We have kept this service under review while we took action to cancel the providers registration as a result of breaches in regulation resulting in people receiving inadequate care.

We took action to cancel the provider's registration following our inspection in April 2015 as the provider had failed to make the significant improvements necessary. These legal proceedings have now concluded and we are able to report on the outcome of the actions we have taken. The provider appealed against our decision to cancel their registration. This appeal was heard by the Care Standards Tribunal, this appeal was dismissed by the tribunal and their registration was cancelled on 11 May 2016.

This unannounced inspection took place on the 27 and 29 October 2015. Thistlegate House provides accommodation and personal care for up to 18 older people. There were 5 people with complex care needs associated with dementia and restricted mobility, living in the service when we visited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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 registered manager owned the home in partnership with one other person. This person is referred to in the report as co-owner. They both live in the home and were both present providing care alongside the staff.

We had inspected the service in January 2014, January 2015 and April 2015 and had concerns about the quality of care. There were breaches of regulations and we told the provider to take action to ensure they met the regulations.

During our inspection we found a number of the concerns identified at these previous inspections remained. People's care was not assessed appropriately and this meant that care did not reduce the risks that people faced and might not meet people's needs.

Staff did not know where to report abuse to and the information available to them was out of date. This meant there might be delays in reporting abuse which would put people at an increased risk of harm.

Staff did not have a shared understanding of the evacuation procedure and fire exits were blocked.

Consent to care was not sought in line with legislation and this put people at risk of not receiving care that was in their best interests. This also put staff at risk because they were providing care that people had not agreed to without the protection of the law.

There were enough staff but their training was not all up to date and this put people at risk of receiving inappropriate or unsafe care.

Care staff were all kind and compassionate but people were sometimes treated in ways that were not respectful. Records sometimes contained language that was judgemental and did not respect the person it referred to.

The registered manager did not operate a system that was effective in ensuring people received good quality care. They had not responded appropriately to concerns identified in our previous inspections or to requirements made by environmental health professionals relating to the safety of the kitchen. The registered manager shouted at inspectors on a number of occasions during our inspection.

Staff were working to increase the meaningful activities available to people. The staff had tried a variety of activities with people during a weekly scheduled activity slot. This remained insufficient to meet people's well-being needs.

Appropriate applications for DoLS had been made and granted for three people and a further application had been submitted.

People had access to health care professionals and advice had been sought about some aspects of people's health.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe because staff did not know how to report abuse appropriately. This put people at risk of harm.

People were at risk of avoidable harm because risks were not managed safely.

Inadequate

Is the service effective?
The service was not effective because people's consent to care was not sought in line with the Mental Capacity Act 2005.

People had access to advice and support from health care professionals but advice was not always followed and information was not always shared.

Requires improvement

Is the service caring?
People were sometimes treated in ways that were not respectful but most staff treated people with kindness and respect.

People told us their care was not rushed but sometimes they did not feel heard.

People's end of life wishes had been recorded although it was not clear how these decisions had been made.

Requires improvement

Is the service responsive?
The service was not responsive because people's needs were not reviewed effectively and this meant they were at risk of receiving inappropriate care.

Requires improvement

Is the service well-led?
The service was not well led because the guidance and requirements from other agencies had not been followed. The action plans from previous inspections had not been carried out. Environmental health requirements had not been acted upon. This put people at continued unnecessary risk.

The registered manager did not engage professionally with the inspection process.

Inadequate

Thistlegate House

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 27 and 29 October 2015 and was unannounced. The inspection was undertaken by two inspectors.

During our inspection we spoke with four people and spent time with all five people. Some of the people were not able to describe their experiences with words. We looked at the care records relating to five people.

During our visits to the home we spoke with the registered manager and co-owner, and three staff.

We also spoke with two community nurses, a community psychiatric nurse, a physiotherapist, a GP, a social care professional with expertise in the Mental Capacity Act 2005 and a local authority worker with expertise in environmental health.

Before our inspection we reviewed information we held about the service including notifications of incidents and the action plan that the provider had sent us after our previous inspections. A notification is the way providers tell us important information that affects the care people receive. We did not request a Provider Information Return (PIR). A PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during our inspection and spoke with the co-owner and registered manager about their governance of the home.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2015 we found that care was not appropriately assessed, planned or delivered to keep people safe. Safeguarding procedures did not adequately protect people from the risk of abuse. Recruitment procedures were not sufficient to reduce the risks associated with employing unsuitable staff. We judged that there had been breaches regulation. We took action and required that the provider meet some regulations by 9 April 2015. In April we found that sufficient improvements had not been made and took further action. At this inspection we continued to have concerns that risk assessments were not being carried out in a way that protected people from the risks of unsafe or inappropriate care. During this inspection we found that sufficient improvements had not been made to reduce the risks of unsafe care.

People were not protected from avoidable harm because risks were not consistently identified, assessed or managed.

People were not always protected against the risks associated with falls. One person had been assessed as being at a high risk of falls. There was no care plan in place to describe how this risk should be managed to keep the person safe. The registered manager and care staff told us that they could always hear when the person moved independently and went to help them. However, music was playing in the lounge area could have an impact on staff's ability to hear the person moving. The person's bedroom was located on the first floor by the stairs. We observed the person walking down the stairs wearing only one shoe which was placed on the wrong foot. We alerted staff who had been unaware that this person was walking independently who intervened.

We spoke with staff and the registered manager about strategies to reduce the risk of the person falling such as moving to a downstairs room or using sensor technology to alert staff. Staff told us they had discussed the fact that the person had an upstairs room and felt they liked this room too much to move. The registered manager as they told us that sensor technology had been tried 10 years previously and was not reliable. The registered manager remained convinced that they would hear if the person moved independently. The person was placed at risk of harm as their risk of falls was not adequately assessed and plans were not in place to keep them safe.

Another person living in the home was identified as being at risk of falls. Their falls risk assessment had been updated in May, June and September 2015 stating they had not had any falls since January 2015. There was a fall recorded for this person in the accident book in May 2015. This fall should have been referenced in their falls risk assessment and consideration given as to whether their care plan needed changing as a result.

One person was at risk of harm if they left the building unsupervised. A risk assessment had been completed identifying that there was a risk that the person could leave the grounds and "venture out onto the main thoroughfare alone". The action required highlighted that the person was subject to a Deprivation of Liberty Safeguard but did not describe how staff should monitor their whereabouts. During our inspection the front door was not always locked and we observed the person moving around unsupervised. The person remained at risk of leaving the building unsupervised as their risks were not adequately assessed and plans were not in place to keep them safe.

We spoke with the registered manager, the co-owner and two staff about fire procedures in the home. The registered manager told us that they had not recorded evacuation plans for each person in the home because they would want to give information to the fire brigade in person to reduce the risk of misunderstanding. They told us that the fire brigade would be best placed to evacuate the two people who could not walk to leave the building. The co-owner and one member of staff described evacuating these people. The member of staff told us they could use a piece of equipment to move one person down stairs. We were told by the registered manager and co-owner that this equipment was no longer in use. The co-owner said a person could be lifted down stairs. The other member of staff referred to leaving people behind two fire doors. There was not a consistent understanding of a safe fire procedure shared by all the staff. Personal evacuation plans are meant to assist the registered person to plan an appropriate evacuation process, not to inform the fire brigade. Fire exits were blocked by draft excluders and furniture throughout the building. People were at risk because there was not an effective plan in place should people need to be evacuated

Inadequate

Is the service safe?

from the building. A fire officer made an announced visit to Thistlegate house in December 2015. They found that the overall standard of fire safety evident was satisfactory, and that no fire exits were blocked on the day of their inspection.

The premises were not managed in a way that reduced risks to people. At our inspection in January 2015 we recommended that the service consider current and appropriate guidance on infection control and take action to update their practice accordingly. At this inspection there continued to be areas of exposed wood on surfaces in bathrooms and bedrooms. This meant it would not be possible to clean these areas effectively. One person's window was mouldy and the seal on the secondary glazing was not in place. Another person's toilet brush had toilet paper on it and liquid in the base of the container. In August 2015 an environmental health visit led to requirements for action within a month of the inspection. These included requirements that fridge temperatures were recorded consistently, replacing seals on the fridges and above the sink, ensuring cleaning records were maintained and that a fly screen was cleaned. None of these actions had taken place putting people at risk of harm. The staff had gloves and aprons available to use when they supported people with personal care.

People did not receive their medicines safely. We looked at the medicines records of two people and found inaccuracies in the recorded amounts of some medicines. This meant people may or may not have received medicines that had been signed for as given. One person was prescribed a medicine to support their breathing. This was signed for daily but there was no record of how many capsules should have been in the medicines cabinet. Another person had medicines prescribed to help with the symptoms of a progressive health condition. The amounts held for two of these medicines did not tally. The co-owner told us that they thought one error was because a member of staff had signed for medicine they had not given. There were medicines that needed to be returned to the pharmacy as they had been refused. Some of these were stored safely in the medicines cabinet. Some were in a tub in an unlocked drawer in a room that was not always locked. There was a risk that people would not receive their medicines as prescribed because the methods of administration were not robust or safe.

People were not protected from harm through appropriate assessment and care planning. There were not effective plans in place to deal with emergencies. The premises and equipment and medicine administration were not being managed in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff told us they had received safeguarding training but were not able to describe the correct process should they suspect someone was at risk of harm or was being abused. The co-owner and two care staff told us they would speak with the owners and then report to the Care Quality Commission rather than the local authority safeguarding team in the first instance. This was reflected in the home's policy. This was not a safe procedure. We asked the co-owner about this and they told us they had the contact details for the local authority as they had sought guidance as to how to complete Deprivation of Liberty Safeguard applications. This was not the same team who safeguarding concerns should be raised with. The co-owner and registered manager had not sought the correct information to enable their staff to follow effective processes and systems to protect people from abuse. There would be a delay in reporting possible abuse to the appropriate agencies. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff all told us that there were enough staff to meet people's needs and that they did not have to rush to ensure that people's personal care needs were met. No new staff had been recruited since our last inspection. At this inspection we looked at the records relating to three members of staff and found that there was no record of gaps in employment for one of these members of staff and that the reference they provided had been sought by them rather than the service. There was no reference sought from the staff member's care employer. The Health and Social Care Act 2008 states that this information should be held about staff employed by the home. We asked the co-owner about this and they told us that they knew they should record this information and the staff member had not worked in care for a number of years and so they did not believe they would be able to get references from this employer. They were aware of the reason for this staff member's employment gap but had not recorded it.

Requires improvement

Is the service effective?

Our findings

At our inspection of 9 and 14 of January 2015 we found that people's consent to care was not always sought in line with legislation, and staff training was not always reflected in the way they worked and there was a risk that people's health needs were not addressed. There were breaches of regulations. We took action and required that the provider meet some regulations by 9 April 2015. In April we found that sufficient improvements had not been made and took further action. At this inspection we found that people's consent continued to not be sought in line with legislation and that staff training was not reflected in their practice. We also found improvements in access to healthcare but advice from healthcare professionals was not always followed.

Staff sought consent in a practical manner, for example asking people if they wanted help with personal care. However agreements about care provision and specific restrictive interventions continued to be provided without reference to the framework of the MCA. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was no policy available about how to implement the MCA. We found examples of staff intervention with people that required the framework of the MCA to ensure they were lawful. For example, one person with dementia had a wedge that restricted their movement put in place to stop them falling out of bed, and another person's care records stated that they: "became very aggressive kicking and pinching. It took three carers to dress (person's name)." This was a situation that was likely to reoccur due to the person's dementia. Both these people had dementia that affected their ability to make decisions and DoLS were in place. This meant that their capacity to consent should be assessed. If these people were assessed as not having capacity to make the decisions a best interest decision should have been made. If they were assessed as having capacity it would not be legal to restrict them without their consent. These assessments had not been made.

Another person was supported during the night to use a urine bottle. This had been highlighted as potentially intrusive at our inspection of April 2015 when records detailed they were woken two hourly. At this inspection we were told they were not woken but woke themselves. We discussed night care with the person, they were unclear about the support they received and there were indications that they did not understand the questions. In this situation, where a potentially intrusive care provision was being proposed, it was necessary that the MCA be followed to ensure care was in the person's best interests. This had not been followed and appropriate professional guidance had not been sought to inform a best interest decision.

The co-owner, who wrote and reviewed people's care plans, told us they would have discussions before making a decision about people's care. We asked how they would know whether or not a person could make the decision for themselves and they were not able to describe how they would assess a person's capacity to make a decision in line with MCA. The co-owner was not aware of what should be considered when assessing people's capacity to make decisions and told us: "We'd ask a few times we know them so well."

The law also describes how decisions should be made for people who do not have capacity to make them themselves. It states that all efforts should be made to help someone make the decision including consideration as to whether they could make the decision at another time. We asked a member of staff whether a person with dementia found it easier to make decisions at different times of the day. The member of staff told us they only worked at specific times and told us: "I only know (the person) in this time. (The person) is variable." They described making decisions about how to support people based on how they were at this time and did not know if people's capacity to make decisions varied across time. Information about how

Requires improvement

Is the service effective?

dementia and other mental health issues affected people's capacity to make decisions about their care was not available to staff in people's care plans. This meant that people were at risk of staff making decisions on their behalf that they could have made at another time.

When discussing professional input to decision making on behalf of people they told us that professionals, and other visitors, to the home upset people. People's capacity to make decisions about their care was not being assessed in line with the MCA. Best interest decisions were not being made in line with the MCA.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection DOLS authorisations were in place for three people and applications had been made for one other. One person had conditions attached to their DoLS that they be engaged in activities. Records indicated that this was not happening frequently beyond staff chatting with the person during support to meet physical care needs.

Since our last inspection there had been increased input from health professionals and guidance had been sought relating to some aspects of people care such as a seeking advice about a person's mobility and health condition when their condition deteriorated. However, they were not always given all the information they needed to give appropriate advice. The health professional was asked to advise on how to support the person when they were helped to move. They were not told that the person moved independently and as a result they did not advise about the safety of this. The health professional identified that the person could benefit from a review of their medicines and placed a referral with the GP.

After our inspection we received information from a health professional who had advised the co-owner in March 2015 about the equipment needed to support a person safely with their mobility. They visited the person in November 2015 and found that the appropriate hoisting equipment was not being used and that the sling was not used correctly. They also found that the person was receiving personal care during hoisting. This is not good practice as it puts people at risk of harm and does not respect their dignity. This meant the person's needs were not being met safely.

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

Care plans had been updated to include a description of people's oral care needs. One person had started to decline their medicines more frequently and this led to input from the GP. Guidance had been sought regarding nutrition input and healthcare professionals determined that this would be necessary if the staff became concerned regarding swallowing or weight loss. A GP told us that they believed staff contacted them when people needed medical attention.

People told us the staff were kind. One person told us that staff didn't always understand them. The majority of staff training was up to date in line with the time frames the owners had laid out. Staff told us that they found training useful and that it reinforced that they were doing the right thing. This did not reflect our findings in relation to staff understanding of safeguarding, fire safety, safe moving and handling or the MCA. At our inspection of January 2015 we highlighted that a member of staff with responsibility for cooking for people had not undertaken food safety training since 2009; the certificate indicated that this needed to be repeated in 2012. At this inspection we found that this training had not been completed and the member of staff had been cooking for people living in the home during this time period. The co-owner told us that this would be done and we received information that this was completed on 30 October 2015. The registered manager had not updated their infection control, health and safety and moving and handling training since July 2013. They were called upon to assist when people fell and took a lead in these situations, were responsible for ensuring staff followed safe procedures and they also took a lead in home maintenance. Staff were carrying out tasks without appropriate training and this put people at risk of unsafe and inappropriate care.

We spoke with two members of staff who told us they felt supported by colleagues and the co-owner and registered manager. They told us they would be able to access training if they asked for it.

The cook knew people's likes and dislikes and described how they added milk and cream to a person's food who had lost weight. We saw this person was also given biscuits with their drink in the afternoon. People told us the food at Thistlegate House was good. One person told us: "The soup

Requires improvement

Is the service effective?

is nice and hot… All food is usually alright". We observed that some people ate in their rooms and others ate in the dining room. One person who was eating in the dining room told us they preferred to eat in their room but were encouraged to eat in the dining room. We asked them about this and they realised that staff thought this was best for them however they commented that it wasn't "very social" because it was usually only with one other person. We asked staff about lunchtimes and they told us that staff supported people who needed help in their rooms and two people usually ate together in the dining room.

Requires improvement

Is the service caring?

Our findings

At our January 2015 inspection people were referred to with disrespectful language in their care plans and people had not been asked about their end of life wishes where this was appropriate. There was a breach of regulations and we asked the provider to make changes. During this inspection we found that improvements had been made in relation to people's wishes at their end of their life. However, people's dignity was not always respected.

The registered manager did not always behave respectfully when around people living in the home. On the first day of our inspection we sought reassurances about a person's cough. We witnessed the person coughing as they had a drink and ate their lunch. The co-owner told us they believed this was a habit and we highlighted that it could be an indication of difficulty swallowing. A GP visited the home to see someone else in between our visits and was asked to review the person's cough. Whilst we were visiting this person in their room on the second day of the inspection the registered manager entered the person's room and shouted at us to leave. He remained standing in the person's room whilst shouting at us after we had left the room. It became apparent that the person had been upset about the GP visit earlier that morning and had been reassured by staff. The registered manager told us this was the inspectors fault as we had expressed concern about the cause of the cough. The registered manager did not check how the person was or ask them if they wanted us to leave before shouting at us in the person's room.

People were usually treated with kindness but their opportunities to make choices were not always respected, and language used to describe their behaviour in records was judgemental. When we were introduced to people by the co-owner they turned off people's music and television without consultation. It is helpful to people with communication difficulties to remove distractions when they are communicating however this should be done with consent or consultation. The language used about people continued to be disrespectful in care plans where people were described as "uncooperative" and having "fits of temper". This demonstrated a lack of understanding of people's needs. Language used about people is important because it shapes decisions made about their care.

There were five people living in the home and we saw that staff checked on them throughout our visits. When staff spoke with people they were kind and used terms of familiarity. People said the staff were kind and told us that they were able to live aspects of their lives in ways that they chose. For example, people who were able to make choices whether or not to join others in communal areas in the morning and afternoon, how they spent their time in their rooms and they ate food that they liked. However, two people described situations when they did not believe they were listened to with regard to choices about their day to day life. One person told us that when it was their bath day a member of staff came and told them it was time for a bath. They told us this was not their choice and sometimes they did not want a bath. We asked them if they could have the bath at another time and they told us that they were told it was "already running" so they have it then. Another person discussed drinks and commented that it was cold drinks with lunch. We asked if they could ask for a warm drink at lunch and they told us we must be "joking". There was a risk that routines that were followed to ensure people's needs were met were not flexible because people were not asked if they wanted something different.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's wishes regarding end of life care had been recorded in the front of their care plans. The information described whether they wished to remain at Thistlegate rather than go to hospital. There was evidence that these wishes had been discussed with people's next of kin.

We discussed people's choices with staff and they described how some people were able to choose where they went in the building and whether or not to take part in any activities. They described how they encouraged people to make decisions about things like the clothes they wore as a way of reinforcing decision making skills. They also described how they supported people to retain independence in personal care and eating by encouraging them to use the skills they had. One person went out with a relative and we saw that staff considered their dignity and helped them to wear appropriate clothing for these trips.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on January 2015 we found that improvements required to ensure people received appropriate and safe care had not been sustained. During this inspection we found that care plans were being reviewed but that they did not always reflect people's needs appropriately. We found that weekly activities were now available to some people living in the home.

We spoke with the co-owner and the registered manager about how the service was responsive to people's needs. The registered manager told us: "We are here 24 hours a day." The co-owner described how care plans were updated stating: "We do that as it happens."

Records did not reflect people's care needs in an accessible manner. All care records had been updated since our last inspection with additional dated comments whilst the original care plans remained on file. This made it difficult for the inspectors to ascertain people's current needs. For example, one person's care plan described them as self-caring and independent in January 2013. Additional information had been included in the following years, over which time the person's needs had changed substantially. The original care plan did not reflect the care required, as the person had developed dementia and was now dependent on staff for all personal care. This put people at risk of receiving inappropriate care because care plans are kept to guide staff on the care and support people need. At Thistlegate House there was a live in co-owner and registered manager and a small staff team who knew people well. This provision could not be guaranteed and care plans should protect people from receiving inappropriate care.

Staff told us they knew the people they cared for well and shared information verbally about changes in their needs. One member of staff explained that when the staff team met at training they all said the same things about people. Another member of staff described how they planned their work to reflect how people were each day. They explained they decided who to support with drinks and food first after they had visited them all.

Staff understood people's care needs as they were generally understood in the home but there were aspects of people's care that had not been assessed appropriately. We asked about a person's mental health needs in response to observations and discussions with the person and staff. The co-owner told us they took medicines because they were "low" and we saw they had been prescribed a medicine that is prescribed for depression. We asked care staff if this person suffered with any mental health conditions and they told us that they didn't. They told us they did not think they were depressed. They also told us that the person didn't enjoy doing things they previously had enjoyed and it was difficult to get them to engage with activities. There was no reference to mental health needs in the person's care plan. The failure to explore how their mental health impacted on them, their daily life and their enjoyment of activities meant the person was at risk of receiving care that did not reflect their mental health needs or promote their well-being.

At our last inspection we found that people were not involved regularly in meaningful activity. At this inspection we found that a member of staff was taking on an increased role in providing an opportunity for activity on a Thursday afternoon. Poetry, stories, singing, chair based exercise and music had been made available to the three people who used the communal areas of the home. The member of staff was committed to finding things that people enjoyed doing. They told us: "I research it myself. They (the co-owner and registered manager) are receptive to ideas." We discussed other plans and they said that they had been talking about introducing music into one person's bedroom a few weeks ago and planned to discuss this further. A person told us they enjoyed the poetry and described the music they enjoyed listening to. Records indicated that this was not available to everyone every Thursday and that people who stayed in their rooms did not have access to regular meaningful activity.

One person had a Deprivation of Liberty Safeguards authorisation in place which had a condition that they experienced more activities. We saw that staff had recorded reading poetry to this person on one afternoon in the month preceding our inspection. The co-owner told us: "We are supposed to stimulate (them) but it doesn't really work." However, a record in the person's care plan stated that: "(Person) appears to be enjoying listening to poems/ stories etc. carried out by carer. A few moments every day spent with (person) has made (person) more alert." There had been an improvement in the availability of meaningful activity but this was not sufficient to promote people's well-being and meet their needs because it was

Requires improvement

Is the service responsive?

predominantly restricted to one day of the week and was not consistently available to people who did not leave their rooms. One member of staff told us: "The care is good, but you don't have the activities."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no complaints recorded since our last inspection. We asked how visitors and people would raise concerns and the co-owner explained that they always speak with relatives so that they feel welcome and able to share concerns. They gave an example of a relative pointing out an environmental hazard and this being dealt with immediately. They told us that they are with people all the time so they would know if they were not happy about something. There was a risk that people would not say if they were unhappy about aspects of their care unless specifically encouraged to do so.

Inadequate

Is the service well-led?

Our findings

At our inspection of January 2015 people were not protected by a robust and safe quality assurance system there was a breach of regulation and we asked the provider to take action. At this inspection we found that the service was not well led because the leadership did not work effectively with other agencies, engage professionally with the regulatory process or objectively review the quality of care people received. During this inspection we found that necessary improvements had not been made.

The leadership structure of the home included the registered manager and co-owner providing day to day staffing cover as well as management oversight of the home. The registered manager chose not to engage with feedback stating that our feedback had no bearing on the report. They also shouted that they would be back to "deal" with "it all" if they heard the co-owner was upset by feedback discussions with us. The co-owner had told the registered manager that they were not upset.

We were concerned about the effectiveness of the registered manager's approach to ensuring quality. They told us that their presence in the home and that of the co-owner was adequate to ensure quality and reiterated this view throughout our discussions and explained a more formalised approach would only be necessary in a much larger home. They asserted that they knew everything that went on in the building. We asked about the maintenance of the home and they told us they had a plan of maintenance but also that the staff made them aware straight away if any work needed doing and then it would be "done in an instant". They explained this further saying: "We are here every day … we put it right - every minute of every day… The whole thing is so open we are constantly walking through the house." We then asked about two specific maintenance issues we had noted during our inspection. There was a small hole in the ceiling of a bedroom into an attic void. This could have put people at additional risk if there was a fire. The registered manager said that this had been left by an electrician "weeks ago" and that the electrician needed to be asked why it is not finished off. We also asked about the lack of hot water in the toilet opposite the lounge which we had seen used by a person who lived in the home. We had asked a member of staff about this on the first day of our inspection. The registered manager told us this was a ladies toilet and they had not been made aware of the lack of hot water. They told us this would be addressed. The system of being available in the home at all times had not led to these maintenance issues being addressed and dealt with in a timely manner. This put people at risk.

People did not receive high quality care that complied with legislation because the registered manager and co-owner did not work positively with external agencies. Requests and requirements made by statutory agencies were not prioritised. We asked how information from other agencies was used to ensure quality. The registered manager told us this information was acted on. We highlighted that they had been told the food fridges were operating outside accepted boundaries at a visit from Environmental Health on 5 August 2015. Records since this visit showed this had not been rectified and other required actions such as cleaning and replacing broken seals had not been undertaken. The registered manager told us that they took it on trust that staff would complete records and did not check these. They told us they used the kitchen too every day and this was a "back stop" to the situation and highlighted that there was no impact as people were not ill. They said the work would be done as Environmental Health would come back. This was not an adequate response and people had been at risk of unnecessary harm. After our inspection we received information following the Environmental Health Officer visit to the home on 25 November 2015. They found these requirements had not been met.

Records were not sufficient to enable the registered manager and co-owner to monitor the regulated activities. Kitchen cleaning records had not been completed since April 2015. The accident and incident book did not reflect care delivery records. We identified three falls that had not been recorded in the accident book. The co-owner told us: "Staff should record accidents in the accident book." The registered manager told us that they took it on trust that all these records were completed. This did not reflect the oversight necessary for the safe management in the home.

We also found that omissions previously identified to the registered manager and co-owner had not been rectified. This included omissions relating to the implementation of the Mental Capacity Act 2005 which had been had been highlighted to the registered manager and co-owner by the local authority in February 2014 and May 2014 and the Care

Inadequate

Is the service well-led?

Quality Commission in January 2015. Out of date staff training and records relating to safe recruitment had also not been rectified following our inspection in January 2015. The failure to address these omissions put people at risk.

Quality assurance was not undertaken in any formal ways and the registered manager explained that they had the experience to determine the method required. However, this informal system was not effective in identifying the issues identified during this inspection or checking on the improvements already identified.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There is a requirement that the Care Quality Commission is notified of the outcome of Deprivation of Liberty Safeguard applications. This had not happened at the time of our inspection; DoLS had been authorised for people living in the home from February 2015.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010.

Checks were made on equipment in the building by external companies and records indicated that these had been carried out. We were unable to see the boiler certificate and asked the registered manager to locate it. They told us they would chase up the engineer who had carried this out and make it available to us. We received this documentation on 26 November 2015.