

J.E.M. Care Limited

Ann Challis

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 22 and 23 August 2017 and was unannounced. We last inspected Ann Challis on 5 April 2016. At that time we rated the service requires improvement overall and found the service was meeting the requirements of the regulations.

At our last inspection we made recommendations in relation to providing a dementia friendly environment, care planning in relation to dementia and strengthening governance processes. We found the provider had acted on these recommendations, but found ongoing shortfalls in the processes to monitor and improve the quality and safety of the service. Improvements had been made to make the home more accessible to people living with dementia and to improve care planning for people living with dementia.

At this inspection we identified three breaches of two of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to keeping accurate records of care, provision of safe care and treatment and good governance. You can see what action we have told the provider to take at the end section of this report. We have also made a recommendation that the provider reviews guidance in relation to implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Ann Challis is a residential care home for women. The service provides care and support to up to 23 older people some of whom are living with dementia. There were 21 people living at the home at the time of our inspection. The home has a secure garden area and communal facilities include two lounges and a dining area that are open plan to one another.

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'. 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.

People told us staff treated them with dignity and respected their privacy. We found staff knew the people living at the home well and they were able to talk in depth to us about people's needs, preferences and social histories. Staff interacted well with people and were quick to act to make sure people were comfy and received the support they needed.

We found records were not always kept up to date and did not always accurately reflect people's planned care or the care they had received. For example, records relating to the application of cream medicines had not been completed for several days and one person's records showed they had been administered an antibiotic on one occasion when this was not correct.

Care plans were personalised to people's needs and had been regularly reviewed. However, they were not always up to date and did not always reflect the care people currently received or needed. We found staff

were aware of people's care needs despite this shortfall. However, this would increase the risk of inconsistent care being provided.

Staff assessed risks to people's health and wellbeing, and measures were identified to help reduce the risk of harm occurring. However, risk assessments were not always up to date. In one case we found the use of bed-rails had not been risk assessed to help determine they were safe and appropriate to be used for that person.

Staff received a range of training relevant to their job roles. They told us they received adequate training and support to allow them to meet people's needs effectively. People told us staff supported them to see a health professional such as a GP if they had any health concerns.

Staff had assessed people's capacity to provide consent to their care plans or in relation to other decisions about their care. We saw examples of documented best interests decisions where these were required. However, we found one person who was subject to potentially restrictive practice did not have a recorded best interest decision and the registered manager had not submitted a Deprivation of Liberty Safeguard (DoLS) application.

Staff had worked in a person-centred way to identify activities that might be of interest to people living at the home based on their previous occupation. Some people living at the home had previously been employed as typists or machinists. The home had purchased a typewriter and sewing machine to allow people to use their skills in these areas if they wished to do so.

The registered manager worked 'on-rota' as a member of staff providing direct care and support to people. This meant they had very limited time in which to carry out their management responsibilities, although they told us delegation of tasks helped them manage the service effectively.

A range of audits and quality checks had been undertaken by the registered manager and the provider. However, they had not identified or ensured action was taken in a timely manner to address the concerns we found during the inspection. We found the registered manager took action to make improvements in response to feedback from relevant persons included the Care Quality Commission, local authority and infection control team. However, some of these improvements were not sustained. For example, we found the local authority quality assurance team had identified issues in relation to the completion of cream charts six months prior to our visit and this was an on-going issue at our inspection.

Staff felt well supported by the registered manager. Staff, relatives and people living at the home told us they would feel comfortable approaching the registered manager to raise any concerns they might have.

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 consistently safe.

Risk assessments were not always up to date. The use of bedrails for one person had not been risk assessed.

Medicines were stored and administered safely. However, records of medicines administration were not always complete and accurate.

There were sufficient numbers of staff available to meet people's needs in a timely way. We saw people received support promptly when they required it.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

One person was subject to potentially restrictive practice and there was no recorded best interest decision or DoLS application.

Staff received regular supervision and a range of training relevant to their job roles.

A range of healthcare professionals had been involved in people's care and support. People told us staff contacted GPs or other professionals promptly when required.

Is the service caring?

Good ●

The service was caring.

Staff knew people well and had developed positive relationships with them.

People told us staff supported their independence. Staff were able to provide examples of how they supported people to retain their independence.

People told us the service had a 'homely' feel.

Is the service responsive?

The service was not consistently responsive.

Staff reviewed care plans regularly, but did not always reflect the care people were currently receiving.

A range of activities were offered to people. The service had considered what activities would be of interest to people based on their previous occupations.

People told us they would feel confident raising a complaint. We saw action had been taken in response to verbal complaints raised with the registered manager.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Audits and quality assurance processes had not identified nor addressed the issues we found in a timely way.

The registered manager was afforded only minimal time 'off rota' in which to complete management tasks.

Staff told us they enjoyed their jobs and felt supported by the registered manager.

Requires Improvement ●

Ann Challis

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 checked 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 22 and 23 August 2017 and was unannounced. The inspection team consisted of one adult social care 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.

Prior to the inspection we reviewed information we held about the service. This included any notifications the service had sent us about safeguarding, serious injuries or other significant events that had occurred whilst providing a service. We reviewed any feedback we had received about the service, including any information received via a 'share your experience' form completed on the Care Quality Commission (CQC) website. Since our last inspection we had received one share your experience form, and had received one complaint about the service by phone. We used this information to help plan our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had returned their completed PIR to us in March 2017.

We contacted other stakeholders for feedback on the service. This included the local authority quality and contracts team, Trafford Healthwatch and the infection control modern matron working in the Trafford local authority area. We received feedback from the quality and contracts and infection control modern matron who shared their most recent monitoring visit reports with us. We considered this feedback when planning the inspection and have referenced the findings of these reports in the main body of this report where relevant.

During the inspection we spoke with eight people who were living at the home, and two people's relatives who were visiting at the time of the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk

with us. We spoke with five staff. This included the registered manager, the deputy manager, two care assistants and the cook. We also spoke with a local authority food safety officer who was carrying out a food hygiene inspection on the first day of our inspection.

We looked at records relating to the care people were receiving. This included four care files and care plans, medication administration records (MARs) and daily records of care. We also reviewed records related to the running of a care home, including: three staff personnel files, rotas, training records, supervision records and records of audits and quality assurance checks.

Is the service safe?

Our findings

People told us they felt safe living at Ann Challis. They were confident that staff would provide them with the support they needed and that their belongings were secure. One person told us, "There's no way people can get in. The building is secure and my belongings are safe. They have a safe." A second person said, "I feel very safe because I've been here a long time and everyone is friendly."

We saw medicines were stored securely in a lock medicines trolley or a controlled drugs cabinet if required. Controlled drugs are medicines that are subject to additional legal requirements in relation to their safe storage, administration and destruction due to the risk of their misuse. Medicines that required refrigeration were kept in a lockable fridge and the temperature was checked on a daily basis.

Prior to our inspection, we received feedback from the local authority quality assurance team from their last visit to the home in February 2017. Part of their feedback to the home had been a recommendation to include plans relating to the administration of 'when required' (PRN) medicines in people's care plans. We found the registered manager had acted on this advice and saw evidence of PRN protocols in people's care files. These detailed when staff should administer PRN medicines, and the expected effect of the medicine. This would help ensure these medicines were administered effectively and safely when they were required.

The quality assurance team had also identified shortfalls in the completion of records of the administration of cream medicines. We looked at minutes from staff meetings in April and June 2017 which showed the registered manager had advised staff of the importance of completing these records accurately. However, at this inspection we found staff had not completed any of the cream charts we looked at for three days prior to the inspection. This meant we could not be certain people had received these medicines as prescribed.

We checked the stocks of a sample of medicines and whether the remaining quantities matched with the amount that staff had recorded as being having been administered. In most cases we found the administration of medicines other than cream medicines had been accurately recorded. However, in one instance we found there were two more tablets of an antibiotic remaining than the medication administration record (MAR) indicated should be left. We asked the registered manager to investigate this and they later told us the medicine had not been given on one occasion due to the person being out of the home. Staff had incorrectly recorded that the medicine had been administered on the MAR. We also found one person was prescribed thickening agent to be used in their drinks. Whilst this was noted on the MAR, there was no record that the thickener had been used by staff on either the MAR or another record such as a food and fluid intake chart.

Shortly after our inspection the registered manager requested their pharmacy to carry out an audit of their medicines procedures. They provided us with a copy of the findings of this audit, which did not identify any significant concerns with the way the home was managing medicines. However, the shortfalls we identified in relation to record keeping were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people we spoke with told us there were enough staff on duty to meet people's needs in a timely way. Comments included, "They're there [staff] if you want them", "Usually they come straight away", "[My relative] is safe because there are always people about." One person told us staff were not always on hand to respond as promptly as they should to altercations between two people living at the home. We discussed this with the registered manager who was not aware of any such incidents. We were unable to find any further evidence of any altercations between people at the home at the time of our inspection.

During the inspection we observed that staff responded promptly to people's care needs. The main communal area in the home consisted of two lounges and a dining area that were open plan to one another. We saw staff ensured there was always at least one member of staff present in this area to provide support and assistance to anyone who should need it. Staff members we spoke with told us they found there were always sufficient numbers of staff on duty to allow them to meet people's needs.

Staff were aware of their responsibilities in relation to safeguarding. They were able to describe signs of potential abuse or neglect that they would report to the registered manager or deputy manager. We saw there was a safeguarding flow chart displayed in a staff area, which would help ensure staff were aware of the correct reporting procedures. Staff and the registered manager were able to provide examples of instances when they had been pro-active in identifying and escalating potential safeguarding concerns to the local authority safeguarding team. We saw safeguarding was a regular topic of discussion at staff team meetings, and the registered manager had emphasised that safeguarding was 'everybody's business'. This would help re-enforce the correct reporting procedures and ensure staff remained alert to identifying potential safeguarding issues.

Staff were aware of procedures to follow in the event that someone had an accident such as a fall. We saw staff had completed accidents records and post-incident observations in the event that someone had sustained a fall and remained at the home. This would help ensure any injuries that were not immediately apparent would be recognised and acted upon.

Staff had carried out risk assessments of potential hazards effecting people's health and wellbeing. This included risk assessments relating to mobility, falls, skin integrity and malnutrition. However, we found risk assessments were not always up to date, sufficiently detailed, or did not always reflect the current measures staff were following to keep people safe. For example, one person's risk assessment indicated there should be a door sensor and other sensors in their room to help manage their risk of falls. We checked their room and this equipment was not in place. The registered manager told us these measures were no longer required due to a change in this person's mobility, and bed rails were now in place. However, there was no risk assessment in place to demonstrate staff had considered whether bed rails were safe and suitable for use with this person. The registered manager completed the relevant risk assessment during our inspection, and concluded bed rails were appropriate for this person.

A second person's risk assessments we looked at stated they should be supervised by staff when eating their meals due to a risk of choking. During the inspection we saw there were staff in the communal areas when this person was eating. However they were not always in direct sight of a staff member. We discussed this with the registered manager who told us direct observation by staff was not required, and talked about additional control measures that were in place such as ensuring the person was not seated where they could potentially reach foods of an unsuitable texture. However, this detail was not reflected in the risk assessment. Whilst staff we spoke with were aware of the current risk management strategies, this would increase the likelihood that a consistent approach would not be followed, particularly if new staff or agency staff started working at the service.

Staff had completed personal emergency evacuation plans (PEEPs) for people living at the home. PEEPs provide information on the assistance a person living at the home would require to evacuate in the event of an emergency. However, we found two people's PEEPs were not up to date. One person's PEEP had the wrong room number on it, and a second person's PEEP had not been reviewed following a significant decline in their mobility.

These issues in relation to carrying out suitable and sufficient risk assessment were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that routine servicing and tests required in relation to the safety of the building had been completed. There had been checks at the required intervals of the electrical fixed wiring, gas, lifting equipment (such as hoists), portable electrical appliances and the water system.

Regular tests of the fire alarm and emergency lighting had been carried out, and we saw evidence that fire drills had been recently conducted in May and August 2017. We reviewed the service's fire risk assessment and found this was very basic and consisted of yes/no tick boxes. No issues of concern in relation to fire safety had been identified in the risk assessment. Due to the age of the premises, which had also been extended and altered over time, we were concerned the fire risk assessment was not sufficiently detailed. We discussed this with the registered manager who recognised this, and showed us evidence that they were looking into purchasing a risk assessment carried out by a specialist third party fire risk assessor. Shortly after our inspection the registered manager confirmed the risk assessment had been arranged to take place in October 2017.

During our tour of the building we found window restrictors were of a design that could be over-ridden to allow windows to be fully opened. Guidance issued by the Health and Safety Executive (HSE) recommends that window restrictors should be robust and tamper-proof. We discussed this with the registered manager who told us they did not believe anyone living at the home was at risk of either opening or falling from the windows.

We recommend the service reviews relevant guidance and the safety measures at the home in relation to the prevention of falls from height.

The service had followed robust procedures when recruiting staff to help ensure new workers were of suitable character to work with vulnerable adults. We saw applicants were required to complete an application form and provide a full work history, including an explanation of any gaps in their employment history. Proof of identity had been obtained along with references from previous employers and a health declaration completed by the staff member. Staff had disclosure and barring service (DBS) checks in place as required. DBS checks can provide information on previous convictions and whether an applicant is barred from working with vulnerable people. This helps employers make safer decisions when recruiting staff.

Prior to our inspection we received a copy of the home's most recent infection control audit carried out by the infection control modern matron in May 2017. The home had received a green 'RAG' (red, amber green) rating, with some actions being identified to help the home make further improvements. The registered manager was able to provide us with an updated copy of the infection control action plan, and was able to tell us about the changes that had been made to make improvements to infection prevention and control practices at the home. We saw personal protective equipment (PPE) was available for staff use throughout the home. We spoke with a food safety officer who was carrying out an inspection during our visit. They told us they had not identified any major issues, and the home was later awarded a five 'very good' for their

standards of food hygiene.

Is the service effective?

Our findings

At our last inspection in April 2016 we found there were limited adaptations to make the environment more 'dementia friendly' in order to support people's independence. We found some improvements had been made in this area. The home had introduced pictorial and directional signage to help people find their way around the home. Other adaptations made that would help people orientate around the home and support their independence included the introduction of distinct theming to different rooms, contrasting colour grab rails and people's photos on their bedroom doors. People told us they were able to regularly access the secure garden area. One person told us, "I go in the gardens if it's nice. Get a chair and go and read my paper."

We saw the carpet at the home was old and worn, and was heavily patterned. This has the potential to cause confusion to some people living with dementia who may have impaired visual perception. The registered manager told us they were trying to maintain a homely feel, and people living at the home who were able to participate in a survey also indicated they preferred to have patterned carpet.

People told us the home was kept clean, and this was also our observation during the inspection. One person said, "I like my bedroom. They [the staff] keep it nice and clean." However, along with the worn carpet, we saw much of the furniture in the home was old and worn. For example, chairs were stained and some had ripped fabric on the seat or arm covers. This would also make it difficult to clean these items. The registered manager told us they hoped to replace much of the furniture in the near future.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

The registered manager told us there were nine current DoLS applications that had been submitted to the supervisory body (the local authority) and one of these had been authorised. Staff told us they would always ask for people's consent before providing any care or support. This was confirmed by people we spoke with. One person said, "Staff use 'May I?' They are gentle unrushed and respectful." Staff had a reasonable understanding of MCA and DoLS. They told us if someone was not able to provide consent to care they would act in their best interests. They were also able to provide examples of when people may require a DoLS due to the use of restrictive practices.

We saw people's care files contained capacity assessments in relation to specific decisions such as whether a person could consent to their care plan. Where an individual was identified as lacking capacity, the registered manager had in most cases, completed a best interests decision form to help determine what care should be provided. However, we found one person who was indicated as not having capacity had bed-rails in place. The registered manager told us this person would potentially be able to get up from bed independently, and this was therefore potentially a restrictive practice. However, there was no documented best-interests decision or DoLS application for this person. The registered manager told us they had had previous discussions with this person's family and had agreed it was in this person's best interests to use bed-rails. They completed a best-interests decision form during the inspection. The registered manager told us they had not submitted a DoLS application for this person as they were not actively attempting to leave the home, and this was therefore not a priority application. However, this should not delay an application when one is required.

We recommend the provider reviews and follows guidance in relation to the implementation of the MCA and DoLS.

People told us they were able to get a drink or snack when they wanted, and we saw drinks were offered regularly throughout the day. There were drinks dispensers and cups available to people in the communal areas of the home to allow people who were able to get a drink when they chose. Feedback from people living at the home was generally positive in relation to the meals they were provided. Comments included, "Yes, meals are quite good", "Meals vary, but they're alright" and "They're very good in the kitchen. There's a great variety of food. What I get is very good and there is always two veg."

The mealtimes we observed were relaxed and well organised. People received any help, support and encouragement they required to eat and drink promptly. We saw people were offered a choice of meal and were asked if they had had enough to eat. We visited the kitchen and saw there was a list of people's dietary requirements displayed. This included information on people's weights and any nutritional risk. This would help ensure kitchen staff were able to provide people with appropriate nutritional support.

Records in people's care files showed a range of health professionals had been involved in their care. This included GPs, district nurses, opticians and podiatrists. People told us they were confident staff would arrange for them to see a GP or other health professional promptly in response to any health concerns they had. One relative we spoke with told us, "They [the staff] pick up on health issues quicker than I do. They arranged for a doctor to come out to check [family member's] chest complaint the other week." We saw staff monitored people's weights where a need had been identified. This would help ensure any change in that person's health would be recognised and acted upon.

Training records showed staff had undertaken a range of training relevant to their job roles. This included safeguarding, first aid, MCA and DoLS, nutrition, food hygiene and dementia. We saw staff were in the process of completing additional booklet format training where they had been able to select topics of interest that they felt would be beneficial to improving their practice. We saw staff had selected to complete training in topics including mental health, autism and behaviour that challenges. Staff told us they received sufficient training to enable them to feel competent and confident in meeting the needs of the people they provided support to.

Staff told us they received regular supervision, which they found useful. They also told us they would not hesitate to approach the registered manager for support or advice should they feel this was required. Records of supervisions showed staff had received recent supervision within the last two to three months. We saw supervisions had been used as an opportunity for the registered manager to provide staff with

feedback on their performance, set objectives and identify any areas where further support may be required. One staff member told us, "I do get supervision. It's good. It provides an opportunity to get concerns off your chest. I'm also comfortable approaching [registered manager] with any concerns."

Is the service caring?

Our findings

People told us staff were caring and treated them with respect. Comments included, "I don't think they'd work here if they weren't [kind and caring]", "I like it here, very nice staff" and, "All the staff get on well together and they're fine with all the residents."

People told us they liked that the service had a 'homely' feel. One person commented, "The home's old fashioned and works in an old fashioned way like home... It's an extension to a home. You're still a person here." A relative we spoke with told us, "Overall I'm very happy with the way they [the staff] look after and treat [family member]. The place feels like a real home."

During the inspection we observed positive interactions between staff and people living at the home. Staff were conscious to make sure people were comfy. For example, we saw the sun was in one person's eyes whilst they were eating their meal. Staff quickly noticed this and drew the curtains back for them. At one point in the inspection we saw a person had chosen to get up later, and after most people had finished breakfast. Staff greeted them pleasantly using their first name and said, "What are you having this morning?"

It was apparent that staff had developed positive relationships with people living at the home. Staff were able to talk to us in detail about people's likes, dislikes, interests and preferences. We observed that staff spent time talking with people when they were not engaged in care tasks. People living at the home were comfortable approaching staff to ask for assistance or to start a conversation. When asked if they thought staff were kind and caring one person pointed to a member of care staff and said, "That's a good one." The registered manager told us staff worked long, full day shifts. They told us they had found this helped improve the consistency of care provided to people living at the home.

People told us family and friends were able to visit them freely. One person told us, "I have plenty of visitors. I can see them in the lounge, my bedroom or the dining room." A relative we spoke with said, "I'm made to feel very welcome. I will usually get offered a drink." All the staff we asked told us they would be happy for a family member or loved one to receive care at Ann Challis. We were aware that one staff member had a relative living in the home. They told us they felt staff had a good rapport with relatives, and that having a family member in the home had helped them understand the point of view of relatives better than would otherwise have been possible.

Staff told us they would help maintain people's privacy by knocking on people's doors before entering, closing the door when providing personal care and offering a private room for people to use for any health appointments taking place in the home. People we spoke with confirmed that they felt staff respected their privacy. Staff understood the importance of maintaining confidentiality. One member of care staff told us, "Work stays in work." We saw this message had also been reinforced by the registered manager at a recent team meeting.

People told us staff supported and encouraged them to retain their independence. This included allowing

people the freedom to make their own choices around their routines and care. One relative told us, "They [the staff] would always want [my relative] to do things for themselves." Staff told us they would always encourage people to be involved in their care as far as they were able. One staff member said, "We encourage people to do what they can. For example, [Person] will say they can't do something. But with support and reassurance they can." We saw in one person's care file that it was noted that adapted cutlery had been ordered to help the person continue to eat independently of staff support due to arthritis making it difficult for them to use standard cutlery.

The service produced a monthly newsletter for people living at the home. This provided information on activities, events and people's birthdays. We also saw there was a copy of the home's 'service user guide' in each person's room, which provided information about the home that might be useful for people. The register manager told us there was no-one living at the home who required support from an advocate. However, we saw information about a lay advocacy service was displayed on a noticeboard should anyone want to get in touch with these services.

The registered manager told us they and the deputy manager had completed accredited end of life training. They told us other staff had completed online training in end of life care. We saw people had a 'preferred priorities for care' document in place that detailed their preferences in relation to end of life care. The registered manager told us, and records confirmed that there was regular liaison with other services such as the district nurse service when people were receiving end of life care support.

Is the service responsive?

Our findings

People had care plans in place that provided staff with detail about their health and social care support needs. This included detail about people's life histories, likes, dislikes and preferences. This would help staff understand how to provide people with care in a person centred way. The local authority quality team told us at their last visit in February 2017 they had advised the service to carry out monthly review of care plans and to ensure all sections of care plans reflected the care a person was currently receiving.

We found staff had completed monthly reviews of care plans. However, in some instances we found that care plan reviews detailed changes in people's support that then contradicted the main care plan. This would increase the risk that staff would not follow the most up to date plan of care for people. We also found instances where care plans did not reflect the current support being provided to people. For instance, one person's care plan indicated they were not able to hold a cup and needed a high level of support from staff to eat and drink. The registered manager told us this was no longer the case and this person was now able to eat and drink independently. A second person's care plan stated they had no mental health support needs. However, this contradicted an assessment carried out by that person's last care provider and we saw staff had contacted this person's GP for support in relation to their mental health. A third person's care plan stated that their skin was intact. However, we found this person was having wounds dressed by the district nurse and they required support to reposition in bed hourly. We found there were no records of repositioning. In all cases we found staff were aware of the correct support these people required. However, this was not always reflected clearly in the care plans, which would increase the risk of staff providing inconsistent care.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at what assessment was carried out prior to people moving to live at the home. One person had moved to the home approximately one month prior to the inspection. We were unable to find a record of the pre-admission assessment carried out. The registered manager showed us notes that had been kept in a diary that showed discussion of this person's needs had taken place with the family prior to the person moving to the home. The registered manager told us there was no standard form that was completed as part of the pre-admission assessment. They completed a record summarising that discussions with this person's family had taken place prior to admission.

We recommend the provider reviews their procedures for carrying out and recording pre-admission assessments.

At our last inspection in April 2016 we found people did not always have a support plan in place relating to dementia when this was relevant. We recommended the provider review their processes in relation to dementia care planning. At this inspection we found people's needs in relation to any support they required due to living with dementia were reflected in their care plans. The registered manager also told us the life history tools had been introduced since the last inspection and were another way that helped staff provide

people living with dementia with person centred care.

We received a mixed response when we asked people whether there were enough activities provided to keep them occupied. Comments included, "I like to play cards and watch telly", "We have walks out in the park, or go somewhere in the minibus", "I watch TV and speak to others. There are entertainers, singers, that sort of thing. Sometimes we play cards", "There isn't much going on" and, "There isn't an awful lot [of activities]... been on one trip to a golf range. Very seldom we have games and dancing."

During the inspection we saw staff involved people in activities such as singing, dancing and bingo. We saw people joined in with these activities and were smiling and laughing along with staff. The home employed an activity co-ordinator who had been off work on annual leave. They had left a note on the board by the home's entrance that said, "Hi All, I'm on a week's holiday so no activities from [activity co-ordinator] but all the lovely staff will keep you busy. We have a busy time coming up in September and don't forget our daily newspaper." There was a list of forthcoming activities displayed, which included a tea dance, luncheon, trip to a safari park, and a visit from a brass band.

People were also encouraged to take part in activities they had previously enjoyed or had particular skills in. For example, we saw one person knitting, and a second person was supported to do some drawing. Staff told us some of the ladies living at the home had previously worked as machinists or typists and the home had obtained a type-writer and sewing machine to allow people to undertake these activities if they wished. The registered manager told us some people living at the home had typed up some poems for the resident's newsletter. This showed the home was working in a person centred way to meet people's social support needs.

People we spoke with told us they did not have any complaints, but would feel confident raising any concerns they had with a member of staff. Minutes from the last resident's and relative's meeting recorded that the registered manager had emphasised that people were welcome to provide feedback and raise any concerns they had either at the meeting or outside the meeting directly with the registered manager. We looked at records of complaints and saw three verbal complaints had been raised since our last inspection. The outcome of these complaint and any actions taken to resolve them were recorded in the complaints file.

Is the service well-led?

Our findings

There was a registered manager in post as required by the service's conditions of registration with the Care Quality Commission (CQC). We saw the registered manager was included on the rota as a member of staff providing direct care when they were in. The registered manager confirmed they were not supernumerary when they were on the rota and had no dedicated 'off-rota' time in which to complete management tasks. They told us they generally had two hours between shifts that allowed them to complete certain management tasks.

We expressed concern that this allowed the manager only very limited time in which to manage the service. They told us this concern had been discussed with the directors of the company that own the service and there was ongoing consideration about how best to manage this. The registered manager told us they made effective use of delegation of tasks to the deputy manager and senior carers, which allowed them to run the service effectively. We saw certain audits, such as an audit of accidents and incidents had been delegated to these staff to complete.

Since our last inspection the provider had sent questionnaires to people using the service to gain their opinion on the decoration of the service. The findings had been used to help inform how the décor was updated. There was a suggestions box at the entrance to the home, and the registered manager encouraged people to provide feedback about the service either directly or via resident and relatives meetings. The scope of the formal surveys was limited. However, people we spoke with told us they felt staff listened to them and that they could discuss any matters of concern with the registered manager.

We saw monthly audits were undertaken of medicines and care plans. An infection control audit had been completed in April 2017. An accident audit was completed monthly that would help the registered manager monitor any trends in accidents and incidents that occurred in the service. Regular weekly checks of the kitchen service had also been completed. The provider had also completed regular audits of the service. Each audit focussed on one of the five key questions the CQC asks about services: Is the service Safe, Effective, Caring, Responsive and Well-led?

We saw an action plan had been produced based on the findings of internal and external audits, including feedback from the last CQC report and the local authority's quality monitoring visit feedback. We saw evidence that the registered manager had acted on the feedback received, although the outcome had not always been a successful improvement in the quality of the service. For example, the local authority quality monitoring team identified issues in relation to the completion of cream charts in February 2017. We saw the registered manager had addressed this issue with staff. However, we found this to be an ongoing issue at this inspection six months later.

The audits and checks carried out had also not been sufficiently robust to pick up issues we identified in a timely manner, such as the incorrect recording of a person's antibiotic administration or issues around the completion of care plans and risk assessments. Potential safety issues such as window restrictors that didn't meet current guidance in relation to their design was also unidentified prior to our inspection.

These issues were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems were not operated effectively to ensure the effective monitoring and improvement of the safety and quality of the service.

Staff told us they felt supported and they told us they were comfortable approaching the registered manager with any concerns or suggestions they might have to improve the service. Staff told us they felt appreciated for the work they did, and they said they were happy working for the service. One staff member told us, "I love what I do," and another said, "I think the staff team are very good. We are chatty and sociable and I think that passes onto the ladies."

Services such as Ann Challis are required to send notifications to the CQC about significant events that happen during the course of providing a service. This includes notifications of deaths, safeguarding, DoLS and serious injuries. We found the registered manager had submitted statutory notifications as required. The service was displaying its most recent performance rating of requires improvement on the provider's website and within the home as is a legal requirement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not adequately assessed risks to the health and safety of people using the service. Regulation 12(1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and complete records of care were not consistently maintained. Systems in place to monitor and improve the quality and safety of the service were not effectively implemented. Regulation 17(1)