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Ashmeadows

Inspection report

Moorbottom
Cleckheaton
West Yorkshire
BD19 6AD

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15 September 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over two days, on 6 and 15 September 2016. The inspection was unannounced on both days. The last inspection was done in December 2015 and there were six breaches of regulations identified at that time, which meant the service was in special measures. Some improvements had been made to meet the requirements, but not enough, and we identified continued breaches at this inspection.

Ashmeadows is a small care home that was formerly the local vicarage, situated next to the local church. It has capacity to accommodate 17 people in 13 single rooms and two shared rooms. There were 16 people living in the home at the time of the inspection.

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.

The home had a friendly atmosphere and people told us they were happy and content, but we found continued concerns in the quality of the service and although there had been some progress made since the last inspection, this was limited.

Staffing levels were poor. This was raised at the last inspection and had not been addressed and there were not enough staff to meet people's needs. The suitability checks for new staff were not thoroughly carried out and some staff were not adequately trained or supported to carry out their role safely.

Not all staff had sufficient knowledge of safeguarding and we had not been notified of significant events.

Medicines were managed safely although the recording was not always clear enough to avoid mistakes being made.

There were some very strong odours in the home and there were poor procedures to prevent the risks from legionella.

Risks were not all assessed thoroughly, mitigated or monitored to ensure people's safety.

We found there was a lack of understanding of the legislation around people's mental capacity and we saw there was restrictive practice in place which meant the provider did not always act in accordance with the Mental Capacity Act 2005 or the Human Rights Act.

Staff had a kind and caring approach on the whole and people's dignity and independence was promoted well. Relationships between staff and people were mostly supportive.

People enjoyed the meals and food was well presented and appetising. Mealtimes were sociable occasions and people were offered appropriate regular support and encouragement to eat and drink, although weight management audits were not robust.

There was a lack of meaningful activity and people had little to occupy them. Personal care was not in line with people's preferences.

Quality assurance systems were not thoroughly used and audits carried out lacked consistency and rigour.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that although some improvements had been initially made, there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staffing levels were not adequate to meet people's needs and staff were not recruited safely.

Risks were not sufficiently assessed or mitigated to ensure medicines management, premises and equipment were safe and the risk of infection was minimised.

Staff lacked understanding of safeguarding procedures.

Is the service effective?

Inadequate

The service was not effective

Staff training was not sufficient to ensure staff had the necessary skills and abilities to carry out their role.

There was poor understanding of the legislation around people's mental capacity and there was restrictive practice in place which meant the provider did not always act in accordance with the Mental Capacity Act 2005.

People enjoyed the food and had regular opportunities to eat and drink, although systems for monitoring people's weight were not robust where there were concerns.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff had a kind and caring approach and interacted well with people.

People's dignity and privacy was regarded in the daily routine, although staff had not received training in this or in equality and diversity.

Staff involved and included people when they supported them with everyday care tasks.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have enough to do and there were few meaningful activities or opportunities for social interaction.

People's personal care needs were not met in line with their requirements or preferences, such as for bathing and showering.

Complaints were recorded and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was unable to perform their duties because they were required to provide care for people.

Quality assurance systems had been put in place since the last inspection, but were not used consistently or thoroughly to identify, monitor and address action to improve the service.

There had been insufficient improvement made to address breaches at the last inspection.

Ashmeadows

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 6 and 15 September 2016 and was unannounced. There were two adult social care inspectors on both days of the inspection.

We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed a poster to inform people and visitors that we were inspecting the service and inviting them to share their views.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with seven people, two care staff, the cook, the cleaner, the activities coordinator, the registered manager, the operations manager and the provider as well as two visitors.

We looked at care documentation for four people, four recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Inadequate

Is the service safe?

Our findings

People we spoke with said they felt safe at Ashmeadows. One person said, "I can just please myself but I know help is there and that's why I feel safe here". Another person said, "I like it here and I wouldn't be safe if I lived on my own". However, some people said there were not enough staff. One person said: "Don't get me wrong, they're lovely, they're just worked off their feet". Another person said: "It's not good enough, we're kept waiting, that's not right".

Not all staff were aware of how to identify a safeguarding concern and the procedure to follow to ensure people were safe from harm. There had been incidents that had occurred in the home which the Commission was not notified about, some of which were safeguarding matters. We noted from two local authority safeguarding case conferences there were concerns about neglects and acts of omission which were substantiated.

We saw there were improvements to documentation following recommendations made at one of the safeguarding case conferences; staff completed body maps to note any injuries or bruising a person may have. However, the file of safeguarding information shown to us was incomplete as there was missing information from accidents and incidents which should have been recorded as safeguarding matters.

Risks to individual people were not all identified or mitigated. For example, we saw on one person's records they had been provided with a different bed and had subsequently fallen from the bed and sustained a serious injury. However, there had been no risk assessment prior to the person using the bed, in spite of them being a high risk of falls.

Safety in moving and handling was not sufficiently considered. There were three people in the home who required two staff to assist with their moving and handling, yet staff on the rota were not all skilled to do support them.

Where we saw people needed a walking frame to transfer from their chair to a wheelchair, this was used in the lounge area, but not taken to the toilet with people and it was not possible to see how those people would be supported from the wheelchair to the toilet and back again without the necessary equipment.

Personal Emergency Evacuation Plans (PEEPs) were recorded, although there was detail missing for staff to know how to support individuals. For example, one person's PEEP asked 'Do you require assistance to evacuate?' and the response was 'Yes' but there was no other detail. We saw a file of PEEPs located in the dining area, but this was out of date and contained information about people who were no longer resident in the home.

Accidents and incidents were recorded, although significant incidents had not been reported to the Commission. For example, we saw several accident records which showed people had been injured and gone to hospital. We discussed this with the registered manager who said they were not aware such matters needed to be reported to the Commission.

We had concerns at our last inspection about the safety of the premises and equipment. We saw the provider had taken some steps to improve the safety of the premises, such as fitting window restrictors, ensuring the basement and attic areas were free from clutter, clearing the fire escape routes, carrying out fire safety training with staff and upgrading the kitchen. However, we found continued concerns with premises safety. For example, one bathroom upstairs was accessed via a steep step and posed a risk to people with restricted mobility, cognitive or visual impairment. As previously, yellow and black hazard warning tape defined the step but this was worn and the floor surface was rippled. We saw a ceiling hoist had been installed above the step, but staff were unable to tell us if or how this could be used. We saw a note attached to say this equipment had not been checked for safety and as such could not be used.

On the second day of the inspection we saw there was a flood in the basement laundry; this had also occurred at the previous inspection in December 2015. The operations manager told us this was because of a faulty pump, but stated this had only happened on the days of the inspection.

We found a gas inspection record dated May 2016, in which the gas engineer had noted 'concern for safety' as there had been defects in the gas meter. A safety notice had then been issued because a situation had been identified which may have been hazardous. We contacted the gas engineer and were advised that the potential hazard was that of carbon monoxide and the gas meter needed replacement.

We immediately spoke with the provider about this and they told us they had taken no action to replace the meter and they disagreed this was a safety concern. However, the following day the provider installed carbon monoxide detectors in the premises to help mitigate the risk.

Safety documentation showed the passenger lift had some parts that were in need of replacement and although the lift was in operation we found the recommendations by the lift company had been repeatedly made with no evidence of action taken by the provider.

We asked the provider to show us some clear evidence of gas safety in the home and the safety of the passenger lift. We received this information five days after the inspection was completed.

Staff were not robustly recruited to ensure people were cared for by those with the relevant skills to do so. For example, we looked at three staff files and found very little information in the interview notes to show their experience, skills and abilities had been checked. One of the files we reviewed for a new member of staff showed they had no relevant experience and it was not clear how they had been prepared for their role. Where there were gaps in applicants' employment history there was no evidence this had been queried and references for one member of staff were dated after they had started work in the home. Disclosure and Barring Service (DBS) numbers were written in staff files, but there was no evidence to show when these had been obtained or how thorough the checks had been. We spoke with the registered manager who told us they had problems with staff shortages due to high levels of absence and they had interviewed some new care staff. However, they said interviews had been carried out in the dining room during a day when the home was very short staffed and the registered manager was also meant to be caring for people. This meant that neither the interview process or the role of caring for people could be done thoroughly.

Staffing levels in the home were very poor and did not meet the needs of the people living at Ashmeadows. There were 16 people living in the home at the time of the inspection and three of these needed two staff to assist at a time with their moving and handling. Only two staff were deployed at a time, day and night, and this was not sufficient to meet people's needs. One person's care record showed an additional staff member was needed to support them between the hours of 5pm and 8pm, yet we saw from the rotas this was rarely achieved. People had to wait to be assisted and we saw communal areas such as the lounge, were

frequently unattended by staff..
Staff in non-caring roles had to switch roles and become care assistants when there were staff shortages. For example, the registered manager was sometimes the cook, sometimes a care assistant and the cleaner was sometimes a care assistant. This meant their usual roles were not being filled and left a gap in the service delivery.

We found from staff rotas and speaking with staff there were extremely long hours being worked with few, if any, rest days. The registered manager told us this had been particularly a problem during recent weeks, due to staff sickness and holidays. The rotas we looked at showed the registered manager had worked 10 consecutive shifts totalling 98 hours and was scheduled to work four more shifts. One of the care staff had worked 120 hours in 10 consecutive shifts. Whilst staff said they were willing to do this to cover the staff shortages, we had concerns that staff may be too tired to care for people safely. We saw the registered manager was extremely tired and we discussed with the operations manager our concerns about the effectiveness and competence of staff working excessive hours. The operations manager made alternative arrangements to manage the home and arranged for the registered manager to go off duty.

Staff we spoke with agreed the staffing levels were not sufficient to enable people's needs to be properly met and said this was 'stressful at times'. One professional who had visited the home recently told us they were 'very concerned' that staffing levels were so poor and they had observed people waiting for staff attention.

We saw from staff rotas the registered manager was frequently deployed as a care assistant and cook, and the domestic and activities staff were deployed as care assistants. This meant whilst those staff in other roles were doing care tasks their own work was not being done. We asked the operations manager to increase the staffing levels the same day and they told us they contacted an agency to supply additional staff.

Concerns about staffing levels were raised at the last inspection and we found the registered provider had done little to address this matter. Therefore the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18(1) because there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

Staff we spoke with understood their responsibilities with regard to medicines and they knew the procedures to follow to ensure this was done safely. Daily storage temperatures and expiry dates were regularly checked and recorded to ensure the effectiveness of the medicines.

We found medicines were appropriately stored, administered and disposed of and procedures were being followed in line with good practice guidelines. Before people were given their medicines, staff consulted with them and asked if they wanted to take them and discussed whether they had any pain. We saw staff were patient and waited until each person had taken their medicine before moving on to support another person. Details of medicines given were documented on the medicines administration records (MARs).

However, where some people required medicines only when needed (PRN) rather than at set times the protocols for these were inconsistent, not reviewed against people's requirements and sometimes out of date. We saw the MARs for people who had PRN medicine did not correspond with the PRN record. It was unclear from one person's PRN record when glucose should be given for diabetes and we noted the person had unstable blood sugar levels. We queried this with staff and with the visiting nurse who confirmed this should only be given in an emergency. We discussed with the registered manager the documentation around PRN medicines needed to be made much clearer to avoid a mistake being made. We also saw gaps

in the recording of topical creams and not all entries were signed by staff to say the creams were applied or declined.

At the start of the inspection the registered manager told us the home had tested water samples for legionella and these had shown positive. They told us further samples had been sent for testing and the results had not yet come back. We asked the registered manager how the risks were being assessed and managed. The registered manager told us there had been no risk assessment carried out and they were unable to produce any documentation from the water testing company.
We referred our concerns to the local authority environmental health department and an officer went to visit the home after our first day of inspection. When we returned for day two of the inspection, the registered manager told us they had responded to the advice from the environmental health officer and had undertaken some training in relation to legionella. They had increased the hot water temperature from the taps in the home to 50°C to control the risk of legionella. However, this gave us further concerns that there may be a potential scalding risk to some vulnerable people in the home. The registered manager told us and we saw there were risk assessments in people's care plans for the risk of scalding and warning signs near the taps. However, we found the risk assessments were not specific to each person and control measures stated that staff should supervise people when using the hot water taps. As we already had identified staffing levels were inadequate, this meant the risk assessment could not be implemented safely.

On the second day of the inspection, the cooker and one of the boilers were not working and there was no hot water in the home. The operations manager told us the boiler would be repaired the same day and later provided evidence this had been done. However, there had been no hot water for staff to wash their hands. We spoke with the cook who said they were using the water from the kitchen water boiler for hygienic food preparation. We found the hand sanitiser dispensers and some soap dispensers were empty, which compromised infection control measures.

Some areas in the home had strong offensive odours, such as sanitary waste bins and some bathroom areas. There were two bathrooms on the first floor. As at the last inspection, one of the bathrooms was a designated sluicing area but we saw from assisted seating round the toilet, this was also in use as a bathroom by some people. The other bathroom contained a sanitary waste bin but this had a broken lid and was particularly odorous. We saw from the staff rotas that at weekends there were no cleaning staff on duty. We referred our concerns about cleanliness control to the infection prevention and control team.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(a)(b)(d)(e)(g)(h) because risks were not sufficiently assessed or mitigated to ensure medicines management, premises and equipment were safe and the risk of infection was minimised.

Staff had access to a suitable supply of personal protective equipment (PPE) and we saw this was used appropriately. When the cleaning staff member was involved in cleaning duties, we found they understood their role and what was involved in minimising the risk of infection.

Inadequate

Is the service effective?

Our findings

People told us staff were able to do their jobs properly. One person said: "They [the staff] do a good job, I know they do. Even when they're short-handed they don't cut corners with me". Another person said: "I don't think I'd know if they had any training, that's not for me to know". Another person said: "They're not bad at their jobs, well that's just what I think anyway".

New staff had an induction checklist in their file but this did not evidence how thoroughly they were prepared for their role. For example, we saw one member of staff had been employed with no previous experience or training, their start date was recorded before their induction date which meant they were not adequately inducted into their role. The induction checklist in two staff files we saw was shown to have been completed in one day.

We found staff had completed training in managing medicines since the last inspection and the registered manager checked staff competency in this area. Staff we spoke with said they felt they had appropriate support for training to support them to care for people. One member of staff we spoke with told us they 'may need to raise their voice' when working with people. We saw this member of staff speak loudly and with little patience with one person, which showed a lack of understanding of the person's needs. The person told us they had not had training in challenging behaviour. We discussed this with the operations manager and the registered manager.

Staff training was not all completed to ensure people were cared for by those with suitable skills to do so. We saw from staff rotas that out of 42 shifts we sampled, there were 33 shifts that did not have staff trained in first aid on duty. The registered manager told us there were three staff who had current first aid knowledge but due to high levels of absence it was not possible to ensure they were deployed or available. We saw staff were not all trained in moving and handling. On one occasion the rota showed the registered manager and the cleaner were the only staff on duty, yet neither of them had up to date moving and handling competency. There were three people in the home who required two staff to assist with their moving and handling but they were not always supported effectively.

Records showed the registered manager had carried out competency checks of some staff's moving and handling practice, however, their own moving and handling training was out of date.

We saw evidence some staff had engaged in supervision meetings with the registered manager and staff we spoke with said they had regular supervision to support them in their work, although these had not been possible during recent weeks due to staff shortages and the registered manager covering care tasks.

Staff we spoke with said they felt the registered manager supported them in their work by being involved in people's care. The registered manager told us they enjoyed being involved in care, but this meant their manager's role was not being fulfilled.

Concerns about staffing were raised at the last inspection and we found the provider had done little to address this matter. Therefore the provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18(1)(2)(a) because staff were not appropriately trained or supported to enable them to effectively carry out their duties.

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). The registered manager told us two people had authorised DoLS in place and there were a further five requests made. We did not see any evidence the registered manager had queried the progress of DoLS applications with the local authority.

We found there was a lack of understanding of the legislation around people's mental capacity and we saw there was restrictive practice in place. For example, we saw the communications book contained a notice for all staff to lock two people's doors at night whilst they were in their rooms. We discussed this with the registered manager who told us that the people's family members had asked for this decision to be made 'for reasons of safety', without any lawful authority to do so, and neither person had given consent for this to happen. This was a significant infringement on these people's human rights. We asked the registered manager what might happen in the emergency event of the need to evacuate the home, should the doors be locked. The registered manager told us staff held a master key along with the medication keys, but there had not been any detailed consideration for the people's rights or safety. The registered manager told us and confirmed by email the practice of locking people in their rooms at night would cease immediately.

We saw some evidence people's wishes were considered, such as if they wished to stay in bed later in the morning. However, on one person's care record it was noted they had requested not to be checked through the night. The person was deemed to have capacity to make decisions for themselves, yet there was a consent form signed by their next of kin. We found a mental capacity assessment in one person's file for a 'specific decision' but this did not state what the decision was. Records were not clear whether people's relatives had lasting power of attorney, even when it was stated they had responsibility for people's finances.

Staff we spoke with had some knowledge of people's mental capacity, although this was not robust and it was clear staff lacked understanding of DoLS, why they were requested and who had authorised safeguards in place. We saw from training records all staff had received training in mental capacity, although there was little evidence through our discussions with staff that this training had been effective.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulations 11(1) because people's care and treatment was not always provided with their consent; and Regulation 13 (4)(5) because the provider did not always act in accordance with the Mental Capacity Act 2005 and Regulation 17 as decisions related to the MCA were not recorded.

People said they enjoyed the meals and we saw the food was well presented and in suitable quantities for people. People were invited to the tables, which were appropriately set and they sat together sociably to eat their meals. Meals were brought to people already plated up and staff reminded people what they had

chosen.

Staff told us there was one person in the home who required one to one support to eat their meal. We spoke with the cook who was very aware of people's individual needs, their likes and dislikes and had a list of people's choices that day. We heard people being asked what they would like to eat. We looked at the menus which were based on a four-week rota and included nutritionally balanced choices. We saw there was a plentiful supply of food stocks, including fresh fruit and vegetables and these were all clearly labelled and dated. We looked at records which showed regular grocery deliveries to the home.

People were offered appropriate support and encouragement to eat and drink and staff gave reminders throughout the day. Staff told us if people were hungry in between mealtimes, provision was made to offer a range of snacks according to people's choice. We saw jugs of juice with the day's date written on the jug and this was readily available and replenished as well as hot drinks on the tea trolley which staff brought round.

One person said: "I've not been here long but the food is very good". Another person said: "I always enjoy my dinners, they make nice meals here".
The registered manager knew the nutritional risks for people and identified who had been referred to the speech and language therapy team (SALT) or dietician. The senior care staff was not aware of any of the people who had lost weight, although one person had significantly lost weight.

We saw on people's care records, people's dietary preferences were detailed and staff noted when a person lost weight along with the possible explanations for this. For example, records showed where one person had cut out sugar from their diet, their weight reduced. Where weight loss was identified it was not always clear what action had been taken and risks were not made clear in care records. For example, one person had no recorded weight since 22/08/2016 despite losing weight and their care plan stated 'no risks identified at this time'. Another person's care record stated on 24/08/2016 'to weigh weekly' yet there was no evidence this had been done.

We looked at the registered manager's weight audit from May to August 2016. Out of 17 people, we found 12 had steadily lost weight, three had gained weight and two had stayed the same. It was not clear from the audit what action was taken in relation to people's gradual weight loss, although on some people's care records we saw appropriate referrals had been made to dieticians and GPs. Food and fluid was recorded for people although there was no evidence of any analysis of the information.

Other professionals had been consulted about people's care and health needs and we spoke with one visiting nurse who said the staff were proactive in contacting them with any concerns and receptive to advice given. Staff we spoke with told us they would be able to identify areas of health concern, such as pressure care concerns and would involve the district nurse without delay. In people's care records we saw where staff had identified concerns, such as infections or the need for dental care and followed this through so people were referred appropriately. We saw people's routine health care appointments were noted in the diary and in their individual care records, such as chiropody appointments, dentist reviews and eye tests.

Requires Improvement

Is the service caring?

Our findings

People said the staff were kind and caring. One person said: "No matter how busy they are it doesn't affect the caring side of things". Another person said: "I feel they care for me well, it's like a family here". One person said: "Everyone looks after us well here". One person told us the service was 'alright and welcoming'. Another person said: "It's small and homely, that's what I like and the staff have a very good attitude".

We saw staff interacted with people in a warm and caring way, with friendly banter used appropriately. One member of staff joked with a person about 'doing the hokey cokey' and they had a laugh together.

There was a good rapport between people and staff on the whole and when people needed additional reassurance staff noticed and supported them with kind words and appropriate touch, such as hand holding. Most staff used smiles, gentle tones of voice and a calm manner when interacting with people, which helped people to feel settled and at ease. However, we saw one member of staff was less patient with some people. The staff member said they used a 'raised voice' at times and we saw this happened when people's behaviour occasionally became challenging for the service.

On day one of the inspection the provider arrived and spent some time in the communal areas with people. We saw they supported staff with tasks to be done and interacted with people, although in a limited way.

People were discreetly informed and consulted when staff supported them with their care, with explanations and choices given, such as whether they wished to sit to the table, which chair they would like to sit in and if they needed help with personal care.

The registered manager and staff showed compassion for the people they cared for. The registered manager told us they knew the people very well and we could see from the quality of their interaction this was so. They told us 'the residents' gave them motivation to work at the home and gave praise for the caring nature of the staff team. All staff we spoke with said they would be happy for their own relative to be cared for at Ashmeadows. One member of staff said: "Caring is brilliant. Staff bend over backwards". One visiting professional told us: "Staff really do care about the people here. It's a small home and it's cosy".

People's privacy and dignity was promoted in the routine of the day and staff encouraged people's independence in everyday tasks. For example, one we spoke with one person who chose to keep their own key to their room and be involved in their own laundry. They told us: "I like to do things for myself as much as I can. Staff know that and they don't interfere".

We saw one person's bedroom was marked as a fire exit route as it had doors at either end, which may have compromised the person's dignity in the event of an emergency evacuation.

Care records detailed people's personal preferences, their cultural and spiritual needs and their social histories. Staff we spoke with said there had been no equality and diversity training and we saw this was not listed on the training matrix.

Requires Improvement

Is the service responsive?

Our findings

People told us they sometimes did not have enough to do. One person said they enjoyed 'anything musical' and the provider mentioned the piano in the conservatory. The person said they had 'never heard it play', but they spoke about the instruments they could play. The person told us: "We make our own entertainment if there's nothing happening". Another person said: "I'm too young to die, I need stuff to do. My family take me out sometimes".

Where people could independently pursue their own activities we found staff supported this by ensuring their resources were available to them, such as for writing or painting. But where people were dependent upon staff for support with activities, this was very limited. We saw the activities staff engaged with people in a memory game and a colouring activity, but their time in the home was brief and did not meet people's individual social needs in a meaningful way. We saw in one person's care record it stated they would like to go out to the town centre and look at the shops, but there was no evidence this happened. The activities list on the wall was out of date.

When staff attended to people's physical care needs they engaged in conversation and it was clear staff knew people well; we heard staff occasionally chatted with people about their local interests and who might be coming to visit them.

We observed the lounge areas were frequently unattended by staff and people sat passively with little interaction or stimulation. On one of the inspection days we saw the television played with the sound off and there was music in another part of the room.

One person told us there were not enough staff to help them to shower daily as they wished to. They said they had a shower every three days and this was not their choice. We looked at this person's care record and sampled some dates which confirmed the person had not been supported to shower daily but at intervals of four days, three days and seven days.

We saw in the staff room there was a list of 'bath days' on which people needed a bath/shower and on which days. This did not relate to people's individual preferences, but the routine of the home and the tasks to be completed. We noted from records only one person had used the bath since March 2016. The registered manager told us they supported one person to use the bath, but said most people preferred the shower. However, it was not clear from people's care records they had been given a choice. One person we spoke with said they would 'love a bath' but said: "It's probably not possible, I don't know".

The home had installed a new call bell system since the last inspection and we saw this was used by people, who told us staff 'tried their best' to respond in a timely way. Staff said this system was much better than the previous one.

We looked at four care records which contained detailed information that was easy to locate. We saw some people had signed their care record and there was evidence of other professionals having been consulted

about people's care and health needs. On some people's records we saw it was stated they gave permission for a [named person of their choice] to read their care plan, but this was not signed or dated by anyone. Daily activity records contained very little information, such as 'watched tv in lounge' and 'spent day in bed'.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 as care was not person centred.

People said they saw the registered manager frequently and they felt able to approach them at any time with any concerns. One person said: "Oh [manager's name] is lovely, always comes to see me and asks how I am, so I'd say if there was something I wasn't happy about".

We saw the complaints record detailed matters that had been raised with the registered manager. One complaint was about the provider not sharing information about the last inspection findings. We saw the registered manager's responses to complaints received and any action taken, such as investigations carried out. However, the response to complaints was not always made with consideration for people's rights and placed the wishes of relatives over the rights of the individual.

Inadequate

Is the service well-led?

Our findings

People said the home was well run and they knew who the registered manager was. One person said: "[Manager's name] is really good, we know they will do a good job". Another person pointed the registered manager out and said: "That's the one who's in charge, over there".

There was a registered manager in post and people, staff and visitors told us they were visible and involved in the service. One visitor said the registered manager knew the people who lived there well and was approachable and available to discuss matters when needed.

Staff told us they saw the provider occasionally and the operations manager more often. They said they had contact numbers for the operations manager if needed. The registered manager said they had support from the operations manager approximately once a fortnight.

We spoke with the registered manager who told us they had been unable to be fully involved in managing the home in recent weeks due to staff shortages and being more involved in the day to day caring tasks for people. They said as a result, some managerial tasks had slipped as they had not had the time to complete any.

We saw there were improved systems implemented following the last inspection for monitoring the quality of the provision. However, we found although the systems in place were initially used following the previous inspection, there was a decline in the detail of information in the following months. Quality assurance systems were not consistently used and there were gaps in the regularity of which audits were carried out by the registered manager. For example, we saw the care plan audit tool had not been updated since April in one person's care file. Daily walkarounds were not done daily as stated; we noted 10 had been completed in June 2016, nine in July and two in August 2016, with none recorded from 2 August 2016.

Where some initial audits had identified areas to improve, such as the dining room audit which highlighted 'redecoration before 30/05/16', this action had been deferred and a note on the audit said 'not done; to be done before 11/09/16'. There were gaps in the records of audits and these did not always show what action had been taken or by whom when matters were identified. Bedroom checks identified issues to be addressed but there was no evidence these had been done. Some matters had been addressed and noted when complete, such as the laundry room monitoring checklist and we saw the provider had been involved in some of the oversight.

Manager weekly handover documentation gave a short overview of matters such as accidents and incidents; hospital admissions; infections; changes to medicines; challenging behaviour; staff sickness; complaints; environment and other relevant information. We saw these were completed in a very brief way from January to July 2016, although there was no recorded information for August 2016. Where hospital admissions had occurred due to accidents there were no statutory referrals made to the Commission. There was no evidence of any accident or incident analysis to identify trends or patterns for individuals or the service.

Some documentation relevant to premises safety checks, such as fire equipment and fire exits, were in place. Policies and procedures were reviewed and care plan review dates were listed in the staff room. However, some safety checks were not carried out consistently. For example, monthly water temperature checks were done in January, March, May and July, not monthly as stated. Bath and shower temperature checks which stated were done weekly were not recorded weekly and the window restrictor weekly checks had not been done since 23 July 2016. Following the environmental health inspection, we noted there were daily water temperature checks carried out.

Documentation relevant to people's care, such as MARs and accident/incidents were filed in an ad hoc way; we found a pile of miscellaneous paperwork in the office and a similar pile of mixed content documents in the staff room. These also included recruitment documentation and there was no evidence of how this information was being managed. We spoke with the registered manager who told us they would make sure they filed the information appropriately, but said they had been unable to complete tasks like this due to being required to care for people during staff shortages.

Handover records showed people's care needs had been discussed in detail between shifts. Staff we spoke with were not informed of the environmental risks identified at the inspection, such as legionella and said they had 'not been told'.

We looked at 10 quality assurance questionnaires which showed there were positive suggestions and compliments received. We found the provider had addressed some issues identified at the last inspection in December 2015, but there were concerns at this inspection that resulted in continued breaches of the regulations. Improvements, where made, had not all been robustly sustained and there was poor oversight of the quality of the service.

The provider was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 as there was a lack of good governance in the service.