A L A Care Limited

Whetstone Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 29 and 30 November 2016. The first day of our visit was unannounced.

At our last inspection on 11 and 12 November 2015 we asked the provider to take action to make improvements in two areas. We asked them to improve practice relating to assessing people's capacity to consent to their care and support and with regard to good governance. At this inspection we found that the provider had not made the necessary improvements. We identified that the provider was in breach of two of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Whetstone Grange provides accommodation for up to 38 people who require personal care and support. There were 28 people using the service at the time of our inspection including people living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not all of the concerns raised at our last inspection had been addressed. These were around assessing people's capacity and the monitoring of the service.

When people were unable to make their own decisions, capacity assessments had not always been carried out and decisions had not always been made for them in consultation with people who knew them well. The staff team involved people in making day to day decisions about their care and support. Staff members we spoke with were aware of their responsibilities under the Mental Capacity Act 2005.

There were systems in place to monitor the service being provided. However, these had not always been effective in identifying shortfalls, particularly within people's care records.

Not everyone we spoke with felt there were always enough staff on duty to meet the needs of the people using the service. Questions were raised as to whether two waking night staff were sufficient to support 28 people when four of those needed the assistance of the two night staff at any one time.

Risks associated with people's care and support had not always been assessed.

People's plans of care did not always reflect the care and support that people needed and staff members did not always follow the instructions contained within them.

People had received their medicines as prescribed. Systems were in place to regularly audit the medicines held and the appropriate records were being kept.

Appropriate checks had been carried out when new members of staff had started working at the service. This was to check that they were suitable and safe.

An induction into the service had been provided for all new staff members and ongoing training was being delivered. This enabled the staff team to provide the care and support that people needed.

People's nutritional and dietary requirements had been assessed and a balanced diet was provided, with a choice of meal at each mealtime. Monitoring records used to monitor people's food and fluid intake did not demonstrate that people received the food and fluids they needed to keep them well.

People were supported to access the healthcare services they needed such as GPs and community nurses.

People told us that the staff team were kind and caring and they treated people with respect. Whilst this was observed, the actions of some staff members meant that people were not always treated in a caring or respectful manner.

The staff members we spoke with felt supported by the registered manager. They explained that they had been provided with the opportunity to meet with them on a one to one basis to discuss their progress. They also told us that there was always someone available for support and advice should they need it.

Staff meetings and meetings for the people using the service had been held. These meetings provided people with the opportunity to be involved in how the service was run.

An activities leader had been employed to provide activities or assist people to enjoy interests or hobbies that were important to them. However, this was only for eight hours a week. When they were not present people spent large amounts of time on their own and without meaningful interactions.

A complaints procedure was in place and people felt that any concern raised would be dealt with to their satisfaction.

Checks had been carried out on the environment and on the equipment used to maintain people's safety and a business continuity plan was in place for emergencies or untoward events.

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.

There were not always enough staff suitably deployed at night to meet people's needs.

People felt safe living at Whetstone Grange and the staff team knew what to do to keep people safe from harm.

Risks associated with people's care and support had not always been assessed.

An effective recruitment process was being followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's plans of care did not always show that decisions had been made for them in their best interest or in consultation with others.

A balanced and varied diet was provided. Records relating to nutrition and hydration were not always accurately completed and did not demonstrate that people received the food and fluids they needed to keep them well.

People were supported to access healthcare services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The actions of some staff members meant that people were not always supported in a caring way.

People told us the staff team were kind and caring.

The staff team understood the needs of the people they were supporting.

People were offered choices on a daily basis and were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's plans of care did not always reflect the care and support they needed.

The staff team did not always follow the instructions within people's plans of care.

People's needs had been assessed to make sure that they could be met.

A complaints process was in place and complaints received had been handled appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Auditing systems were in place to monitor the quality of the service being provided though these did not always identify shortfalls within people's care records.

Staff members we spoke with felt supported by the registered manager.

People were able to share their views of the service provided.

Whetstone Grange

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 the 29 and 30 November 2016. The first day of our visit was unannounced. We returned announced on the second day.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit 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. We reviewed the information within the PIR along with information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law.

We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had any feedback about the service.

At the time of our inspection there were 28 people using the service. We were able to speak with ten people and four relatives of other people using the service. We also spoke with, the registered manager, the deputy manager, seven other members of the staff team and a visiting healthcare professional.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also 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 reviewed a range of records about people's care and how the service was managed. This included seven people's plans of care. We also looked at associated documents including risk assessments and medicine administration records. We looked at records of meetings, three staff recruitment and training files and the quality assurance audits that the senior manager and registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

Risks relating to people's health, welfare and safety had not always been assessed when they had first moved into the service. Whilst it was noted that the risks presented to people who had lived at the service for some time had been assessed, this was not the case for people who had recently moved in. This meant that the risks associated with people's care and support had not always been identified, minimised or appropriately managed by the staff team. This included the risks associated with assisting people to move which could have resulted in harm to both the person using the service and the staff member assisting them. We did note that the risks associated with one person's care and support had not been reviewed since July 2016. We were told this should be carried out on a monthly basis.

We looked at the maintenance records kept. Regular safety checks had been carried out on the environment and the equipment used for people's care and support. Checks were also being carried out on the hot water in the home to ensure it was safe. We did note that in three people's bedrooms the temperature of the water was recorded between 48 and 49 degrees centigrade. It is recommended by the Health and Safety Executive that to avoid the risk of burns, hot water in people's bedrooms should be around 44 degrees centigrade. There was no evidence that any action had been taken regarding this.

On the day of our visit we found the service to be extremely cold, particularly within the lounge areas. A number of the people using the service required blankets to keep them warm and we noted that the temperature did not improve until around lunch time. We saw in the minutes of a staff meeting held on 12 October 2016 that a staff member had brought up how cold the home was, particularly at night and had suggested doors between the lounges and the conservatory. There was no evidence to show that this suggestion had been taken on board.

During a walk around the home we noted that the carpet on the main stairway was badly stained. We also found a used incontinent pad discarded on the ground floor toilet floor.

Care workers thoughts on the staffing levels at the service varied. Whilst some told us there were, in their opinion, enough staff to meet people's needs, others did not. One care worker told us, "I think there are enough staff on." Another explained, "I don't think there are enough staff on duty now that we have more respite people."

We looked at the staff rota. This showed that there were two waking night staff at night to support the 28 people living at the service. The registered manager explained that there were currently four people who required the assistance of two care workers. This meant there were not enough staff to support those people should they require support at the same time, nor the other people using the service.

We discussed the staffing levels with the registered manager. They acknowledged the issues raised and told us that this would be looked into.

People who were able to speak with us told us they felt safe living at Whetstone Grange. This was because

they felt safe with the staff members who supported them. One person told us, "I've been here six weeks and I feel very safe." Another explained, "I didn't feel safe at first living in such a big house, it made me frightened, but I am ok now." A third told us, "Yes I feel safe here and staff know what they are doing when they move me in the hoist."

Visitors we spoke with agreed that their relatives were safe living at the service. One told us, "I think [relative] is safe here and I think the staff know what they are doing and pop in to see [relative]." Another explained, "[Relative] is as safe here as anywhere, I have never noticed anything of concern."

Staff members we spoke with knew their responsibilities for keeping people safe from harm. They knew the signs to look out for to keep people safe and they knew the procedure they needed to follow if concerns about people's health and safety were identified. This included reporting their concerns to a senior member of staff or the registered manager. One care worker explained, "If you see any concerns, you can tell a senior or the manager, or the director. If you felt that nothing was being done, you could also go to the Care Quality Commission (CQC) or to safeguarding [the local authority safeguarding team]." Another told us, "I would go and see the senior. If it still carried on I'd go and see [registered manager] and speak up because we can't be unsafe." This showed us that people were protected from abuse and avoidable harm because the staff team knew what action to take should they be concerned for someone.

The registered manager and senior staff members we spoke with were also aware of their responsibilities for keeping people safe. They knew the procedures to follow when a safeguarding concern had been raised with them. This included referring it to the relevant safeguarding authorities and CQC. This meant that the local authority, who has responsibility to investigate safeguarding concerns, could investigate further if necessary.

An up to date fire risk assessment was in place and fire drills had taken place, though the last recorded fire drill was March 2016. Staff members we spoke with knew their individual responsibilities in the event of a fire. Personal emergency evacuation plans (PEEPS) had been completed. These plans showed the staff team how each individual must be assisted to safety in the event of an emergency.

A business continuity plan was in place for emergencies or untoward events such as fire or loss of power. This provided the management team with a plan to follow to enable them to continue to deliver a service should these instances ever occur.

We checked the recruitment files for three members of the staff team and found that appropriate recruitment processes had been followed. Previous employment had been explored, references had been collected and a check with the Disclosure and Barring Service (DBS) had been carried out. (A DBS check provided information as to whether someone was fit to work at this service.) This showed us that the provider took the appropriate steps to make sure that only suitable people worked at the service.

People using the service told us that they felt there were, on the whole, enough staff members on duty to meet their care and support needs. One person told us, "I think there is just about enough staff on." Another explained, "Sometimes there isn't enough staff on but they can't help that. Very short at the weekends." A relative we spoke with agreed. They told us, "Perhaps on a Sunday you have to go looking for staff, but apart from that it's ok." We observed the staff team at work and noted that they had little time to stop and chat with people because they were busy completing their daily tasks.

We looked at the way people's medicines had been managed to see if people had received these as prescribed. We saw that they had. There was an electronic medicines administration record system in place

which helped staff to administer medicines as prescribed. The records seen included a photograph of the person using the service and these were completed to show that medicines were administered regularly. The medicine trolley was secured when not in use. The temperature of the room and fridge used for storing medicines was checked daily and was within required limits.

We observed a senior care worker during their medicine round. They had a good understanding of people's individual needs, they offered water to each person, they were unhurried and offered reassurance where required.

Protocols were in place for medicines prescribed 'as and when required'. This included pain relief for when a person was in pain and medicine to be taken when a person became anxious. These protocols informed the reader what these medicines were for, how often they should be offered and the process to be followed. We did note for one person, the protocol stated 'ensure [person using the service] ABC chart is completed and attempt other options before giving the medicine.' This person had received their 'as and when required' medicine six times between October 2016 and November 2016. No ABC charts had been completed and the reason for giving this medicine had not been recorded in their records. This meant that the staff team could not demonstrate that they had followed the instructions within the protocol.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that the registered person had not protected people against the risk of receiving care and treatment without their consent or in line with the Mental Capacity Act (MCA) 2005. The MCA is a law that protects people who do not have mental capacity to give consent. We found this to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us the actions they would take to address this. These included training the staff team in MCA and improving their documentation.

At this inspection we looked to see that decisions about people's daily lives had been completed in line with the Mental Capacity Act. We found that sometimes they had, whilst other times they had not. 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 make decisions 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 DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

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 had made applications for DoLS authorisations in respect of people who lacked mental capacity to make their own decisions about their care and support. At the time of our visit there was one authorised DoLS in place. We found that this person was being supported in line with the authorisation.

We did note that mental capacity assessments had not always been carried out when people had been assessed as lacking the capacity to make a decision about their care or support. For example, one person was receiving their medicines covertly in their food. A letter had been received from their GP stating that this would be in their best interest. However, the registered manager had not carried out their own assessment or consulted with other people, such as family members to make sure that it was in the person's best interest for their medicine to be given in this way. Another person had repeatedly refused personal care and repeatedly refused to take their medicine. There was some suspicion that this person lacked the capacity to make these decisions but capacity assessments had not been carried out to determine this. There was no documented evidence to suggest that best interest decisions had been made. The registered manager told us that assessments would be completed in the future to ensure they were working in line with people's best interests.

We found that the registered person had not protected people against the risk of receiving care and treatment without their consent or in line with the Mental Capacity Act (MCA) 2005. We found this to be a

continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members had received training on MCA and DoLS and those we spoke with during our visit understood its principles. One care worker told us, "It is to protect people who can't make decisions for themselves; it's about making decisions in their best interest."

People who were able to speak with us told us that they were looked after well and they felt that the staff team had the skills to meet their individual care and support needs. One person told us, "Yes the staff look after me well." Another explained, "My treatment has always been good." Relatives we spoke with agreed with what they told us. One relative told us, "I feel [relative] is getting the care she needs. The staff are trained and are very patient."

The registered manager explained that staff members had been provided with an induction into the service when they had first started work and relevant training had been completed. Staff members we spoke with and the training records we looked at confirmed this. One care worker explained, "I had dementia training yesterday and first aid last week. There's plenty of training." Another told us, "I had an induction and I shadowed and had all my training like dementia training, first aid, COSSH and equality and diversity."

Although staff training had been provided we did not always see this being put into practice. This included moving and handling training.

Staff members we spoke with told us that the registered manager was supportive and available if they needed help or advice. One staff member told us, "I do feel supported and I feel I can talk to [registered manager]."

We saw that whenever possible, people who were assumed to have capacity had been involved in making day to day decisions about their care and support. We observed the staff team offering choices and supporting people to make decisions about their care throughout the day. One of the people using the service told us, "You can choose what to do, whether to join in the activity and what to eat at mealtimes." A member of staff told us, "I always offer choices, people might not have capacity but they can still make choices. There are two choices at mealtimes and I like to open the wardrobe and say, 'what would you like to wear today'."

Monitoring charts to document people's food and fluid intake were used for those people assessed to be at risk of dehydration or malnutrition. However when we looked at the records belonging to five people, we found that these had not been completed consistently. For example one person's food and fluid chart showed us that they were provided with no food or fluids on the 21 November 2016 and nothing until 2pm on 22 November 2016 when they were given a cup of tea and a biscuit. Another person's chart showed that they had received a cup of tea and biscuits between 8pm and 10pm on 21 November 2016 but nothing else had been offered until between 2pm and 4pm the following day. These charts did not demonstrate that the people were receiving the food and fluids they needed to keep them well. This meant that effective monitoring of people's food and fluid intake could not be carried out.

People using the service told us the meals served at Whetstone Grange were on the whole good. One person told us, "The food is quite good really, you have a nice choice and I can't see what there is to grumble about." Another explained, "Well to me it's very bland, they don't use salt and you know why they don't use salt. But you do have a choice." A third told us, "I think the food is great, reasonable, I think you could have something else if you didn't like what was on the menu."

Menus were devised on a four weekly cycle and provided a variety of meals and choices. The menu for the day was displayed for people's information, though it was noted that this was rather small and difficult to read. The cook had access to information about people's dietary needs. They were knowledgeable about the requirements for people who required a soft or fork mashable diet and for people with diabetes. One of the people using the service told us that they were vegetarian. They told us, "Food is great, I am a vegetarian but if they haven't got anything on the menu they tell me I can have two puddings and some fruit." We discussed this with the registered manager and the cook who explained that vegetarian options were available and they had visited the person we spoke with who had shared their preferences with them.

People's lunch time experience varied. Whilst some people were supported appropriately, others were not. There was little interaction between the people using the service and the staff members serving their meals. One person was being supported by a member of the staff team when another staff member came into the dining room asking for assistance. The staff member left the table without explaining to the person they were supporting that they were leaving. They returned to the dining room 15 minutes later. They picked up the persons meal from the table and took it to the kitchen asking the cook to warm it up. They did not speak directly to the person. The staff member then sat back down next to the person but said, "No it's too hot." So they assisted them with a drink. Fifteen minutes later they recommenced supporting the person with their meal, again with little interaction.

A number of people received their meals in their bedroom. Meals were taken to people's bedrooms uncovered. This meant they were not protected or kept warm. We observed one staff member deliver a meal to a person who was in bed. The staff member placed the tray on a set of drawers and summoned another member of staff to assist them in getting the person in a position in which they could eat their meal. This took some time. Once in a suitable position they were supported with their food. This had been sat on their chest of drawers for a considerable length of time and no attempt was made to re-heat it.

At 1.40pm, an hour and ten minutes after lunch was served we visited a person in their room to enquire as to whether they had had their lunch, they told us no. They also told us that they had not had a drink since returning to their room at 10am. We enquired at the kitchen and they had not realised the person had not received their meal. The kitchen staff enquired with a staff member who also hadn't realised that the person had not received their meal. A meal was reheated and taken to the person's room, uncovered. On arrival the staff member noticed there was no table to place the food on and went to find one. The table she returned with had only one locking device working and said to the person, "Just be careful." The meal was placed on the table in front of the person with a cold drink. No choice of hot or cold drink was offered. The meal served appeared dry and unappetising and the majority of the meal was left uneaten.

People had access to the relevant health professionals such as GP's, chiropodists and community nurses. This was evidenced through talking to them and their relatives and checking their records. One person told us, "Yes I can ask the staff to make me an appointment to see the doctor." Another explained, "Yes you can see a doctor, I can look after my nails though, so I don't see a chiropodist."

Requires Improvement

Is the service caring?

Our findings

During our visit a member of the staff team did not show respect to the people using the service. We observed them march into the dining room, where people were sitting and swear loudly, which was loud enough to be heard. We shared this with the registered manager who immediately acted on this.

We observed support being provided throughout our visit. The majority of the time the staff team showed a good understanding of people's needs. We saw examples of staff supporting people in a caring manner. This included reassuring one person when they became anxious and supporting another person to use the bathroom in a discreet manner.

However, we also saw a number of exceptions to this. For example, one person who was cared for in bed was assisted to change their position. The staff member proceeded to raise the head of the bed but stopped realising the person was on their side. The staff member said they would have to get another member of staff to help move them. Two staff members returned and proceeded to carry out the move. One staff member said we need the slide sheet and went to find one. At this point the person did not have the warm quilt covering her and although had a nightgown on was exposed to the cold. The staff member returned with the slide sheet and made several attempts to place the sheet under the person using a variety of folds and rolls. In the end they managed to achieve the turn but failed to explain to the person when the final move was to take place which ended in the person expressing distress. The staff member apologised and reassured them, making sure they were comfortable. This showed us that the staff members did not put their moving and handling training into practice.

One person was seen walking around the service and throughout the morning wandered in and out of the dining room. At times they seemed to become quite distressed. Staff offered reassurance as they were going about their duties with other people. Staff members distracted them with a hot drink which seemed to calm them but this person seemed to require more engagement and interaction from the staff team than she received.

We visited one of the people using the service who had just been placed back into bed following their breakfast. They were feeling very anxious and we observed excellent caring interactions from a staff member who tried to reassure them. However, when we looked around their room we noted that it was very basic. There was no television or radio to stimulate them or to detract their thoughts when they were feeling anxious. We were told that they could drink independently but there was no bedside table where drinks could be placed and there was no easy chair where they could sit when out of bed. We discussed this with the registered manager who acknowledged this and told us that this would be addressed.

For people who were unable to move around independently, assistance was provided by the staff team with the support of a hoist. We noted that whilst the majority of the staff team explained what they were doing and put the people they were supporting at ease, others did not, with little interaction being noted. For example, we observed one person asking a staff member if they could move them from the lounge chair into their electric chair. The staff members brought the hoist and attached the person's personal sling on to the

hoist. They checked it was attached safely and talked to them, checking their legs and arms were safely out of the way. However, on another occasion we observed two staff members transfer a person from a chair into a wheelchair. The person was quite distressed and the staff members reassured them, but once the move started the staff members spoke to one another and lost focus of how the person was feeling, thus allowing them to become more distressed.

We noted that one of the people using the service had very dirty finger nails. We brought this to the attention of the registered manager who organised a member of staff to attend to them. The staff member who had assisted the person that morning had failed to notice what we saw.

People who were able to talk with us told us the staff team were kind and caring and they treated them in a respectful way. One person told us, "Yes the staff are really brilliant, defiantly show respect and dignity. The staff have to care for a few grumpy residents but they still remain caring." Another told us, "Privacy and dignity is good they always draw the curtains, they are very kind and considerate."

Relatives we spoke with agreed with what they told us. One relative explained, "The staff are kind, they look after [relative] really well." Another explained, "We are always made welcome, the staff are always friendly and kind."

We saw the staff team respecting people's privacy and they gave us examples of how they ensured people's privacy and dignity was respected. One staff member explained, "When I am assisting someone to the toilet I always close the door. When I am helping someone with personal care I always explain what I'm doing." Another told us, "I close the curtains and doors when helping people and if they don't want me in the room, I will stand outside."

People using the service had whenever possible been involved in making day to day decisions about their care and support. One person told us, "Yes we are able to make choices; I get fed up with everybody after my tea so I go up to my room and sit with the radio on." A staff member told us, "We give people choices all the time, people can decide what to eat and what to wear and [person using the service] chooses to stay in their bedroom."

For people who were unable to make decisions about their care, either by themselves or with the support of a family member, advocacy services were made available. This meant that people had access to someone who could support them and speak up on their behalf.

Relatives told us that there were no restrictions on visiting times and they were always made welcome by the staff team. One relative told us, "We can visit anytime and we are always made welcome." One of the people using the service told us, "Visitors can come whenever."

Requires Improvement

Is the service responsive?

Our findings

Whilst some of the people who were able to speak with us told us that they had been involved in planning their care when they had first arrived at the service, others told us they had not. One person explained, "I've not been involved in any care plan but if you don't like how they are doing things you tell them." Another told us, "I have been involved in my care plan, things won't be put right unless you tell them." One of the visitors we spoke with shared that they had not yet been involved in the planning of their relative's care.

The registered manager explained that people's care and support needs were always assessed prior to them moving into the service. The exception to this was if the person was moving in as an emergency placement for example, on discharge from hospital. When this was the case their needs were assessed on arrival at the service. People's records we looked at did not always reflect that their care and support needs had been thoroughly assessed.

We looked at seven plans of care, two of which belonged to people who were staying at the service on a respite basis (short term). This was to determine whether they reflected the care and support that people were receiving. We found that some care plans were comprehensive whilst others were very basic. Through checking these records we identified that the staff team had not always followed the directions recorded within them. For example, one person had been identified at risk of their skin breaking down. Their plan of care stated that they must be seated on a pressure relieving cushion at all times. On the day of our visit we found them sat without their cushion. They did not start to use this until 11.30am.

One person's plan of care stated, 'Repositioning is very important for the prevention of pressure sores and skin tears'. Staff were directed to reposition this person when in bed, every four hours in the day and every two hours at night. When we checked the repositioning charts it was evident that these did not demonstrate that these directions had been followed. On 3 November 2016 the charts showed that the person had been hoisted to bed at 3pm, at 4pm they had been repositioned from their left side to their right side and at 7.30pm they had been tilted. There were no further entries to say that they had been repositioned either during the rest of that evening or through the night. On the 11 November 2016 the person had been helped out of bed at lunch time and then assisted back to bed at 1.30pm. There was no evidence to demonstrate that they had been repositioned at all after this time until 8am on 12 November 2016.

Two people had been identified at risk of losing weight and their plans of care stated that they were to be weighed and monitored on a weekly basis. Both of these people's records showed that they had last been weighed, one on the 18 September 2016 and the second on 19 September 2016. This meant that the staff team had not monitored these people's weight as directed in their plan of care.

The plans of care for two people who were on a respite stay were very basic in content. They did not include the people's personal preferences or the tasks the staff members were required to carry out to meet their individual care and support needs. Only one had a moving and handling risk assessment completed even though both required one.

The personal care and physical wellbeing plan included in another person's plan of care stated 'May refuse bath or shower. Will have full body wash daily and independent with personal care needs. Chooses clothing daily. When we checked the personal hygiene charts completed by the staff team these showed that this person had refused all personal care tasks on every day in November with the exception of three days. We saw in their records that their GP had been contacted in August 2016 because concerns were raised regarding their refusal to take their medicines and their agitation. Their GP advised them to record the behaviour and contact their CPN. There was no record that this had taken place. A nutritional screening tool had been completed and this determined that the person was at risk of malnutrition. We saw in their records that on 21 and 22 November 2016, they had eaten little and on the 25 and 26 November 2016, they had refused to both eat and drink. There was nothing in the records to show that this had been acted on.

During our visit we observed the staff team supporting people. It was evident that they were completing the care and support tasks required of them, however because they were so busy, there seemed little time left for them to interact and socialise with the people using the service. People were therefore often left to their own devices in one of the lounges or the dining room.

People were offered opportunities to be involved in activities they enjoyed. The things people liked to do had been explored. An activity coordinator was employed for two hours a day, four days a week and provided both group activities and one to one sessions during this time. On the day of our visit people were making Christmas decorations which from the conversations around the table, people clearly enjoyed. One of the people using the service told us, "It's a very good home but we sit here and do nothing all day and all afternoon, though [activities coordinator] who also works nights comes in to do craft activities which I am enjoying. She is very good. Before her there was absolutely nothing. We could do with more things to do." Another person explained, "I write, read and do quizzes and sometimes I go to the activities, but they don't go on for very long, I don't get bored."

People using the service and their relatives or representatives knew who to talk with if they had a concern of any kind. One person told us, "I would tell the boss if I wasn't happy with anything." Another explained, "I get on well with the boss lady. You could say if you don't like something." There was a formal complaints process for people to follow and this was displayed. When complaints had been received by the registered manager, these had been investigated and acted upon.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that the registered person had not protected people against the risk of receiving care and treatment that was not effectively assessed and monitored. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us the actions they would take to ensure the proper assessing and monitoring of the service. This included introducing daily audits of people's records.

At this inspection we looked at the monitoring systems that were in place. The registered manager had completed a range of audits to monitor the service being provided however, these audits had again not picked up the shortfalls within people's care records that were identified during our visit. These included shortfalls within the completion of food and fluid charts, repositioning charts, people's plan of care documentation and risk assessments. For example, we found that for people who had been assessed as at risk of dehydration and malnutrition, their monitoring charts were not up to date or accurate and did not demonstrate that they had received the food and fluids they needed to keep them well. For people assessed as at risk of developing pressure sores, their repositioning charts were again not up to date or accurate. This meant that there was no evidence to confirm that they had been repositioned to reduce damage to their skin. People who had been identified at risk of losing weight, their weight had not been monitored as directed in their plan of care. People who were at the service for respite, their plans of care did not reflect the care and support they needed and risk assessments had not always been carried out. The records seen did not demonstrate that the people using the service received the care and support they needed to keep them safe and well.

The daily audits that the registered manager had introduced following our last visit did not identify the shortfalls we found. Although the senior staff had signed to state that checks had been made on this paperwork, they had clearly missed the omissions within them.

We found that the registered person was not assessing or monitoring the service effectively to ensure its quality and safety. They were also not keeping accurate and up to date records of people's care and treatment. This was a continued breach of Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Regular checks had been carried out on the environment and on the equipment used to maintain people's safety. We found regular audits had been carried out and up to date records had been maintained.

People who were able to speak with us felt that the service was well managed and the registered manager was approachable. One person explained, "Yes I do think the home is well led they really look after you, I am happy here." Another told us, "Yes I think it is [well led], the manager has been to see me." A relative stated, "It's an excellent place, staff are very good, very caring always helpful. If I had a comment or complaint I would see one of the carers [relative] is always well dressed and clothes washed." Another told us, "It feels very welcoming and friendly when I visit. I would not know who is in charge though and I'm not sure they have my contact number."

Staff members we spoke with told us they felt supported by the registered manager and felt able to speak to them if they had any concerns or suggestions of any kind. One staff member told us, "If you need anything it's done. Management are lovely. You can go and speak to them at any time."

Staff meetings had taken place. These provided the staff team with the opportunity to be involved in how the service was run. Issues discussed at the last team meetings included rotas, training and the needs of the people using the service. Meetings had also been held for the people using the service and their relatives, though we were told that these were not always well attended. Topics discussed at a meeting held in April 2016 included future events such as a fish and chip night, a summer party and a movie night. We were told that these had all taken place.

Surveys had been used to gather people's feedback on the care and support they received. These were being completed on an annual basis. People using the service had been supported to complete surveys in September 2016 and these showed that they were satisfied with the care and support they received. Surveys had also been sent to relatives of the people using the service. The surveys returned also showed that they were satisfied with the care and support their relative received. Comments in the surveys returned included, "Care – excellent, staff – excellent." And, "Much improved since last time with new manager."

The registered manager understood their responsibilities and kept the CQC informed of events at the service, such as deaths, accidents and incidents. This was important because it meant the CQC could monitor the service.

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 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements to obtain the consent of the people using the service in relation to their care and treatment provided in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards were not followed.