Indigo Care Services Limited

Ashbury Court

Inspection report

43 Sea Road
Westgate-on-Sea
Kent
CT8 8QW

Tel: 01843834493

Date of inspection visit:
04 July 2017
06 July 2017

Date of publication:
26 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 4 and 6 July 2017 and was unannounced.

Ashbury Court provides accommodation and personal care for up to 37 older people. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. There were 22 people living at the service at the time of our inspection. The service is situated next door to another care home service run by the same provider. Ashbury Court no longer share staff and management with the other service. The number of people using the service and the complexity of their needs had reduced since our last inspection. No new people had begun using the service since December 2016.

At the last inspection on 30 November and 1 December 2016, we found the service was in breach of six regulations and required the provider to make improvements. The service was rated Inadequate and placed in special measures. The provider sent us information about actions they planned to take to make improvements. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements.

At this inspection we found some of the necessary improvements had been made, however we found continued breaches of regulations and new breaches of three regulations. Further improvements were required in other areas. People told us staff were kind, however we found that people were not always treated with care and respect.

A registered manager was working at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was supported by an operations manager and a deputy manager. The provider's oversight of the service had improved however, they had failed to take action to make sure they and the registered manager had made all the necessary improvements. The registered manager had not monitored staff to make sure they had completed tasks correctly. Shortfalls in the practice of some staff had not been identified so they could be addressed. Other checks, such as checks on the building and equipment had been completed and action had been taken to address any shortfalls.

Staff knew the signs of possible abuse and were confident to raise concerns they had with the registered manager. However, the registered manager had not always taken action to keep people as safe as possible.

Some people had behaviours that may challenge and did not receive consistent support to manage this. Records of behaviours to help staff and health care professionals plan the support people required were

inaccurate. Other records, such as reviews of people's care were not always accurate. Important information, such as letters from people's doctors had been removed from their records and had not been used to plan their care.

Changes in people's health had been recognised and acted on, however there had been a delay in supporting one person to have an injury checked at the hospital. People had been supported to have regular health checks such as eye tests.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people were restricted.

Staff followed the principles of the Mental Capacity Act 2005 (MCA) and supported people to make choices in ways they understood. However, people's capacity to make specific decisions had not been assessed correctly. People who knew people and their wishes well had been included in making decisions in people's best interests.

People, their relatives, staff and health care professionals had been asked for their views of the service. This information had not been used by the registered manager to continually improve the service.

The provider's complaints policy had not been consistently followed. Some people told us they had made complaints but had not received a response to these.

Assessments of people's needs were now completed consistently and reviewed monthly. Some risks to people had not been assessed and mitigated. There continued to be unsafe medicines practice.

Staff had completed training and were supported to meet people's needs including keeping them safe in an emergency. Risks identified in the fire risk assessment had been mitigated.

People told us they had enough to do during the day. They were involved in planning and taking part in a range of activities.

CQC had not been notified of two significant events that had happened at the service. Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. We received the notifications following our inspection.

People no longer had to wait for the care they needed. Sufficient staff were deployed to at all times to meet people's needs. Safe recruitment procedures were followed for most staff. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People had privacy and were able to choose the gender of the staff member who supported them.

People told us they liked the food at the service and were able to choose what was on the menu. Meals were prepared to help keep them as healthy as possible.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where

a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception and on their website.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have 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 continued to be unsafe.

People were at risk of harm and abuse. The registered manager had not acted on some safeguarding incidents.

People did not always receive the medicines they needed.

The providers recruitment system had not been followed consistently to make sure all new staff were suitable to work with people.

Risks to people were not always assessed and managed.

Training had been provided to staff about how to keep people safe in an emergency.

There were enough staff to help people when they needed it.

Is the service effective?

Requires Improvement

The service was more effective but further improvements were needed.

Care had not always been provided quickly to meet people's health care needs.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. However, there was a risk that people would not be supported to make important decisions.

Staff had completed the training they needed to meet people's needs.

People told us they liked the food at the service. Meals were prepared to meet people needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with care and respect.

Staff knew people's likes, dislikes and preferences and information about some people's life before they began to use the service.

Staff gave people privacy.

People were supported to remain independent.

Is the service responsive?

Requires Improvement

The service was more responsive but further improvements were needed.

Assessments of people's needs were now completed. Guidance to staff about how to meet people's needs had improved but further improvements were needed.

People and their relatives had been involved in planning and reviewing their care.

People planned and took part in a range of activities they enjoyed.

People's complaints had not always been investigated.

Is the service well-led?

Inadequate

The service continued not to be well-led.

Checks the management team completed on the quality of the service were not effective. The checks had not found the shortfalls we identified.

Further action was required to obtain the views of a range of health professionals. Views shared by staff had not been acted on to improve staff morale and team work.

Records were not all accurate and up to date.

The provider had not notified CQC of important events as required.

Staff were now clear about their responsibilities.

Ashbury Court

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 4 and 6 July 2017 and was unannounced. 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, 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 looked at notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We reviewed information we had received from people's relatives.

During our inspection we spoke with twelve people living at the service, four people's relatives and friends, a community nurse, a community matron, the registered manager, the deputy manager and the operations manager and staff. We visited some people's bedrooms with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at medicines records and observed people receiving their medicines.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Ashbury Court in November 2016 and the service was rated Inadequate. We found that the provider was in breach of a number of regulations. We served three warning notices and told them to take action to make improvements.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. People's comments included, "I think I feel safe because they treat me as they find me", "I feel safe because there is someone watching me all the time" and "I feel safe because there is always somebody to call". However, we found that people were not always safe at Ashbury Court.

Care staff had received training in safeguarding people from harm and knew how to recognise and report different types of abuse. However, the provider's processes had not been followed consistently to make sure people were always safe. Staff told us they would report any concerns to the registered manager. Before our inspection the registered manager notified us of an allegation one person had made. There had been a delay of several days before staff had informed the registered manager. Other people with safeguarding responsibilities including the operations manager and local authority safeguarding team had not been informed as required by the provider's safeguarding policy so they could keep people as safe as possible. The registered manager took action as soon as they were told about the allegations to reassure the person and reduce the risk of the alleged abuse happening again. The person was happy with the action the registered manager had taken and told us, "It was dealt with".

The operations manager had taken action following the incident to develop staff's skills and reduce the risk of delays in reporting allegations occurring again. However, this had not been effective. We found that the staff had failed to take action when a person had an unexplained bruise, including informing the registered manager and local authority safeguarding team. Staff from another service had noted the bruise and informed the person's care manager.

We identified two occasions when staff had not acted to keep people as safe as possible. Following our inspection the registered manager reported the concerns we found to Kent County Council safeguarding adults team.

The provider had failed to protect people from the risks of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On another occasion staff had notified the registered manager immediately about an allegation of abuse. The registered manager followed the provider's protocols, without delay, to help keep people safe.

At our last inspection in November 2016 the provider had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. We served a warning notice requiring the registered persons to take action by 28 February 2017. At this inspection we found continued shortfalls with the way medicines were managed.

People told us they received their medicines when they needed them. One person told us, "I get my tablets regularly. I have Paracetamol and a different one at night". However, we found that one person had not received medicine to help them remain calm. The medicine had been ordered the day after the person took

the last dose but staff had failed to make sure it was delivered the same day. We observed the person was very anxious and worried. They were extremely restless and could not settle, they were tearful at several points during the day. Staff told us this was because they had not received their medicine the night before. We raised this as a concern and the registered manager made sure the medicine was delivered immediately so the person did not miss another doses.

We spoke with the person on the second day of our inspection. They told us they had taken their medicine the two previous nights and they appeared calm and relaxed. During our inspection the registered manager and operations manager reminded staff of the systems in place to order medicines. Daily management checks were then put in place to identify when stocks of medicines were running low and make sure orders were placed and received promptly.

Some entries on people's medicine administration records were handwritten. Systems had not been put in place since our last inspection to make sure these were checked to reduce the risk of mistakes and people not receiving their medicines as prescribed. Changes to the people's medicines were now recorded and had been followed by staff. At our last inspection entries were 'scribbled' out. It was now clear how much stock of each medicine was held. Records of topical medication administration, such as the application of creams were complete.

The provider had failed to operate proper and safe medicines management processes in relation to the ordering medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed medicines 'when required', such as pain relief and inhalers to help them breathe more easily. Guidance had been provided to staff since the last inspection about the 'when required' medicines each person was prescribed, including how many they could take and the time between each dose. When people required their 'when needed' medicine regularly they were referred to their doctor for a medicines review to check the medicines remained effective.

We observed the medicines trolley was no longer left unlocked when staff were supporting people to take their medicines. Medicines were stored at the correct temperature. Staff followed the provider's policies in relation to spoiled medicines. We observed people receiving their medicines. This was done in a caring and respectful way.

At our last inspection in November 2016 we found that risks to people had not been consistently identified, assessed and reviewed. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe. Risk assessments for some people had not been completed correctly. We served a warning notice requiring the registered persons to take action by 28 February 2017. At this inspection we found that further improvements were needed to make sure all risks were identified, assessed and recorded with actions to mitigate them .

One person had fallen in their room shortly before our inspection. Staff told us the person may have fallen because they had tried to walk without calling for staff assistance. They told us that the person did this regularly and this increased their risk of falling. The person had been offered a bedroom in a busier area of the service so staff could monitor them more closely but they chose to keep the same room. Other options to reduce the risk of the person falling again had not been considered.

The person's mobility had been assessed and they were able to 'walk well with tripod and assistance of one staff member'. The person was able to use the call bell to summon staff when they needed support. On the

second day of our inspection the operations manager confirmed that they had discussed the risk with the person. The person had agreed to have sensor mats in their room to alert staff when they stood up. These had been ordered and were due to be delivered and fitted the following day.

The provider had failed to assess and mitigate risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had now been completed to identify the support people needed to move safely. New hoist slings had been purchased and each person had slings to meet their needs. Guidance was available to staff about which sling to use for each move. We observed one person in the lounge being moved safely by staff. The person told us they always felt safe when staff moved them using the hoist.

Risks to peoples' skin health, such as the development of pressure ulcers, had been assessed. Staff followed guidance in people's care plans about to use equipment to support people to keep their skin healthy. This included the type of equipment each person used and the setting required. We observed that people's equipment was being used as planned and no one had a pressure ulcer. Daily checks were completed to make sure that equipment was used correctly.

Checks had been completed on new staff to make sure they were honest, trustworthy and reliable, including police background checks. Information had been obtained about staff's conduct in their last employment and their employment history, including gaps in employment. The provider's recruitment policy did not require candidate's to provide information about their health to make sure they were fit to perform their role. However, registered manager had requested information about candidate's health to help them make recruitment decisions. Action had been taken to improve staff's performance where it fell below the required standard

We recommend that the provider review their recruitment procedures in line with Schedule 3 and regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) 2014, to ensure they know staff are fit to perform the role they are employed to carry out.'

All accidents were now being recorded and the registered manager reviewed and analysed them each month to look for any trends or patterns. Action had been taken to prevent accidents happening again. For example, the falls analysis had identified that one person had fallen a couple of times in one month times. The registered manager found this was because they were not wearing supportive shoes. A falls risk assessment had been completed and discussed this with the person. They had agreed to wear more supportive shoes and had not fallen again.

Actions required following the March 2016 fire risk assessment had been completed. Emergency evacuation equipment was available and staff had been trained to use it. They told us they now felt confident to use the equipment to support people to evacuate from the first and second floors in an emergency.

People's personal emergency evacuation plans (PEEPs) had been reviewed and updated to include the equipment needed to support them to evacuate. They included guidance to staff about how to move people to keep them safe in an emergency. Following our last inspection the local Fire and Rescue Service visited the service and provided advice which the provider and registered manager had acted on. Regular tests were carried out on fire safety equipment.

At our last inspection we found that sufficient numbers of staff had not been deployed at all times to meet people's needs. We told the provider to take action. During this inspection people we told us there were

enough staff to meet their needs and they were not rushed. One person told us, "I'm quite slow but they don't rush me". Other people told us staff usually responded quickly when they asked for assistance. We observed that people did not wait for the support they needed and call bells were answered promptly.

The registered manager used a dependency assessment to decide how many staff were needed to meet people's needs. The number of people using the service had reduced since our last inspection and new permanent staff had been employed to fill the vacancies previously covered by agency staff. The registered manager had plans in place to make sure they were sufficient staff available to meet people's needs when new people began to be admitted to the service, including recruiting additional staff. There were no staff vacancies at the time of our inspection. People told us, "Sometimes we have agency staff but I can't get on with them like I can my own staff" and "One or two have left but the good ones have stayed".

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the registered person's had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. We told the provider to take action.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At this inspection we found that staff had completed training in MCA and followed the principles. Some guidance had been provided to staff in people's care records about how to support people to make day to day decisions. For example, one person's capacity assessment instructed staff to support the person to decide what they wanted to eat by showing them plates of food. We observed staff offering people choices in ways they understood, such as showing them items to choose between. Another person's communication care plan instructed staff to 'allow [person's name] to find the words they need.'

The provider's process to assess people's capacity to make particular decisions continued to be completed incorrectly. For example, one person had been assessed as not being able to make decisions in relation to 'third party treatment including chiropody, hairdressing, optician and dentist'. Staff told us the person was able to make decisions about visiting the hairdresser without support. They also told us that decisions regarding dental treatment were not required at that time. There continued to be a risk that people would not be supported to make important decisions.

The registered persons had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people were not able to make a decision, decisions were made in their best interests by people who knew them well, including staff, their relatives and health care professionals. These meetings had not been recorded as the provider's policy required but other records had been kept. The registered manager and provider agreed this was an area for improvement.

No one was the subject of a DoLS authorisation at the time of our inspection. Applications had been made to the local authority for some people and they were waiting for assessments. The registered manager knew who was waiting for an assessment and when the application had been submitted. Staff made sure

restrictions to people's liberty were minimised, including supporting people to go out and move freely around the service.

At our last inspection we found that care had not been provided to keep people as healthy as possible. We asked the provider to take action. At this inspection we found that action had been taken to improve the way people were supported to remain healthy but this was not consistent. One person told us, "If I have a bad time they [staff] don't hesitate to get the doctor in".

Staff had called an ambulance when they suspected one person had sustained an injury. The person was taken to hospital for checks. They continued to complain about pain for five days when they returned from the hospital. The person's GP visited and said the person should be taken back to the hospital to be checked. When the person returned to the hospital they found and treated an injury. There was a delay of two days before the person was taken back to hospital for further checks as staff could not arrange a specialist taxi.

The provider had failed to ensure people had the support they needed to manage their health needs. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's malnutrition and dehydration risk assessments had been completed accurately each month. People who had lost weight had been referred to a dietician promptly. Their advice had been followed and people had gained weight. The action recorded in one person's care records to support them to gain weight did not include all of the dietician's advice and had not been reviewed accurately. This did not impact on the person as kitchen staff followed up to date information from the dietician and provided the person the high fat diet they required.

Information about people's health conditions had been reviewed and updated to make sure it was correct. For example, one person was living with epilepsy and had not had a seizure while living at the service. Information regarding their epilepsy and the action staff should take if they suspected the person was having a seizure was clearly documented in their care plan.

People were supported to access regular health checks, including eye tests to make sure any changes in their needs were identified. They were supported to attend health care appointments by their family or staff. This was to offer the people reassurance and support them to tell their health care professional about their health and medicines. A chiropodist visited people regularly.

At our last inspection staff had not been trained and supported to fulfil their role. At this inspection new staff worked through an induction when they began working at the service to get to know people, their preferences and routines. Staff had completed refresher training and training in topics specific to people's needs, such as mental health. This had improved the service people received, for example people were now supported to make choices in ways they preferred.

Staff met regularly on a one to one basis with the registered manager to discuss their practice and any training and development needs. Meetings were also held when staff's practice did not meet the required standards and improvements to staff's practice were agreed.

People told us they were able to choose where they ate their meals. People's comments about the food included, "The food is not too bad, you have a choice", "I have a choice where to have my breakfast" and "I'm quite fussy, I don't like chicken but they always offer an alternative. The chef is aware and will always

cook something else".

Kitchen staff had up to date information about people's needs, including any allergies, special requirements such as extra calories and the portion size people preferred. People who required a low sugar or reducing diet were offered low sugar alternatives. One person had chosen to lose weight and we observed the chef discussing with them how they would like their evening meal prepared. Meals were prepared to people's preferences.

The menus continued to be discussed with people and their suggestions were acted on. For example people had asked for condiments to be available for them to choose and these had been provided. On one day of our inspection pudding was semolina and jam. People were offered jam separately and were supported to help themselves to as much as they wanted.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff at Ashbury Court. One person told us, "I'm very glad I've found a place like this where the staff listen. They [staff] are very kind to me and I am well looked after". We found that staff now provided people's support in a caring way. People and their relatives commented, "Staff do their best to please me", "The staff are lovely", "I am quite happy with my care" and "The care has always been good. If my relative is happy I am happy". However, we found that people were not always treated with care and respect.

At our last inspection we found that the provider and registered manager had not made sure that people were treated with respect at all times and required them to take action. Staff had completed training in relation to treating people in a caring and compassionate way since our last inspection. Most staff put what they had learnt into practice and followed the example of the operations manager. We observed people being treated with respect and staff using appropriate language when they spoke with people.

However, we observed that the deputy manager did not treat a person in a caring and compassionate way. We heard them speaking to a person in a short, brisk manner, and say, "That is not what happened", when they were describing an accident to their family. The person was in pain and the deputy manager did not offer them any reassurance during the conversation or check if they were able to take more pain relief medicine. Another staff member offered the person pain relief at the next appropriate time.

Most staff shared the provider's values of kind and respectful care. Staff had not been empowered to challenge other staff, including managers, behaviour when it fell short of the standards required by the provider. There was a risk that the people would not always be treated in a kind, caring and respectful way.

We found that records were more respectful and people were no longer described as 'naughty'. However, further improvements to the records the registered manager kept, such as care plans, were required to make sure they are always respectful to people.

The provider had not taken action to make sure that people were treated with respect at all times. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were visibly relaxed in staff's company and smiled when staff were talking to them. We observed kind and caring interactions between care staff and people. One person was sitting with their lunch in front of them, but not eating anything. A member of staff went to the person and asked them, "What is the matter with your food, you are not eating, would you like something else?" The person looked up and appeared confused, they told the member of staff, "There is something missing." The staff member bent down and smiled at the person, they said, "What is missing, can I offer you soup or a sandwich, maybe if you have something to eat we will work out what is missing?" The person agreed to eat a ham sandwich with encouragement and was visibly more relaxed when they had eaten.

People were able to choose if they had a bath or a shower and told us they were able to choose the gender of the staff member who supported them. One person told us, "There is a choice of male or female carer, I always choose female". Another person told us they preferred one particular staff member to support them to have a bath. They told us, "They give me a bath and are very caring, I don't like anyone else to give me a bath".

At our last inspection we found people were not treated with dignity at mealtimes. At this inspection we observed staff providing people with the support they needed discreetly. They supported people at their own pace and did not leave them to complete other tasks.

People were supported to make everyday choices. Tea was no longer made in a teapot with milk and people were able to choose how much milk and sugar they wanted in their hot drinks. We observed staff offering people choices of several different types of food and drinks throughout the day including biscuits in the morning and drinks at lunchtime. As staff were laying the dining tables for lunch one person requested a white napkin as they preferred these. Staff gave the person a white napkin and checked with other people what colour napkin they would prefer.

Previously people had told us their spiritual needs were not met. At this inspection they told us they were now supported to attend church services. One person told us, "The church lady came in yesterday; we have a service the first Monday of the month".

People told us they were supported to dress as they preferred. One person told us, "Staff don't bully me to get dressed when I'm comfortable in my pyjamas". Another person told a staff member they wanted to buy a new skirt. The staff member fetched a catalogue and they sat together looking at the type of skirt they person may like to buy.

Staff used people's preferred names and people were relaxed in the company of staff. Staff knew about people's preferences, likes, dislikes and interests. Since our last inspection people and their families had been asked to share additional information about their life history with staff to help them get to know people. Information about some people's backgrounds was available for staff to refer to in their records.

People and their relatives had fed back that they did not always know who to speak to about day to day matters. Everyone had been allocated a keyworker. A key worker is a member of staff who is allocated to take the lead in co-ordinating someone's care. People and their relatives had been told who their keyworker was and a picture of the keyworker was displayed in the person's bedroom. One person's relative told us, "My relative now has a keyworker. It is not just lip service, they do the job".

Staff continued to support people to remain as independent as possible. People's comments included, "I keep myself to myself, I'm quite independent", "I was always very independent before I came here and I like to stay as independent as possible" and "I do all my own personal care and I paint my own nails".

People told us they had privacy. One person told us, "The staff always knock before they enter my room and draw the curtains for personal care".

Confidential information about people was held securely. People who needed support to air their views were supported by their families, solicitor or their care manager. The registered manager knew how to refer people to an advocate if they required support sharing their views. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

Some people displayed behaviours that may challenge. Staff had not consistently recorded incidents as required so the information could be used to plan or change their support. For example, one person became distressed when they were in pain. Their care plan stated, 'all agitated behaviour is to be recorded on the appropriate ABC [antecedence, behaviour and consequence] chart for monitoring so that the relevant professionals have up to date information regarding their behaviour'. The person was very distressed on the first day of the inspection. They told staff and inspectors they were in pain and appeared very tense and restless. Staff told us the person was not usually distressed. However, their daily notes stated they were regularly in pain, causing them to become agitated. Staff had not recorded any of these instances on an ABC chart, so the registered manager and visiting care professionals, such as the mental health team could review them to look for any patterns.

Another person's care plan stated, 'their (behaviour) is again a behaviour issue and they know what they are doing but cannot help themselves'. There were no recorded instances of the person's behaviour. We spoke with the registered manager, who confirmed that the person did sometimes have behaviours. The registered manager told us they believed this was behavioural and 'just part of who the person is' and they had made the decision that there was no need to record it when it occurred. Staff told us they did not know if the person's behaviour was deliberate. One staff member said, "I'm not sure if it is purposefully done." Again these instances were not recorded so visiting care professionals team, including the mental health team could look for possible causes.

The provider had failed to design care with a view to achieving peoples' preferences and ensuring their needs are met. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found the registered persons had failed to carry out an assessment of people's needs and preferences and had failed to provide person centred care that met people's needs. We served a warning notice requiring the registered persons to take action by 28 February 2017.

Assessments of people's needs had been completed consistently. They were reviewed each month and had identified changes in people's needs and the care and support they required. For example, one person's needs had changed in January 2017 and they required more support to keep their skin healthy. The review of their assessment had identified the change in their needs and guidance to staff had been amended and was being followed.

Guidance to staff about how to provide people's care had improved since our last inspection; however, further improvements were required. For example, one person's care plan stated 'Requires carers to check pressure areas regularly'. Guidance had not been provided about how often the person's skin needed to be checked. Guidance about the specific areas of the person's skin which were at risk of damage was included on their 'topical medicines' chart. This chart instructed staff to apply cream to their sacrum twice a day. Another part of the person's care plan instructed staff to 'encourage' the person to rest on their bed in the

afternoon 'to relieve the pressure on their sacrum'. The person had a rest on their bed during the afternoons of our inspection. Staff knew the signs that the person's skin may be becoming sore. They had noted a blister on the person's knee and arranged for this to be seen by the person's doctor. The doctor assessed this was not a pressure ulcer.

People and their relatives were now involved in planning and reviewing their care with staff. 'Resident of the day' was taking place and staff from different departments, such as the cook and maintenance person, met with each person approximately once a month to discuss their needs and preferences, and any changes they required. One person's relative told us, "A lot of things have changed recently, staff and residents felt unsettled after the last CQC report but they seem to be much happier now. They are much more on the ball with the paperwork I now get given care reviews to sign off". Another person's relative told us, "My relative has a continence problem and staff recently consulted me about changing the carpet to vinyl flooring for ease of cleaning. I agreed it was a good idea and it has been done".

Changes in the way people preferred their care provided were included in their records for staff to refer to. Handovers were completed between shifts and records were kept about any changes in people's care. 'Flash' meetings were held daily so staff were able to share important information about people's care and raise any concerns. For example, the day before our inspection began, housekeeping staff had noticed one person's pressure relieving mattress had malfunctioned. The person was not using it at the time and staff had time to change the mattress before the person wanted to go back to bed.

People told us they continued to enjoy the activities on offer at the service. One person told us, "We make things and sell them. I do colouring when the activity leader is on holiday". Another person told us, "I have fun when we have glitter, it goes everywhere". A third person said "We always have a Christmas party and a party at Easter and last year in the summer we had a fete".

The activities coordinator was on holiday at the time of our inspection. They had made sure that activities that people liked were still available while they were away. On the second day of our visit people were enjoying a holiday themed day. An extra staff member was on duty and people were chatting about holidays they had enjoyed and places they had visited. Ice-cream cones were offered as snacks and the lunch menu had been changed to include fish and chips.

A process was in place to receive and respond to complaints. Some people told us their complaints were addressed. Two people told us they had not received a response when they had complained. Their complaints had not been recorded or investigated because the registered manager said they had not recognised that they were complaints. We asked the registered manager to investigate these complaints. Shortly after the inspection they told us what action they have taken to resolve them to the people's satisfaction.

Other complaints had been recorded and responded to in line with the provider's policy. One person's relative had complained their loved one was not sitting on a pressure cushion, as required and did not have their hearing aid in. The registered manager had responded to their concern and taken action to ensure this did not happen again. We observed the person sitting on their pressure cushion.

People told us they were confident to raise any concerns they had with the registered manager and staff. Their comments included, "If I have a problem I always get the manager to sort it out for me. She is very good", "I have complained about my room, the radiator doesn't work sometimes so they have given me a heater" and "We have marmalade now we didn't get it till I asked".

Inadequate

Is the service well-led?

Our findings

A registered manager was working at the service. They were led by an operations manager and supported by a deputy manager. The operations manager was available to support the registered manager in the home four days a week and was on call out of hours and over weekends. The operations manager had developed an improvement plan following our last inspection to address the shortfalls we had identified. They had reviewed this monthly and had agreed when each action was complete. Any further improvements that had been identified were added to the action plan.

At our November 2016 inspection we found that staff had not been supported to maintain accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment. We served a warning notice requiring the registered persons to take action by 28 February 2017.

Since our last inspection some improvements had been made to the day to day records care staff kept in relation to the care provided to people each day. For example, daily records were more detailed and advice from doctors and other health care professionals had been recorded. However, we found that some records continued to be inaccurate. For example, the support one person received to enable them to gain weight had been reviewed by their dietician. The dietician had recorded the outcome of their review in the person's care plan stating, 'Stop Aymes (food supplements) once a day and monitor'. Ten days later a member of the management team had reviewed the care plan stating, 'Care plan review, weight up, continues Aymes'. This was inaccurate. We also noted that a member of the management team had signed to say they were part of best interest decisions taken in February 2017, however they did not begin working at the service until April 2017 and had signed the records in June 2017.

Following our last inspection the operations manager had requested all out of date information be removed from people's care records and archived. This was to make sure staff had quick and easy access to current information. We found that current information had been removed from people's records so staff did not have the most up to date information about people. Some important advice from health professionals had been removed so action had not been taken to make sure the advice had been followed and people's needs were met.

One person was living with chronic pain. They had been visited by a mental health professional in January 2017. Staff had recorded in the person's records 'GP will be asked to refer to chronic pain clinic'. The person had seen the mental health professional again in April 2017 and a letter had been received by the service recording the outcome of the consultation. This letter contained essential information regarding the person's care and it had been removed from their care plan. The letter stated, 'needs to be re-referred for assessment of pain management'. No subsequent referral to the pain clinic had been made and the person continued to experience constant pain. the provider's checks had not picked this up.

Staff were not able to quickly access other information we asked for, including advice from heath care professionals. The member of the management team who was responsible for overseeing this process had

not checked to make sure that only out of date information had been removed from the records staff used on a daily basis.

At our last inspection we found that the checks and audits completed by the registered manager had not identified the shortfalls in practice we found during the inspection. We served a warning notice requiring the registered persons to take action by 28 February 2017. At this inspection we found that some of the checks and audits completed continued to be ineffective.

The registered manager had not checked that staff had completed their tasks correctly and had failed to identify the shortfalls in their practice, including the archiving of records and reviewing of care plans.

The registered manager was required by the provider to complete daily 'manager's walk around' checks. It was the responsibility of the deputy manager to complete these when the registered manager was on leave. These checks had not been completed since 30 May 2017. The operations manager had been making sure these checks were completed until the end of May 2017 and had found they had been completed each day. They had checked in June and found that they had not been completed and had required they were done in line with the provider's policy. Subsequent checks had not been completed and shortfalls we found during the inspection had not been identified.

The registered manager and deputy manager had checked people's care plans from time to time. There was no process in place to check the quality of care plans regularly. The checks that had been completed had not identified the shortfalls in care plans and records we found at the inspection.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person. The provider had failed to assess, monitor and improve the quality and safety of the service provided to people continually evaluate and improve the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager continued to complete some monthly checks and audits required by the provider, such as weight and falls audits and medicines checks, in line with the provider's policy. The operations manager counter signed these to say the checks were accurate and we found they were correct.

The management team had completed checks at night to make sure the service was being provided as they required. Where shortfalls had been found these had been addressed. For example, an agency staff member had signed to say that they had checked on people's safety before the checks had been completed. The registered manager had addressed this with the staff member immediately and had contacted the care agency to inform them they would not permit the person to work at the service again.

At our November 2016 inspection we found that the provider had failed to seek and act on feedback from relevant people, including staff and visiting professionals, on the services provided to continually evaluate and improve the service. We served a warning notice requiring the registered persons to take action by 28 February 2017.

People were asked for their views about different areas of the service each month, such as the laundry and hairdressing services. Two people had commented in May 2017 that they were unable to use the hairdressing salon in the next door service since it had been refurbished. Staff told us the people received their hairdressing service in their bedroom. They had not asked the people if they were happy to have their hair done in their bedrooms or explored other ways to provide the hairdressing service to people who wanted but were not able to use the hairdressing salon.

People and their relatives were asked for their opinions about the service every 6 months. The provider collated the feedback and shared this with the registered manager. Some people had commented that they would like a wider variety of foods on the menu. The menu had been discussed with people and new options including salad had been added at people's request.

Following our last inspection stakeholders including district nurses and GP's had been asked for their views. Only one response had been received. Action had not been considered how to obtain a wider range of stakeholder views.

Staff had been asked for their views about the quality of the service. More than half of the staff who responded said staff did not work as a team. Some staff had commented that they did not feel supported to do their role and others had said that their morale was low and they did not feel valued. We asked the registered manager what they had done to support staff to feel valued, improve their moral and support them to work as a team. The registered manager told us they had chatted to staff but had not taken action to address staffs concerns.

Some staff had commented that they did not know what was happening in the wider provider organisations. In response to this the provider was sending weekly updates to the service about what was happening and these were available to staff in the staff room.

The provider had failed to act on feedback from relevant people, including service users, their relatives and staff, on the services provided to continually evaluate and improve the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection staff had not been made aware of their specific roles and responsibilities. At this inspection we found that care staff were clear about their roles and responsibilities and had been held accountable for any shortfall in their practice. The provider's philosophy of care and core values continued to be available to people and staff. The service people received was now more respectful of their right to privacy and dignity and people were supported to have more independence and choice.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury. This is so we can check that appropriate action had been taken. The registered manager had failed to notify CQC of two significant events that had happened at the service, when people had sustained an injury.

The provider had failed to notify the Care Quality Commission (CQC) of significant events. This was a breach Regulation 18 of the CQC Registration Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception and on their website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission of significant events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not taken action to make sure that people were treated with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to identify, assess and mitigate the risks to the health and safety of service users. The provider had failed to operate proper and safe medicines management processes. The provider had failed to ensure people received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from the risks of abuse.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person. The provider had failed to assess, monitor and improve the quality and safety of the service provided to people continually evaluate and improve the service. The provider had failed to act on feedback from relevant people, including service users, their relatives and staff, on the services provided to continually evaluate and improve the service.

The enforcement action we took:

We served a warning notice.