Sage Care Homes (Jasmin Court) Ltd

Jasmin Court Nursing Home

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 19 April 2018 and was unannounced, which meant the staff and registered provider did not know we would be visiting. The service was last inspected on 17 May 2017. The overall rating of the service was requires improvement. At this inspection, we found three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9, Person-centred care, Regulation 18, Staffing and Regulation 17, Good governance. Our findings showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

Jasmin Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Jasmin Court is registered to provide accommodation for up to 50 older people who require nursing and/or personal care. Accommodation is provided on the first and second floors, accessed by a lift. Communal areas such as dining rooms and lounges are situated on the ground floor of the home. At the time of the inspection, 28 people were living at the home; one of those people was in hospital.

At the time of this inspection, the service was being managed by the regional manager and the deputy manager. The previous manager had recently left and had not registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People we spoke with told us they felt 'safe'. Relatives we spoke with did not express any concerns about their family members' safety. However, we received concerns from relatives about the staffing levels at the service, particularly at the weekends.

At our last inspection, we saw the deployment of staff, particularly during mealtimes, could be improved to ensure people were supported appropriately. At this inspection, we saw the arrangements in place to ensure people in their rooms received their meals in timely manner still required improvement.

We found the management of medicines required improvement to ensure medicines were handled safely. We saw evidence of poor stock control and ordering of medicines.

Staff had access to important information to help keep people safe and take appropriate action if concerns about a person's safety had been identified. Staff knew these policies and procedures were available to them.

We found the system in place to ensure that fit and proper persons were employed at the service needed to

be more robust.

We saw there were satisfactory arrangements in place to manage people's monies.

People we spoke with were satisfied with the quality of care they had received. However, we saw that some people had not been supported appropriately with their personal care. This did not uphold their dignity. This showed that sufficient improvement had not been made at the service since our last inspection.

We saw some practices at the service that did not promote dignity and respect. This showed some of the training and support of staff had not been underpinned by the key values of kindness, respect and dignity of care. We also saw some staff did not fully understand the requirements about offering choice and/or obtaining consent. This showed the service had not always been well led.

At our last inspection, we received mixed views from relatives about their involvement in their family member's care planning. At this inspection we found the system in place to ensure that an assessment of needs involved relevant people still required improvement.

We saw that some people's care plans had been rewritten and/or updated since our last inspection. We saw these care plans were more centred on the person and were being regularly reviewed. However, some care staff spoken with told us they had not read people's care plans since they had started working at the service. This showed there was a risk that people would not receive appropriate care and staff had not been provided with sufficient guidance on the person's current care and support needs.

Relatives we spoke with told us the level of activities and quality and suitability of activities could be improved. Comments included, "I don't think the activities always suit people with dementia" and "My [family member] cannot take part in anything, I'm not sure if they get a one to one visit."

The registered provider had a complaint's process in place and this was displayed in the reception area. Relatives we spoke with told us that concerns and complaints were listened to by staff.

At our last inspection, we found the registered provider had not ensured that staff received appropriate training and support to enable them to carry out their duties. At this inspection, we saw that sufficient improvement had not be made to ensure staff received appropriate induction and refresher training and support to enable them to carry out their duties.

At our last inspection, we found the registered provider had failed to ensure that people and their representative views were actively sought for the purpose of continually evaluating and improving the service. The deputy manager told us they had held relatives meetings since the last inspection, but nobody had chosen to attend them. However, some relatives we spoke with were not aware of these meetings or they told us they had never been asked to feedback about the quality of the service.

At our last inspection, we found the registered providers systems to assess, monitor and improve the quality and safety of the service required improvement. At this inspection we saw there were checks completed at the service by senior staff. However, we saw these checks did not always provide a timescale for completing improvement or detail when the action had been completed.

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

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 always safe.

People told us they felt safe.

We saw the systems in place to manage medicines safely required improvement.

We saw that further improvement was required to ensure measures were in place to reduce some people's risk.

Relatives shared concerns about the staffing levels at the service, particularly at weekends.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw that some people living at the service had not received appropriate care.

We found the registered provider had not ensured staff received appropriate support and training to enable them to carry out the duties they were employed to perform.

We received mixed views from relatives about the care their family member had received.

People we spoke with were satisfied with their access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People and relatives made positive comments about the staff.

We saw a few of the practices at the service did not involve people about decisions about their care and people were not given as much choice and control over their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw the system in place to ensure care staff read people's care plans required improvement.

We saw the activities at the service required improvement to ensure all the people living at the service had access to meaningful activities to improve their wellbeing.

The service had a complaints process in place.

Is the service well-led?

Inadequate

The service was not well-led.
We saw the processes in place to ensure the quality and safety of the service were monitored required improvement.

The registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

The culture within the service did not always support the delivery of high quality person centred care.

Jasmin Court Nursing Home

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 19 April 2018 and was unannounced, which meant the staff and registered provider did not know we would be visiting. The inspection was prompted in part by information shared by the local authority and information the CQC had received. The information showed there was emerging risks about the management of the service. This inspection was undertaken to examine those risks. The membership of the inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. The specialist advisor was a pharmacist. 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 our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection. We did not ask the provider to complete a Provider Information Return (PIR) as the inspection was brought forward in response to emerging risk. 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 used a number of different methods to help us understand the experiences of people who used the service. We spent time observing the daily life in the service including the care and support being delivered. During the inspection we spoke with 16 people living at the service, two relatives, the regional manager, the deputy manager, a nurse, a nurse assistant, four care staff, the maintenance worker, an administrator, the activities worker, housekeeping staff and the cook. We looked around different areas of the service; the

communal areas, the kitchen, bathrooms, toilets and where people were able to give us permission, some people's rooms. We examined a range of records including the following: people's care records, people's medication administration records, staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found concerns about some people's individual risks assessment and saw they had not been protected from the risk of receiving inappropriate care. We also saw the measures in place to reduce and to manage the risks to some people required improvement. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Safe care and treatment.

At this inspection, we found some improvement had been made, but we saw further improvement was required to ensure people's risks were reduced and managed effectively. For example, in one person's care plan we saw they had been assessed as having a high risk of weight loss. We saw the person had been prescribed a food supplement. However, we saw their food intake was not being monitored by staff. This showed the measures in place to reduce and manage the risks to the person relating to weight loss required improvement.

We checked to see if medicines were handled safely and stored appropriately. On the morning of the inspection, we observed the nurse and nursing assistant administering medication in the dining room. We saw the nursing assistant did not ensure the medicines trolley was locked each time they went to administer medicines to a person in the dining room. The nursing assistant left the trolley fully open whilst they were administering medicines to people in the dining room. We shared this information with the regional manager, as this is not safe practice. They assured us they would speak with staff to ensure safe practice was adhered to.

We saw the registered provider did not have a clear written training and or induction programme for medicines training for new and existing staff. We saw system in place to ensure the competency of new and existing staff who had responsibility to administer medicines was checked required improvement. The National Institute for Health and Care Excellence (NICE) recommends an annual review of staff knowledge, skills and competencies relating to managing and administering medicines.

We examined a sample of people's medication administration records and saw these were being used correctly and did not identify any errors or omissions.

There was evidence the treatment room and medicines fridge temperatures were monitored. This showed there was a robust system in place to ensure medicines were stored at the right temperatures. Some people were prescribed Controlled Drugs (CDs). These medicines require extra checks and special storage arrangements because of their potential for misuse. We saw CDs were kept in cupboards that complied with the law. We saw the CDs register was being used correctly and the stock balances were correct. We saw the medicines cabinet in the treatment room was not fit for purpose as it was full to capacity. The nurse on duty confirmed that the cabinet was always full. We saw there was no physical separation between the stock belonging to people. We also saw there was no physical separation between different people's boxed medication in the medication trolleys. We saw this would increase the risk of staff not selecting the right person's medication.

We saw evidence of poor stock control and ordering of medicines. For example, we saw examples of medicines of being over ordered and medicines of people who had died had not been disposed of. We saw staff responsible for administering medicines had access to policies in a folder in the treatment room. However, they were not clearly laid out and our findings showed staff were not always following these policies in relation to the ordering of medicines and stock control.

We saw the system in place to report medication errors would benefit from being more robust. We shared our findings about the management of medicines with the regional manager.

During our inspection we observed that staff wore gloves and aprons where required. We noticed the service did not smell fresh on our arrival, but we saw these smells dispersed as doors and windows were opened during the day. Relatives we spoke with told as the service did not always smell fresh and clean and that some of the areas within the service was not kept consistently clean. One of the relatives said, "Some of the corridor areas smell awful at times."

People we spoke with told us they felt 'safe'. Relatives we spoke with did not express any concerns about their family members' safety. However, we received concerns from relatives about the staffing levels at the service and that at times the service was short staffed. One relative said, "They could do with more staff times, especially at the weekend." One person described how this had affected staff responding to their calls for assistance. They said, "Sometimes, when they are short staffed, I have to wait a while I use my buzzer, they [staff] get very busy at weekends." Another person said, "They [staff] don't come, I have to wait."

During this inspection, we spent time observing the daily life at the service including the care and support that was being delivered. At our last inspection, we saw the deployment of staff particularly during mealtimes could be improved to enable people to be supported appropriately and in a timely manner. At this inspection, we saw the deployment of staff had not been sufficiently improved. For example, on the second floor we saw one of the two staff deployed on the floor went to get people's dessert. During this time we saw a staff member leave a person in a specialised mobile chair by the staff desk on the second floor. The person asked repeatedly to go to their room. The remaining staff member told them they were not allowed to take them to their room and it needed two staff to support them to go to bed. When the second member of staff arrived, they told the person they would have to wait until people had been supported with their lunch.

We saw a policy on safeguarding vulnerable adults was available. Staff had access to important information to help keep people safe and take appropriate action if concerns about a person's safety had been identified. Staff knew these policies and procedures were available to them. The staff training records checked verified staff had been provided with relevant safeguarding training.

At our last inspection, we found the system in place to ensure that fit and proper persons were employed at the service needed to be robust. At this inspection, we reviewed two staff recruitment records for two staff who had recently been employed at the service. The records contained a range of information including the following: application, references, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We saw a few concerns in the recruitment records. We saw that both staff member's employment history had gaps in them. There was no explanation for these gaps within their records. It is important that all the information as required in Schedule 3 of the Health and Social Care Act 2008 is gathered. This showed the recruitment system in place required further oversight to ensure all the relevant information was gathered.

During this inspection, we noticed some concerns about the access to outside garden area at the service. For example, we saw staff found it difficult to push wheelchairs through the door in the conservatory because of the lip in the doorway. We also saw that staff were unable to find the keys for the doors in the lounge area. Staff said the keys were normally hung on a hook by each door. We noted it took staff approximately ten minutes to find the keys for the exit doors.

At our last inspection we noticed an outside gate that should be kept locked at all times had been left open by staff. At this inspection we saw that an additional gate had been installed and padlocks were being used to secure the two gates. We saw this had improved the security of the area, but we saw the use of a padlock would require a key to leave the area in case of fire. We spoke with the regional manager about these concerns and recommended they contact the South Yorkshire Fire and Rescue for safety advice. Following this inspection, the regional manager informed us the fire officer had visited the service and recommended a change of locks to be completed on the exit doors and the gates. They informed us this work would be completed by the registered provider.

In the garden area we saw part of the garden wall had fallen exposing the soil behind it. This presented a tripping hazard. The regional manager told us the registered provider was consulting with a structural engineer about the damaged wall. We saw the arrangements in place to stop people accessing this area required improvement and shared this information with the regional manager. The area had been cordoned off with two chairs, some tape and a garden hose.

We spoke with the maintenance worker; they managed the environmental risks and maintained the property. They completed regular checks at the property including the fire safety checks.

We found there were arrangements in place for people who had monies managed by the service. At our last inspection, we noticed the dates on the receipts did not always match those dates logged on the registered provider's electronic accounting system. At this inspection the administrator told us they now ensured these dates matched so an accurate record was kept.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found concerns about the care some people had received. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Person-centred care. At this inspection we checked to see if sufficient improvement had been made.

People we spoke with were satisfied with the quality of care they had received. One person said, "I would not want to live anywhere else." People we spoke with were satisfied with their access to healthcare services. People told us they could see the doctor if they felt unwell. One person said, "I have been seeing my GP regularly lately, the staff see to all that." One relative said "They [staff] call the opticians and dentist [family member] and they [staff] let me know when they do it."

We received mixed views from relatives about the quality of care their family member had been provided. One relative said, "The manager has still not got to grips with some of the smaller things. The staff need to pay attention to detail."

We saw that some people's care plans had been rewritten and/or updated since our last inspection. We saw these care plans were more centred on the person and were being regularly reviewed. However, some care staff spoken with told us they had not read people's care plans since they had started working at the service. For example, one staff member told us they had learnt people's routines from a member of staff who had now left the service. This showed there was a risk that people would not receive appropriate care and staff had not been provided with sufficient guidance on the person's current care and support needs.

We found sufficient improvement had not been made at the service to ensure people received appropriate care that met their needs. During this inspection, we found some concerns about some people's appearance. We saw some people had not been supported to brush their hair. One person had not been dressed appropriately so their dignity was upheld. We saw six people had not been supported to have a shave. We saw four people with unkempt nails that were not clean. For example, we saw one person's facial hair had dried food and debris in it. They also had long unkempt finger nails again with dried food in them. This showed people had not been supported appropriately with their personal care to uphold their dignity.

During this inspection, we saw one person had returned to their room in the morning and they did not receive any lunch. We observed them sleeping over the lunch period. We saw staff used a list to identify which people on their floor required a lunch and this person was not on the list. We spoke with the nurse on duty and made them aware that the person had not received any lunch. This person had been assessed as having a high risk of weight loss and was prescribed food supplements. We saw the person's fluid intake was being monitored, but we saw their nutritional uptake was not being monitored to ensure they were eating enough.

This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Person-centred care.

People we spoke with were satisfied with the quality of food provided and were offered an alternative if they did not like what was being served. Comments included, "You can have whatever you like for breakfast, today I had sausages and tomato" and "All the meals suit me." The cook told us they usually sent a menu choice sheet out the day before requesting people's choice of meal, but this had been forgotten and was being sent out on the morning of the inspection. We observed the arrangements at lunchtime. We saw the dining room was neatly set our and looked welcoming. There was a pictorial menu available. The catering team served meals and the staff were seen to be very calm and patient whilst delivering meals. We noticed there were no portion size offered and those people who finished their meals were not asked if they would like some more. We noticed one person who had a hearing impairment was not offered a choice of meal. One staff member said, "[Person] is very deaf, we know what they like, they have a soft diet anyway." At the end of the mealtime, we saw many people had left drinks in their glasses and some people ate very little, but this was not being recorded by staff.

We spoke with the cook on the morning of the inspection. We asked to see a list of people who required a diabetic diet, but they were unable to locate the list. During the inspection we observed there was some confusion of about one person's dietary needs between staff and the cook. The person asked for a particular item to eat, but there was discussion on whether they could have this item because of a medical condition. We saw the system in place to ensure people's dietary needs were met needed to be more robust.

We looked at the arrangements in place to support people with their meals in their rooms. At our last inspection, we found concerns about the temperature of the food being served. At this inspection, on the second floor, a staff member told us the temperature of the food in the trolley had dropped and they were waiting for the trolley to reheat the food so they could serve it. This showed there was a risk that food safety standards had not been adhered to. We also saw people had to wait a long time for their second course to be served.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests and as least restrictive as possible.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The service was aware of the need to and had submitted applications for people to assess and authorise that any restrictions in place were in the best interests of the person. However, during this inspection we saw some staff removed a few people in their specialised mobile chairs from areas whilst they were asleep and had not gained consent from the person to do so. We were also aware of a recent occurrence at the service where a decision had been made by a senior member of staff to move some people to different rooms within the service without considering obtaining consent. The regional manager

had changed this decision as soon as they had been informed. This showed that some staff did not fully understand the requirements about consent. We also saw some people had been restricted from using the outside space if they used a specialised mobile chair. During the inspection we observed the activity worker asking people who used a specialised mobile chair if they would like to go outside and enjoy the sunshine. The activity worker was informed by staff that "these people cannot go out in these chairs" and when the activity worker asked "why", a member of staff said that they had been "told" that these chairs could not "go outside".

At our last inspection, we found concerns about the training and support provided to staff. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Staffing. At this inspection we checked if sufficient action had been taken by the provider to ensure staff completed induction and refresher training to maintain and update their skills. We also checked if staff had been supported appropriately.

After our last inspection, the registered provider sent us an action plan stating the staff would receive supervision six times per year or more frequently if necessary. The staff records examined showed sufficient action had not been taken to ensure each staff member received regular supervision. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing.

We reviewed the services training matrix. The registered provider action plan stated that staff would receive training in supporting people with challenging behaviour, but we found this training had not been completed. We also saw some gaps in staff training. For example, the matrix showed that some staff had not completed training in the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. The matrix showed that some staff had not completed Health and Safety training. The matrix also showed only one staff member had completed training in equality and diversity and only three staff had completed dementia training.

We also found the systems in place to ensure staff who had responsibility to administer medicines competency was checked had not been improved since our last inspection.

This showed the registered provider had not ensured staff had received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Staffing.

Requires Improvement

Is the service caring?

Our findings

People made positive comments about the staff and told us they were treated with dignity and respect. Comments included, "The staff are marvellous, I will not have a word said against them" and "The staff do all they can to look after me." Relatives we spoke with made positive comments about the staff. Comments included, "The staff offer such care, love and support" and "The staff are wonderful."

We saw there was a range of information available for people, visitors and relatives to look at in the reception area, including information about dignity in care. However, our observations during this inspection showed some people were not being supported appropriately with their personal care to maintain their dignity. For example, one person's dignity was not upheld in the way they were dressed. The person was showing the top of their ankle socks to high above their knees. This remained so until after lunch and their clothing was changed due to incontinence. This showed some people using the service were not well supported or cared for. This showed the staff were not always caring.

We saw examples where people were treated with dignity, kindness and respect. For example, we saw staff interacting respectfully and kindly with people. We saw staff knocking on people's doors prior to entering and gaining consent to enter. We also saw staff knew people well and were able to describe people's likes and dislikes. Relatives and visitors were welcomed in a caring and friendly manner.

However, we saw examples where people were not always treated in a caring way. We saw a few of the practices at the service did not involve people about decisions about their care and people were not always given choice and control over their lives. For example, we saw care staff removing people in their mobile chairs from a room whilst they were asleep without gaining consent. Some people were not allowed to access the external space if they were in a mobile chair. We observed a person being returned to the second floor in their mobile chair and left without any explanation by staff why they had been left in a corridor and not supported to go their room. We observed the person calling out to go to their room over a period of twenty minutes asking to go to their room. We asked the member of staff why the person had been left unattended in the corridor. The staff member told us they would have to wait for the two staff members on the floor to support them to go to their room. The person needed two staff members to put them in bed. We saw the person had not been asked whether they wanted to sit in their room in their mobile chair or wait in their room whilst staff became available. There was only one member of staff on the floor and when the second member of staff appeared they told the person they would have to wait until dessert was served. This caused the person further distress. We saw there was no attempt to obtain other staff to support the person. The person was supported to go their room when a nurse came up to the floor and asked why the person was sat in the corridor. This showed some of the training and support of staff had not been underpinned by the key values of kindness, respect and dignity of care.

This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Person-centred care.

We did not see or hear staff discussing any personal information openly or compromising privacy. Staff told

us they used a handover sheet to pass on information about people's needs.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we received mixed views from relatives about their involvement in their family member's care planning. At this inspection we found the system in place to ensure that an assessment of needs involved relevant people still required improvement. One relative said, "I have never been asked to be involved in reviewing [family members] care plan."

At our last inspection, we found shortfalls and contradictory information in the care plans we reviewed. At this inspection we checked if sufficient improvements had been made. People's care plans were stored in the nurses office on the ground floor. We saw there had been some improvement to people's care plans. We saw examples where people's care plans had been rewritten and they were centred on the person. They were being regularly reviewed. However, we saw the system in place to ensure care staff read people's plan of care required improvement. This showed there was a risk that people would not receive appropriate care and staff had not been provided with sufficient guidance on the person's current care and support needs.

The service employed two activities workers at the service. On the day of this inspection one activities worker was working. They had just started working as an activities worker and hadn't done any training about providing activities. We saw the activities worker was committed to the activities being enjoyable, but we saw they would benefit from further training so they had a better understanding of the physical and psychological benefits of activities on people. We saw the activities worker was utilised by staff to provide support to people during lunch. The activities worker confirmed that when the service was short staffed they were asked to go onto the care rota.

We were told the programme of activities at the service had been reduced and the number of outside entertainers visiting had been reduced due to funding. On the day of the visit the planned activities in the morning were 'one-to-ones' and in the afternoon 'sensory'. Due to the unexpected pleasant weather, some people were encouraged to sit outside by the activities worker. People were seen to enjoy this as they sat in the sun enjoying drinks, eating ice creams and listening to music. However, we saw some people in specialised mobile chairs were not allowed by staff to access the garden area using these chairs. No further activities were seen to take place during the afternoon.

Relatives we spoke with told us the level of activities and quality and suitability of activities could be improved. Comments included, "There are not always enough staff to do activities," "I don't think the activities always suit people with dementia" and "My [family member] cannot take part in anything, I'm not sure if they get a one to one visit."

Some people we spoke with made positive comments about the activities that had been provided. Comments included, "I like it when the singers come. I like to see people dancing" and "I take part in anything that's going, I like a game of bingo." Some people we spoke with told us they enjoyed going to the community school concerts and plays and going to the local tea dance. However, we were told that people in wheelchairs were unable to go on trips outside the service because the transport was not suitable for them.

We saw meeting people's religious needs were not being met as part of everyday practice. There had been a local church involved with the service in the past, but this had stopped. Staff spoken with were unable to provide any explanation why this had ceased.

The registered provider had a complaint's process in place and this was displayed in the reception area. The service kept a log for complaints. We saw a few examples where the outcome had not been recorded. Relatives we spoke with told us they knew how to complain, they told us they did not know who the manager was, but they would inform anyone if they unhappy with the care provided to their family member.

Inadequate

Is the service well-led?

Our findings

The previous manager had recently left and had not registered with the Care Quality Commission since our last inspection in May 2017. They had been absent for a period of time prior to leaving the service. At the time of this inspection, the service was being managed by the regional manager and the deputy manager. The regional manager and deputy manager had been working closely with the local authority and the Clinical Commissioning Group to improve the quality of the service. The regional manager had been regularly visiting the service to oversee the management of the service and to provide support to the deputy manager. The regional manager managed and monitored the quality of the service. For example, responding to any incidents, safeguarding concerns or complaints and resolving any environment and equipment concerns.

The regional manager told us the service had been reviewing people's care plans. We saw some people's care plans had been rewritten and were more centred on the person. However, our observations during the inspection showed some people at the service were not receiving appropriate care. We also found concerns about some of the practices at the service that showed some of the training and support of staff had not been underpinned by the key values of kindness, respect and dignity of care. We also saw some staff did not fully understand the requirements about offering choice and/or obtaining consent. This showed that staff have not been appropriately supervised. This showed there were widespread and significant shortfalls in the way the service had been led.

We saw there were checks completed at the service by senior staff. However, we saw these checks did not always provide a timescale for completing improvement or details of when the action was completed. This showed that staff did not fully understand the principles of good quality assurance and the service lacked drivers for improvement.

After our last inspection, the registered provider sent us an action plan with details of the action they would take to improve the service and meet the requirements of the regulations. Our findings during this inspection showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Good governance.

We received mixed views from relatives about the management of the service. Some spoke of the improvements over the past few months, whilst others felt that "things were still not right". Relatives were unsure of who was actually managing the service. One relative said "I don't know who the manager is at the moment, but I could talk to any of the staff up here (1st floor) if I needed to." None of the people we spoke with knew who the manager was. One person said, "I don't know who the manager is, there has been some ups and downs." However, we saw people visually responded to the regional manager when she came into the dining room at lunch time. People smiled at her and chatted with her as they recognised her face and

friendly demeanour towards them.

There was a relatives and residents meeting for April 2018 displayed in the reception area. The deputy manager said the meetings in June, September and December 2017 details had been displayed, but nobody had chosen to attend. However, one relative told us they were not aware of any relatives meetings as they would like to share their thoughts. Another relative told us they had never been asked about what they thought about the quality of the service. This showed the systems in place to ensure that people and their representative views were regularly sought for the purpose of continually evaluating and improving the service needed to be more robust.

A quality audit had been completed with people living at the service in September 2017. These results showed an overall result of 68 percent out of a possible 100 percent. We saw a corresponding action plan had not been completed to improve the service. A quality audit had also been completed in February 2018 by the regional manager. This included an action plan to improve the service. The actions included reviewing the cleanliness of the home and the improving the quality of the meals.

The regional manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received appropriate care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff received appropriate training, supervision and appraisal to enable them to carry out the duties they are employed to perform.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes had been established and operated effectively to ensure compliance with regulations.

The enforcement action we took:

A warning notice was issued.