Mylan Limited

Wychdene

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 29 March 2018. The inspection was unannounced. Wychdene is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Wychdene is registered to provide accommodation and personal care for 24 older people. There were 19 people living in the service at the time of our inspection visit.

The service was run by a company who was the registered provider. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At the last comprehensive inspection on 27 and 28 July 2017 the overall rating of the service was, 'Requires Improvement'. We found that there were five breaches of the regulations. This was because there were shortfalls in the arrangements made to manage medicines in the right way so that people reliably received safe care and treatment. Also, suitable arrangements had not been made to obtain people's consent to the care they received. Furthermore, we noted that there were oversights in the maintenance of the accommodation. In addition, we found that people did not always receive care in a way that promoted their dignity. Lastly, we concluded that the registered persons had failed to operate quality checks to enable problems in the running of the service to quickly be put right.

We told the registered persons to take action to make improvements to address each of our concerns and they subsequently told us that this had been done. However, at the present inspection we found that only one of the breaches of regulations had been met. This referred to the arrangements made to obtain people's consent to the care and treatment they received. The four remaining breaches had not been suitably addressed because suitable arrangements had not been made to ensure that people consistently receive safe care and treatment. Also, the accommodation was not designed, adapted and decorated in a way to meet people's needs and expectations. In addition, people did not always receive care in way that promoted their dignity and quality checks had not been completed in a robust way to ensure the smooth running of the service.

Full information about CQC's regulatory response to the breaches of regulations noted above will be added to our report after any representations and appeals have been concluded.

At this inspection we also found a further breach of regulations. This was because the registered persons had not completed suitable background checks before two new care staff had been appointed to assure

themselves of the applicants' previous good conduct. You can see what action we have told the registered persons to take about this shortfall at the end of the full version of this report.

As a result of these breaches of regulations 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 registered persons' registration of the service, will be inspected again within six months. The expectation is that registered persons 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 registered persons 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. When 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 registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Our other findings at the present inspection were as follow. People had not been fully safeguarded from the risk of financial mistreatment. Although there were enough care staff on duty the registered persons had not established a robust system to ensure that sufficient care staff continued to be deployed to meet people's changing needs for care. Also, records did not clearly demonstrate that there were effective systems and processes to enabler lessons to be learned when things had gone wrong.

Arrangements were in place to assess people's needs and choices so that they did not experience discrimination. Also, care staff knew how to provide people with the reassurance they needed if they became distressed. Although in practice care staff knew how to care for people in the right way, some of them had not received all of the training that the registered persons considered to be necessary. People were helped to eat and drink enough to maintain a balanced diet. Also, suitable arrangements had been made to help people receive coordinated care when they moved between different services.

People were given emotional support when it was needed. Also, they had also been supported to express their views and be actively involved in making decisions about their care as far as possible. This included them having access to lay advocates if necessary. Furthermore, confidential information was kept private.

People had not been offered sufficient opportunities to pursue their interests and to engage in social activities. Although people received responsive practical assistance sufficient steps had not been taken to present information to them in an accessible way. However, suitable arrangements had been made to promote equality and diversity and to manage complaints. Furthermore, provision was in place to support people at the end of their life to have a comfortable, dignified and pain-free death.

Care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. Also, the registered persons were actively working in partnership with other agencies to support the development of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Suitable arrangements had not been made to ensure that people always received safe and harm free care.

People had not been fully safeguarded from the risk of financial mistreatment.

Background checks had not been completed in the right way before new care staff were appointed.

The arrangements in place to learn lessons when things had gone wrong were not robust.

There were sufficient numbers of suitable care staff on duty.

Is the service effective?

Inadequate

The service was not effective.

Parts of the accommodation were not designed, adapted and decorated to meet people's needs and expectations.

Arrangements were in place to assess people's needs and choices so that they did not experience discrimination.

Although care staff had not received all of the training they were said to need in practice they had the knowledge and skills they needed to provide practical assistance.

People were helped to eat and drink enough to maintain a balanced diet.

There were suitable arrangements to enable people to receive coordinated care when they used different services.

People had been supported to receive on-going healthcare support.

There were suitable arrangements to obtain consent to care and treatment in line with legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff had not been fully supported to provide care in a way that always promoted people's privacy and dignity.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Although in practice people received responsive care, information was not always presented to them in an accessible manner.

Suitable arrangements had been made to promote equality and diversity.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.
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Is the service well-led?

Inadequate

The service was not well led.

Suitable arrangements had not been made to ensure that the service met regulatory requirements by learning, innovating and ensuring its sustainability.

There was a registered manager and care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns.

The service worked in partnership with other agencies to promote the delivery of joined-up care.	

Wychdene

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 registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 29 March 2018 and the inspection was unannounced. The inspection team consisted of an inspector, a special professional advisor and an expert by experience. The special professional advisor was a registered nurse who examined particular parts of the care people had received that were intended to promote their good health. An expert by experience is someone who has personal experience of using this type of service.

During the inspection visit we spoke with 12 people who lived in the service and with six relatives. We also spoke with four care staff and the registered manager. We observed care that was provided in communal areas and looked at the care records for seven people. We also looked at records that related to how both parts of the service were managed including staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection on 27 and 28 July 2017 we found that the registered persons had not established suitable arrangements to assess, manage and reduce risks to people's health and safety so that they consistently received safe care and treatment. This was because medicines were not always managed in line with national guidance. In particular, the administration of some medicines was not always being recorded in the right way so that it was clear that each person had been offered all of the medicines prescribed for them. Also, medical advice had not always been sought when people repeatedly declined to use medicines that had been prescribed for them. These shortfalls had increase the risk that the people concerned would not fully benefit from using medicines in the right way.

At the present inspection we found neither of these problems had been fully addressed. Also, we noted that on the day of our inspection visit two people had not been given their morning medicines at the right time. This was because care staff had decided to give them later on in the day as the people had not been available to take them at the correct time. However, this arrangement was poorly managed as the registered persons had not consulted with the people's doctors to check that the delayed administration of the medicines was safe. Furthermore, in the case of one of the people records showed that this practice was a regular arrangement in that it had occurred five times during the course of March 2018. A further concern involved the way in which some medicines were being stored. It is important that medicines be kept in conditions that are neither too warm nor too cool as incorrect temperatures can compromise their therapeutic effect. However, records showed that out of a total of 24 days in March 2018 medicines kept in the treatment room were being kept at a temperature that was too high.

Also, the registered persons had not suitably assessed and confirmed that the service's fire safety equipment provided people with a sufficient level of protection. Although they had completed a risk assessment of the fire safety regime operated in the service, prompt action had then not been taken to put right a number of significant shortfalls that had been found. This was the case even though the assessment had concluded that there was a 'medium risk of moderate harm' that 'could result in injury of one or more occupants'. The assessment that had been completed on 23 November 2017 stated that 14 improvements were 'high priority' and needed to be completed 'within one month'. Nevertheless, 10 of these items remained to be completed and the registered manager could not tell us when they were due to be done. Also, records that showed that regular checks had not been completed to confirm that the service's fire alarms, emergency lights and fire extinguishers remained in good working order. Furthermore, records of the fire drills that had been completed were incomplete and so we could not be assured that they had been completed in the right way. These shortfalls all contributed to reducing the level of protection people had from the risk of injury in the event of a fire.

In addition, suitable arrangements had not been made to prevent the occurrence of avoidable accidents and other untoward events. This included there being a number of trip hazards one of which was a steep ramp that changed the level of the floor in one of the corridors. There was no signage to warn people about the presence of the ramp and this created the risk that someone would not be aware of the change in floor level resulting in them tripping and falling. Also, in one bedroom a ramp that led to the en-suite bathroom

was poorly constructed resulting in it bending and wobbling from side to side if any pressure was put on it. Another concern referred to the carpet in one of the bedrooms. This was because it was worn and uneven to the point of showing the pattern of the floorboards underneath. A further problem was in the conservatory where there was a section of unfinished pipework that projected a sharp metal point at ankle height. This created the risk that people would catch and injure their skin. In addition to these concerns, suitable arrangements had not been made to provide one person from the risks associated with living in a damp environment. This was because there was a large patch of damp damage on the ceiling and wall of their bedroom resulting in the room having a musty smell.

Robust arrangements had not been made to assess, review and monitor the provision needed to promote good standards of hygiene. We were told that an infection control audit was regularly completed so that potential risks to the prevention and control of infection could quickly be addressed. However, this process had not been robust as it had not identified and resolved a number of shortfalls. In the en-suite bathroom of one bedroom the occupant had not been provided with any soap, disposable towels or toilet paper. Also, in one of the communal toilets there was no soap and no plug to enable people to wash their hands using the wash hand-basin. A further shortfall was the condition of the pedestal surrounds used in two bedrooms to support the wash hand basins. These were constructed from laminated chipboard. They were in such a poor condition that the laminate was worn away resulting in the chipboard becoming damp, discoloured and dirty. We also noted that two people had not been supported to wear clean clothes and in relation to this a person told us, "I don't think my clothes are very clean really and I don't feel my room is either. I would like my carpet cleaned." These oversights had reduced the registered persons' ability to promote good standards of hygiene in order to prevent and control the risk of infection.

In their Provider Information Return the registered persons told us that they operated robust arrangements to ensure that lessons were learned and improvements made when things had gone wrong. The registered manager said that as part of this they carefully analysed accidents and near misses so that they could establish how and why they had occurred. However, when we examined the circumstances relating to three occasions in 2018 when a person had fallen we found the records to be incomplete. This was because there was no account of the steps that had been taken to help prevent the same accidents from happening again. Consequently, we could not be sure that suitable steps had been taken to promote the safety of the people concerned.

All of these shortfalls had reduced the registered persons' ability to consistently deliver safe and harm-free care and treatment. We raised our concerns about the management of risks to people's health and safety with the registered manager. They assured us that each of the shortfalls in question would be addressed as soon as possible in order to better ensure that people received safe care and treatment which met their needs and expectations. However, they were not able to give us a clear timescale within which the registered persons would complete the necessary improvements. Therefore, we concluded that there was no realistic prospect of the required changes being made in a prompt way or being sustained.

Failure to assess risks to people's health and safety and to do all that is practical to keep people safe was a continuing breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We examined records of the background checks that the registered persons had completed when appointing two new care staff. There were oversights in relation to each person because the registered persons had not undertaken all of the necessary checks. In both cases the registered persons had not obtained a suitably detailed account of the applicants' employment history. This oversight had reduced their ability to determine from whom they needed to seek assurances about the applicants' previous good

conduct. Furthermore, even though one person's records showed that they had previously worked in a residential care setting registered persons had not established how well they had performed their duties. These shortfalls had reduced the registered persons' ability to be confident about the applicant's previous good conduct and suitability to be employed in the service.

However, records showed that the registered persons had checked with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct. In addition, the registered manager told us that no concerns had been raised about the performance of either member of staff. Furthermore, the registered manager assured us that the service's recruitment and selection procedure would immediately be strengthened to address each of the shortfalls we had identified.

Failure to operate effective recruitment procedures to obtain satisfactory evidence of applicants' conduct in previous employment was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, care staff were able to promote positive outcomes for people if they became distressed and needed assistance to keep themselves and other people safe. When this occurred care staff followed the guidance in the people's care plans so that they supported them in the right way. An example of this was a person who became worried because they could not clearly recall when they would next receive a visit from one of their relatives. This occurred in the morning while they were sitting in a communal area where they were becoming anxious and loud in their manner. A member of care staff recognised that action needed to be taken to keep the person and others around them safe from harm. The member of care staff gently reminded the person that one of their relatives usually visited them every day in the afternoon. This information reassured the person who became relaxed and who was then happy to accept a cup of tea.

People told us that they felt safe when in the company of staff. One of them said, "It's okay here, a bit rough around the edges but homely." Another person commented, "I do feel safe now that I am here, the staff are here to help you know and they let us know that." A person who lived with dementia and who had special communication needs smiled and held hands with a nearby member of care staff when we used sign-assisted language to ask them about their experience of living in the service. Also, relatives told us that they were confident that their family members were safe. One of them remarked, "I chose this place from all of the ones we saw because it felt right. The décor is poor but the staff are excellent."

We found that although care staff knew how to recognise and report situations in which people may experience abuse, the registered persons did not operate suitable systems when assisting people to manage their personal spending money. This was because records of the personal spending money held on behalf of two people were incomplete as they were not supported by receipts to confirm when money had been spent on their behalf for things such as seeing the hairdresser and the chiropodist. These shortfalls had increased the risk that mistakes would be made and financial mistreatment would occur. Also, the amount of cash held for one of the people did not match the amount of money that the records said should have been present. This was the case even though the registered manager had audited and confirmed the accuracy of the record the day before our inspection visit. We highlighted these oversights to the registered manager who told us that in future suitable receipts would be obtained from the hairdresser and chiropodist. They also told us that the incorrect cash balance would be checked again to identify what had gone wrong and that as necessary the person would be reimbursed for any money owing to them.

The registered manager told us that they had carefully calculated how many care staff needed to be on duty. However, they had not used a recognised tool when completing their assessment. As a result we could not

be confident that changes in people's needs for care would quickly be identified and reflected in staffing levels in the service. Nevertheless, records showed that the service was being staffed in line with the minimum level set by the registered persons. Furthermore, we concluded that in practice there were enough care staff on duty because we saw people receiving the practical assistance they needed.

Inadequate

Is the service effective?

Our findings

At our last comprehensive inspection on 27 and 28 July 2017 we found that national guidelines had not consistently been followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. This was because the registered persons had not always carefully established if people had the mental capacity to make decisions for themselves. This is necessary so that when necessary people can receive extra help to ensure that decisions are always made that are in their best interests.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the present inspection we checked whether the registered persons were working within the principles of the Mental Capacity Act 2005 by obtaining consent in the right way and by applying for authorisations to deprive a person of their liberty when necessary. Also, we checked whether the registered persons had ensured that any conditions on authorisations were met.

We found that the systems and processes used by the registered persons had been strengthened and made more detailed. As a result people had been properly consulted about the care they received and had consented to its provision. Also, the registered manager had completed assessments when it appeared likely that a person lacked the necessary mental capacity to make decisions about important things that affected them. Records showed that the registered manager had involved key people in a person's life ensure that decisions made on their behalf were indeed in their best interests.

Records showed that the registered persons had made the necessary applications for DoLS authorisations. Also, they had carefully checked to make sure that any conditions placed on the authorisations were being met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

The improvements made by the registered persons in obtaining consent to care and treatment in line with legislation had resulted in the breach of regulations being addressed.

At our last comprehensive inspection on 27 and 28 July 2017 we found that the accommodation was not designed, adapted and decorated to meet people's needs and expectations. This was because the accommodation did not have a fresh atmosphere and because some fittings, fixtures and furnishing had not

been well maintained.

At the present inspection we found that although most parts of the service had a fresh atmosphere the accommodation was still not designed, adapted and decorated to meet people's needs and expectations. Four people and two relatives told us that they were not satisfied with the standard of the accommodation. Summarising this view a person said, "It's not the smartest house in town and could do with a jolly good paint job I would say". A relative also remarked, "The place is obviously run-down isn't it. It looks like no one cares about the place as it's tatty. It's a real shame because the care staff themselves are lovely."

There were a number of significant defects in the accommodation. In one of the hallways the skylight was leaking and over time the wooden casing had started to rot away creating the risk that parts of it would fall onto people as they walked underneath it. There was also a leak in the conservatory that had been crudely repaired using sticky tape. Five bedroom doors were scratched and marked and throughout the accommodation furniture was old, mismatched and poorly maintained. In one bedroom there was a large hole in the wooden door surround. The sides of the hole were rough resulting in the risk that people would get splinters in their skin. The garden was not an attractive space. This was because it had been used to store two soiled mattresses and broken furniture that was piled up in two places that were near to paths designed to be used by people who lived in the service.

Suitable steps had not been taken to support people who lived with dementia to find their way around their home. Although signs were fitted to bathroom and toilet doors these did not use easy-to-understand graphics that are often helpful for people who live with dementia. Also, little had been done to distinguish each person's bedroom door so that there was less risk of them entering the wrong room. We saw a person walking up and down hallways because they were not sure which bedroom they occupied. The person was anxious and this was not addressed until a member of care staff provided them with the assistance they needed to find their bedroom.

All of these defects reduced people's ability to receive care in a safe, comfortable and pleasant setting that met their expectations. The registered manager told us that there were plans to develop the accommodation but there were no records to confirm this account. In the absence of any plans we could not be confident that these defects would be addressed in the near future.

Failure to design, adapt and decorate the accommodation to meet people's needs and expectations was a continuing breach of Regulation 15 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

However, people told us they were confident that care staff knew what they were doing and had had their best interests at heart. One of them said, "The care staff here are very good and give me all of the help I need." Relatives were also complimentary about this matter. One of them said, "My family member needs a lot of help and yes they can be quite demanding but the staff are very kind and always very patient."

Arrangements were in place that were designed to assess people's needs and choices so that additional provision could be made to ensure that people did not experience discrimination. An example of this was the registered manager asking people if they had particular expectations deriving from cultural or ethnic identities about how their close personal care should be provided and who should deliver it.

Records showed that care staff had been supported to enable them to provide people with practical assistance in line with national guidance. This included receiving introductory training before they provided people with care. Also, records showed that new care staff had been offered the opportunity to complete the

Care Certificate. This is a nationally recognised training scheme that is designed to ensure that care staff are competent to care for people in the right way. However, care staff had not always received all of the more detailed training that the registered persons said they needed to in order to keep their knowledge and skills up to date. Furthermore, the registered manager was not able to show us a plan to address this shortfall in the near future. This increased the risk that care staff would not have the opportunity to develop their knowledge and skills in line with changes in national guidance. Nevertheless, we found that in practice care staff knew how to care for people who were living in the service at the time of our inspection visit in the right way. An example of this was care staff knowing how to assist people who were at risk of developing sore skin or who needed help to promote their continence. Also, the registered manager told us that they would strengthen the delivery of refresher training in order to address each of the concerns we had raised.

People told us that they enjoyed their meals. One of them said, "The meals are very good and I get more than enough to eat." A person who lived with dementia and who had special communication needs smiled broadly when we used sign assisted language to ask them about their experience of dining in the service. We were present at lunch time and we saw that people were offered a choice of dishes which were well presented.

People were being supported to eat and drink enough to maintain a balanced diet. Records showed that care staff were making sure that people were eating and drinking enough to keep their strength up. Also, the registered manager was aware of the arrangements that needed to be made if a person was at risk of choking. This included people having their food and drinks specially prepared so that they were easier to swallow.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included care staff preparing written information likely to be useful to hospital staff when providing medical treatment. Another example of this was the registered manager offering to arrange for people to be accompanied to hospital appointments so that important information could be passed on to healthcare professionals.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection on 27 and 28 July 2017 we found that people did not always receive care in a way that promoted their dignity. This was because we witnessed occasions on which some care staff were blunt and unhelpful in their manner.

At the present inspection we found that care staff were polite and courteous when speaking with people who lived in the service. Also, people were positive about their experience of receiving care in the service. One of them told us, "It's absolutely the staff who make the place because of their kindness." Relatives were also uniformly complimentary about the care staff. One of them remarked, "I've quite literally never seen a cross word from the staff who seem to get on well with each other and make it a happy place to be."

However, we found that suitable provision had still not been made by the registered persons to fully promote people's dignity. During our inspection visit a number of people had consultations with a visiting chiropodist. We noted that the registered persons had not ensured that the chiropodist realised that it was their responsibility to pick up nail clippings after they completed each person's treatment. Furthermore, care staff did not quickly collect the nail clippings. As a result when we visited two people more than one hour after their treatments had been concluded we found them sitting in their armchairs with nail clippings and dead skin scattered about the carpet near their feet. This was an unsightly and undignified arrangement. A further example of a person's dignity not being fully respected occurred when they were being served their afternoon tea. We were concerned to note that a member of care staff who was serving the refreshments did not ask the person what drink they wanted to have. Instead, they just served them with a mug of tea and also brought them a single biscuit without offering them a choice from the biscuit barrel. Speaking about this arrangements a person who lived in the service shrugged their shoulders and remarked, "That's how it is here."

Suitable provision had not been made by the registered persons to promote people's privacy. This was because a communal toilet, a bathroom and a shower room did not have locks on the doors and so could not be secured when in use. When we were nearby one of these rooms we witnessed a member of staff walk in thinking it was vacant whereas in fact a person was using the toilet. Furthermore, a person told us, "The staff do close doors when they need to and if I'm using the toilet they are usually pretty good but sometimes they can be slapdash and leave me showing all." We also noted that two bedroom doors were not fitted with locks.

We raised our concerns about these shortfalls with the registered manager. They assured us that the new arrangements would be made to address each of shortfalls we had identified.

Failure to ensure that were suitable arrangements to ensure that people consistently received care that promoted their dignity and that was respectful was a continuing breach of Regulation 9 (1) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

On most occasions care staff were considerate and we saw that a special effort had been made to welcome

people when they first moved into the service. This had been done so that the experience was positive and not too daunting. The arrangements had included asking family members to bring in items of a person's own furniture so that they had something familiar in their bedroom when they first arrived. Records also showed that care staff gently asked newly-arrived people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night.

People had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family, friends or solicitors who could support them to express their preferences. Also, records showed and relatives confirmed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Furthermore, the registered manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People could speak with relatives and meet with health and social care professionals in private if this was their wish. Also, care staff had assisted people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. This included written records that contained private information being stored securely when not in use. Also, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

We asked five people to tell us their views about whether they were offered sufficient opportunities to pursue their hobbies and interests. Four people told us that they would like to see this aspect of the service further developed. Expressing this view one of them remarked, "It can be a long day just sitting for most of it. The afternoons are the worst part of the day because everyone seems to be asleep and usually the staff are too busy with other care stuff that they have to do."

People had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. There was no activities manager to make sure that people were invited to enjoy social events. The registered manager assured us that in their absence three care workers regularly worked extra hours each week to organise social activities. These included both small group events held in the lounge and individual support for people who preferred to spend most of their day in their bedroom. However, the timesheets for the members of care staff concerned for the two weeks preceding the date of our inspection visit showed that no extra hours had been deployed in the manner described to us.

We looked at the records that we were told were completed each time someone had been invited to enjoy a social activity. We focused on the invitations two people had received during the course of three weeks preceding the date of our inspection visit. There were no entries in the records to show that the people concerned had been invited to participate in either small group or individual activities. Also, for most of the time during our inspection visit we saw people sitting on their own without anything to engage their interest. Some people were silent and others slept in their armchairs. Two of the people we saw were restless as they repeatedly changed their seating position due to becoming uncomfortable because of the amount of time for which they had been inactive.

Although there was an external entertainer who called each week to the service, people had not been offered the opportunity to have any other regular contacts with the local community. The service had its own transport but we were told that the engine had not been started for many months and the registered manager was not sure if any of the care staff were insured to drive it. They also told us and records confirmed that people had not been supported to go out and about in the community to the shops and to places of interest for more than one year.

We raised our concerns about this aspect of the service people received with the registered manager. They assured us that people would be consulted about the additional social activities they would like to enjoy. They also told us that any necessary extra resources would be made available to develop the calendar of social activities provided by the service.

People said that care staff provided them with all of the practical assistance they needed. One of them remarked, "The staff help me how I like it. They don't take over and they know what I like to do for myself." Relatives were also positive about the amount of help their family members received. One of them commented, "I can see for myself that my family member is always well dressed in clean matching clothes and their hair is neat. These are things that are important to my family member and they're sings to me that

the care is right."

Care staff had prepared a care plan for each person. These described the practical assistance each person needed and had agreed to receive. Records showed and our observations confirmed that people were being given the practical assistance they had agreed to receive in line with their care plan. This included assistance with washing and dressing, getting about safely, promoting their continence and managing healthcare conditions. However, little had been done to present information in a user-friendly way for people who lived with dementia by using multi-media tools such as graphics and colours. This oversight had reduced people's ability to be fully involved in the process of recording and reviewing the care they received. We spoke with the registered manager about this shortfall and they told us that improvements would be made to better support people to access information that was kept in their name.

Care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs through religious observance. Also, documents showed that the registered persons recognised the importance of appropriately supporting people who chose gay, lesbian, bisexual and transgender life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their lifestyle choices.

Arrangements had been made to support people if they wanted to make a complaint about the service. Although the complaints procedure did not present information in an accessible way, in practice people knew what to do if they wanted to make a complaint. Also, the registered persons had systems and processes in place that was designed to ensure that complaints were properly investigated. This was so that complainants could be confident that their concerns had been addressed.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. Also, there were examples of care staff having kindly supported relatives at this difficult time. This included making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection on 27 and 28 July 2017 we found that robust arrangements had not been made to assess, monitor and improve the quality and safety of the service. This was because the quality checks that had been completed by the registered persons not identified and quickly resolved shortfalls in the running of the service.

At the present inspection suitable arrangements had still not been made to ensure that the service reliably met regulatory requirements by learning, innovating and ensuring its sustainability. Although there was a registered manager quality checks had not always been completed in the right way to quickly put problems right. This had resulted in the persistence of the concerns we have described earlier in our inspection report. These issues included oversights in the provision of safe care and treatment, safeguarding people from the risk of financial mistreatment and in relation to the completion of background checks on new care staff. They had also resulted in the other concerns we noted relating to shortfalls in staff training, the promotion of people's dignity and the provision of social activities.

People had not been fully involved in making improvements to the service. Although there had been regular 'residents' meetings' action had not always been taken to respond to concerns that had been raised. We examined the records of three of the most recent meetings and on two occasions there was no action plan to show what had been done to respond to people's suggestions. Even when an action plan had been prepared it had not been put into effect. An example of this was a residents' meeting at which people had requested more opportunities to be supported to access the local community.

The registered manager told us that they recognised the importance of developing a person centred focus in the service and so had introduced a new system whereby they met regularly with everyone who lived there. They said that this was necessary because some people did not want to attend the residents' meetings and so an additional opportunity needed to be provided everyone's voices to be heard. However, this arrangement was not working as intended as there was no evidence to show that changes had been introduced. An example of this was a person who told the registered manager that they regretted not being able to join in with quizzes that they had previously enjoyed. This was because they could no longer easily go the lounge where the quizzes were held due to their poor health. No steps had been taken to give the person the extra support they needed to pursue this part of their social life.

We spoke with the registered manager about the shortfalls we had identified in the arrangements that had been made to enable the service to learn, innovate and ensure its sustainability. Although they assured us that steps would be taken to address each of our concerns, they were not able to describe the actions they would take and the timescale within which the necessary improvements would be completed. Therefore, we concluded that there was no realistic prospect of the required changes being made in a prompt way.

Failure to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activities was a continuing breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, people considered that the day to day provision of care in the service was well managed. One of them said, "I do think that on balance it's quite well run because I get the care I need. The place is a bit run down I suppose and there could be more things to do but the care is the main thing – and that's all right." Relatives were also complimentary about most aspects of the management of the service. One of them remarked, "Overall, the service is quite well sorted but I do think more could be done to the building and more should be done to develop social activities."

A number of systems were in place to help care staff to be clear about their responsibility to provide people with the practical assistance they needed. This included there being a named member of care staff who was in charge of each shift. Also, arrangements had been made for the registered manager to be on call during out of office hours to give advice and assistance to care staff should it be needed. Furthermore, care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision was designed to ensure that care staff were suitably supported to care for people in the right way.

Care staff told us there was an explicit 'zero-tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered persons if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

The service worked in partnership with other agencies. There were a number of examples to confirm that the registered persons recognised the importance of ensuring that people received 'joined-up' care. This included operating efficient systems to manage vacancies in the service. The registered persons carefully anticipated when vacancies may occur so that they could make the necessary arrangements for new people to quickly be offered the opportunity to receive care in the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had not made suitable provision to ensure that all persons employed for the purpose of carrying on the regulated activity were of good character.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had not made suitable provision to ensure that people who lived in the service were treated with dignity and respect.

The enforcement action we took:

We have imposed a condition on the registered persons' registration to ensure that additional people are only admitted to the service when suitable provision has been made to ensure that they are treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not made suitable provision to provide care and treatment in a safe way by assessing risks to the health and safety of people receiving care and treatment and by doing all that was reasonably practical to mitigate such risks.

The enforcement action we took:

We have imposed a condition on the registered persons' registration to ensure that additional people are only admitted to the service when suitable provision has been made to reliably deliver care and treatment in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had not ensured that the premises and equipment were suitable for the purpose for which they were being used.

The enforcement action we took:

We have imposed a condition on the registered persons' registration to ensure that additional people are only admitted to the service when suitable provision has been made to ensure that the premises and equipment are suitable for the purposes for which are used.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not established and effectively operated systems and processes to robustly assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

The enforcement action we took:

We have imposed a condition on the registered persons' registration to require them to regularly submit quality audits to us describing how improvements are being made to the service.