Mrs Diana Dolorse Enilde Williamson

Ashbourne House

Inspection report

213 St Marychurch Road
Torquay
Devon
TQ1 3JT

Tel: 01803327041

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4, 6 and 10 July 2017, the first and third days of the inspection were unannounced.

Ashbourne House is registered to provide accommodation and personal care for up to 28 older people. The service was previously registered with CQC as a partnership but was re-registered in March 2017 with a single provider who had been one of the partners previously registered.

On the first and second days of the inspection there were 18 older people living at the service. One person who required support with their care was also spending the day at the service. Nine people were living with dementia and five people needed the assistance of two care staff with their moving and transferring and personal care. On the third day there were 17 people living at the service. The service does not provide nursing care, and this service is provided by the local community nursing team.

The provider is registered as an individual and there is no requirement for a manager to be registered with CQC. However, the provider did employ a manager and deputy manager to assist them in the management of the service.

The provider did not have an understating of their legal obligations relating to their registration with the Care Quality Commission. The provider was not aware of the implementation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force in April 2015. This meant the provider did not have an understanding of the requirements of this Act and where they were in breach.

The provider was not managing the service in a way that protected people from the risk of harm from unsafe care. Systems in place had not been effectively implemented to ensure people received safe, effective, caring and responsive care and support. Staff recruitment practices were not always safe and staff did not receive supervision and support to ensure they were supported to meet people's care needs. Staffing levels were insufficient to ensure people received support from staff in a timely way. Care plans and risk assessments were not always detailed enough to provide guidance and information to staff about people's care needs and how to mitigate risks to their health and safety. CQC had not been notified of all serious injuries without delay.

Shortly before this inspection, the local authority had provided support to the service through its Quality Assurance and Improvement Team (QAIT). A service improvement plan had been developed which detailed the actions the provider had taken to address the shortfalls in the management systems. However, we saw that some information detailed in the plan was not accurate. Following the inspection we spoke with the members of the local authority commissioning team and QAIT. They raised similar concerns as those identified in this report and took action to mitigate the risks identified.

Prior to this inspection, in July 2017 we had received concerns about staffing levels poor infection control

practices, poor moving and transferring techniques and poor quality of food. We found evidence to support the concerns relating to low staffing levels and some poor infection control practices. We found no evidence to support the concerns relating to poor moving and transferring techniques or the quality of food being served.

There were insufficient staff on duty to ensure people received care in a timely way and in a manner that was person-centred. Records relating to people's care needs and any associated risks were poorly recorded and did not provide an accurate or detailed description to ensure staff could provide safe care and support. People's care plans had not always been updated to reflect their changing needs. Staff were not provided with clear information about people's specific care needs and how they should offer support to reduce their anxiety. We observed some staff were focused on tasks such as completing records and ignored people who were distressed. Supervisions and observations of staff had not identified, or had not addressed these issues in a way that ensured people had positive experiences. This placed people at risk of receiving unsafe care.

Systems in place to reduce risks associated with people's care and support were not always effective and this exposed people to the risk of harm. In addition to this people were not protected from risks associated with the environment. We received information from the local fire service, following a routine inspection in July 2017 that indicated risks relating to fire safety matters had not been dealt with. Following the visit from the fire officer, the provider had met with them and agreed dates for the completion of these matters. Some areas of the service needed additional cleaning or maintenance, and there was a significant odour problem around the service.

Accidents and incidents were recorded but not monitored for patterns that may help reduce the risks of a reoccurrence.

Recruitment practices were not always safe. The provider had failed to properly assess the risks of employing staff who may be unsuitable to work with people needing help with their care needs.

The provider had failed to ensure all staff received appropriate induction and supervision to ensure they were able to meet people's needs. Not all staff received sufficient supervision or had their competence to work thoroughly assessed. Not all staff treated people with respect and promoted their dignity. Staff new to the service and agency care staff did not always receive information about how to safely evacuate people from the building should the need arise.

People's right to privacy was not respected and they were not treated with dignity. Locks were not fitted to all bathroom and toilet doors. People were not always assisted to eat in a dignified and respectful manner that promoted their independence.

People were not provided with appropriate person-centred stimulation and activities. People spent long periods of time without staff interaction. Most people spent their time looking around the lounge area. The TV was on for most of our inspection, but people were not interested in it. Some activities and entertainment were provided and when we saw these taking place, people participated with enjoyment. However, we saw and people and their visitors told us, staff were often too busy to provide any meaningful stimulation for people.

We found the provider and manager were not always supporting people to have choice and make decisions about their care and did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. For example, people who were able to leave the service unaccompanied had to ask staff to open the front door for them before they could leave. However, care staff

were aware of people's right to refuse support and asked people for their consent before they assisted them. People were supported by staff who had a good understanding of their responsibilities should they have concerns people were at risk of abuse.

Complaints were not well managed. Details of who to make a complaint to were incorrect and there was no evidence that all concerns raised with the provider had been dealt with.

Some people's visitors were not happy with the care being provided to their relative and told us staff were unable to spend quality time with people due to low staffing levels. However, other visitors were happy with the care being provided. A quality assurance survey report produced in January 2017 showed 22 people had completed the survey and reported a high level of satisfaction with the overall quality of care being provided. People and their relatives were able to help plan the support people needed by being involved in regular meetings to discuss their needs.

People and their relatives told us they were happy with the quality, variety and choice of food being provided.

People received regular visits from healthcare professionals in order to ensure good health was maintained. People were supported to receive their medicines safely and on time.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We made recommendations in relation to the Mental Capacity Act 2005. We also identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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.

Insufficient staff were employed at the service to ensure people's needs were met.

People were not fully protected from the risks associated with the employment of staff.

Risk assessments did not always contain sufficient detail to help keep people safe.

The environment was not maintained to ensure it was safe for people.

People were not protected against the risks of cross infection.

People were supported to receive their medicines safely and on time.

People were protected from the risk of abuse, because staff had a good understanding of how to recognise and report abuse.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People were not supported by staff who received sufficient induction and supervision to ensure they were competent to meet people's needs.

People did not benefit from a clean, comfortable environment.

People's rights were not always upheld as the provider and manager did not have a good understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

People were supported to receive good quality meals and were offered a choice of menu.

People were supported to receive regular visits from healthcare professionals.

Is the service caring?

Inadequate

The service was not always caring.

People did not always receive care that was respectful and promoted their independence, privacy and dignity.

People did not always receive support from kind and caring staff.

People and their relatives were supported to be involved in planning their care if they wished to.

Is the service responsive?

Inadequate

The service was not responsive.

People were placed at risk of not receiving the care and support they required to meet their needs. Care plans were large documents that did not always contain up to date information for staff on how to meet people's needs. Care was not provided in a person centred way.

People did not benefit from individual social interaction and activities and most people were left under stimulated for long periods of time.

The service did not manage complaints well. Information relating to complaints was not up to date and not all concerns had been addressed.

Is the service well-led?

Inadequate

The service was not well led.

People did not receive good quality care that met their needs, expectations and preferences.

The quality monitoring systems were ineffective and failed to identify and address the serious concerns about people's safety and welfare we found at this inspection.

The provider had not taken sufficient action to ensure people received safe and high quality care from kind, compassionate and competent staff.

CQC had not been notified of all serious injuries without delay.

People's records did not always contain up to date and accurate information.

Ashbourne House

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 checked whether the provider was 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.

Prior to the inspection we had received some concerns about low staffing levels resulting in people receiving poor care. Concerns were also raised about poor infection control practices, poor moving and handling techniques and the poor quality of food. Because of these concerns we brought the scheduled inspection forward.

This inspection took place on 4, 6 and 10 July 2017. The first and third days were unannounced.

One adult social care inspector and an inspection manager conducted the first day of the inspection and one adult social care inspector conducted the second and third days of the inspection. The inspection manager took part in the first day of inspection while observing the practice of the inspector.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information received from staff and relatives as well as notifications (about events and incidents in the service) sent to us by the registered provider. We also received information from the local authority's Quality Assurance and Improvement Team (QAIT) who had been working with the provider.

Not everyone living at Ashbourne House was able to tell us about their experiences. Therefore we spent time in the main lounge on each of the inspection days and used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We met with all the people using the service and spoke with eight people privately. We spoke with five care staff, two agency care staff, three ancillary staff, the provider, the manager and deputy manager. We also spoke with three visitors and two visiting health and social care professionals.

During the inspection we looked at a number of records including seven people's care records, the provider's quality assurance system, accident and incident reports, three staff files, records relating to medicine administration, complaints and staffing rotas.

Inadequate

Is the service safe?

Our findings

We found the service was not safe. People were placed at risk because the provider had not identified and addressed risks associated with the fire detection system. We received information from the local fire authority, following a routine inspection in June 2017 that indicated risks relating to fire safety matters had not been dealt with. The fire service had identified ten matters requiring action. These included electrical installation to be inspected, fire risk assessment to be completed and final exit doors to be fitted with easily openable locks. Following the visit from the fire officer, the provider and fire authority had met and agreed dates for the completion of these matters and some works had already been completed.

However, during our inspection we found continued risks. People could not easily evacuate the service in the event of a fire because fire exits were not visible or were obstructed. On the first day of the inspection we saw one person sat in a chair in front of the fire exit in the lounge. There was also a curtain across the door so people would not know it was a fire exit. We pointed this out to the provider who moved the chair, but later we saw a table had been placed in front of the exit and the curtain was still drawn across the fire door. On the second and third days the exit was clear and people could see it was a fire exit.

People were not protected in the event of a fire because information about how many people there were in the building and their room numbers was not accurate. On the first day of the inspection we were told there were 20 people living at the service. However, we were told on the third day of the inspection that there had only been 18 people living at the service. On the first day of the inspection we asked for a list of people living at the service that would be given to the fire service in the event evacuation of the premises was needed. The list contained incorrect information. Some people's room numbers were incorrect and the list did not contain the names of everyone living at the service. This meant that if the premises needed to be evacuated staff and the fire service would not have the correct information for them to safely evacuate people. This list was updated during the inspection, but the new list showed one person's surname incorrectly. This was also corrected during the inspection. We also saw that some people's emergency evacuation plans did not contain sufficient information to guide staff about their support needs should they need to be evacuated. For example, one person's evacuation plan stated they had short term memory problems and could become anxious, but there were no instructions on how staff would help the person should they become anxious during an evacuation. The provider and manager agreed to update the plans and on the third day of inspection we saw they had been updated.

On the first day of inspection we spoke with one member of staff who was new to the service and was working their second shift. They told us they had not been shown where the fire exits were and would not know where to evacuate people to. We asked the manager about this and they told us it was the team leader's responsibility to ensure the new staff member was aware of evacuation procedures. We spoke with the staff member again on the third day of inspection and they confirmed they had been given the information. However, we spoke with a member of agency care staff on the third day of inspection and they told us they were working their second shift there, but had still not been given details of how to safely evacuate people. This showed us the manager had not ensured all staff had the required information. However, since the inspection the provider has assured us that all staff have received fire training and all

new and agency staff will receive this.

People were not protected from the risk of trips and falls. There were several corridors where the carpets were badly rucked and could present a trip hazard. A handrail on the wall outside the kitchen was coming away from the wall and could have caused a person to fall if they had relied on it for support. The provider told us they had delegated routine checks of the premises to a member of staff. However, these defects had not been identified. The provider agreed to ensure repair work was undertaken to remove the rucks in the carpet to minimise the risk of trips and to secure the handrail. The handrail was secured on the second day of inspection. Following the inspection the provider told us a company had visited to arrange a date to deal with the carpets.

The provider told us regulator valves were fitted to hot water taps in all bathrooms and bedrooms. This was to minimise the risk of scalding from hot water. We checked the hot water in one toilet and one bedroom and found the water was not hot enough to scald. However, people were not protected from risks associated with hot water or Legionella Disease. There were no checks undertaken on water temperatures to ensure the regulator valves were working correctly or to ensure the risk of Legionella Disease was minimised.

Risks to people's safety were not always identified or well managed. We saw some people were at risk of falling when walking around the lounge. This was due to their poor mobility and living with dementia. One person's mobility had been assessed on 4 April 2017 and stated the person would sometimes stand and walk with two staff, or would require a wheelchair, standaid or hoist due to their poor mobility and dementia. On the first day of inspection we saw this person standing unaided and walking unsteadily around the lounge unsupervised, sometimes holding on to furniture, as there were no staff in the lounge area. Staff told us the person's mobility had improved and they were now able to get up from their chair and walk unaided. Our observations showed this person remained at risk of falling as they were unsteady on their feet. The person had not been reassessed to take into account their improved mobility or the risk associated with their improved mobility. On the second and third days of the inspection we saw a member of staff, who was supervising everyone in the lounge, supporting the person when they walked around the lounge, which helped minimise their risk of falling.

Risks associated with people choking were not well managed. We saw that some people were at risk of choking and had been assessed by a professional. Advice had been given about the consistency of their food and fluids in order to minimise the risk of choking. Not all staff were aware of this which put people at risk of choking. We were told by one staff member that one person required their fluids to be thickened to 'syrup' consistency. However, the person's care plan stated their fluids should be thickened to 'pudding' consistency which is thicker than syrup consistency. This meant the person was at risk of choking due to the incorrect consistency of fluids being given to them. The 'handover' sheet information for this person given to us on 10 July 2017 indicated the person needed their fluids thickened but did not state to what consistency. This meant agency staff who would rely on this summary for information, were not provided with an important piece of information to help them keep people who were at risk of choking, safe. We spoke with the manager about this and they placed information relating to the correct consistency of people's fluids in front of the folder containing their daily notes. They also said they would highlight this information on staff 'handover' sheets given to staff at the start of their shift.

Assessments carried out to assess the risks associated with the use of bed rails used to prevent people from falling from their bed were incomplete. Assessments had not given proper consideration to the risks bedrails present. We saw one person had bedrails in the upright position but there were no bumpers to protect them from the risk of injury or entrapment on the rails. The risk assessment showed no need for

bumpers to be fitted as the person did not move and could therefore not hurt themselves on the unprotected rails. There had been no consideration that the person may have some movement and therefore could be at risk. We discussed this with the provider and manager who agreed bumpers would provide added protection for the person and following the inspection they told us they had fitted bumpers.

Accidents and incidents were monitored by the manager and provider and a spreadsheet was produced showing the numbers that had occurred. However, these accidents and incidents had not been analysed in order to minimise the risk of reoccurrence. For example, we saw a report of an incident in June 2017 between two people. There had been no analysis of the incident in order to determine how it had occurred and to help prevent a re-occurrence. We saw on the accident and incident spreadsheet for 18 May to 18 June 2017 that one person had fallen twice. The person's mobility plan and risk assessment had not been updated in relation to these falls. This showed the provider and manager did not learn from previous accidents and incidents because they did not look for any patterns that may have developed. We discussed this with the provider and manager who agreed to ensure that all accidents and incidents would be monitored for trends and to update people's care plans to reflect any changes needed to their care or the environment.

Some people had been assessed by the manager as being at risk of developing pressure ulcers, and required their position to be changed regularly in order to minimise the risk. We saw information was recorded in relation to when and how people should be repositioned and that this was taking place as required. Four people had developed pressure ulcers and community nurses were involved in managing their care. Following the inspection we spoke with a healthcare professional who raised some concerns that staff did not always follow advice given by them in relation to pressure relief. They told us staff did not always ensure people sat on pressure relieving cushions as advised. However, we did not see this during our inspection.

Prior to the inspection we had received concerns relating to poor infection control practices. During this inspection we found people were not protected from risks relating to cross infection. On the first day of inspection we saw a member of staff carrying bags containing soiled linen without wearing disposable gloves or an apron. We discussed this with the provider and manager who agreed to make staff aware of the need to use protective equipment when needed.

The laundry area was sited outside the main building. The area was damp and unclean. The laundry floor was bare concrete and not easily washed. The poor maintenance of this area increased the risk of cross contamination from soiled items.

Failure to assess and mitigate risks relating to the health and safety of people including from fire, pressure area care, the spread of infection and failure to ensure the premises are safe is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some staff did wear disposable gloves and aprons as required. We saw liquid hand wash containers, paper towels, disposable gloves and aprons and hand gel available to staff and placed around the service.

Concerns were raised with us that the washing machines were not suitable for use as they were of a domestic type. We saw information that stated while the machines were of a domestic type they had a pre wash facility for soiled items and reached the temperature required to minimise the risk of cross infection.

There were not always sufficient numbers of staff to keep people safe and meet their needs. Prior to the inspection we had received concerns relating to low staffing levels. On the first day of inspection there were 18 people living at the service. There were two care staff on duty when we arrived and another came on duty

mid-morning. The staff member who had come on duty mid-morning told us they were scheduled to have a day off, but they had been asked to come in as there was an inspection by CQC. The provider, manager and deputy manager were also on duty along with three ancillary staff who were the cleaner, the cook and the maintenance person. We received conflicting information in relation to the role of the deputy manager and whether they worked alongside care staff to assist people with their personal care. We were initially told by the deputy manager they worked as care staff during the morning, but then they told us they did not do this. Later they told us they had misunderstood us and that they did help with people who only needed one member of staff to help them. Care staff on duty told us the deputy manager did not help with care tasks except to administer medicines.

During the morning of the first day of inspection we saw people walking unsteadily around the lounge area where they were unsupervised due to staff attending to people in their rooms. One inspector had to intervene in an incident between two people when one person did not like the attention of the other, as there were no staff around. During two particular periods of observation in the lounge by an inspector, we saw that there were no staff in the lounge for periods of eight, ten and 12 minutes. There were 10 people sat in this area and one person was calling out and raising their voice to others in the room. When staff did enter the lounge it was to bring people back into the lounge. At these times interactions from staff were poor and they did not enquire if people needed any assistance. Staff told us they were unable to have anyone supervise the lounge as there were not enough staff on duty.

During the first day of the inspection there was a rushed atmosphere. Five people required two staff to help them with their care needs, which meant staff were often busy attending to those people in their bedrooms or bathrooms. Staff did not have time to spend with people other than when providing personal care. People were told to sit down each time they began to move as there were not enough staff to spend quality time with them. Staff said they were only able to meet people's basic personal care needs and due to the shortage of staff were unable to spend time meeting people's social needs.

Visitors and people told us they were concerned over the staffing levels and lack of supervision of people in the lounge. They told us that over the Christmas period following the last CQC inspection that staffing levels had been increased. At that time there had been four care staff on duty and staff had time to spend with people other than providing basic personal care. A visiting healthcare professional told us they did not think there was always enough staff on duty to meet people's needs safely.

People did not have access to call bells in the lounge and this meant they had to wait for staff to come into the lounge if they needed help. There were two call points on the wall but these were out of the reach of people. One person told us they would "call out" to gain assistance from staff. One person told us they often had an 'accident' because staff were not available to walk with them when they wanted to use the toilet. We asked the manager why people did not have pendant call bells to get attention when needed. They said they thought it was a good idea, but no arrangements were made for people to have them.

The provider showed us a tool they used to calculate staffing levels. This was based on the time taken to meet people's needs and this showed there were enough staffing hours available to meet people's needs. However, the information used to calculate the time needed to meet people's need was incorrect. It did not take into account that when two staff were needed to help the person the amount of staff time was doubled. The total staffing hours provided included the manager and deputy manager both working full time as care staff, which they were not.

We discussed our concerns relating to staffing levels with the provider and manager about how the reduction of staff since the Christmas period had impacted on people. They told us they had reduced

staffing levels because the numbers of people living at the service had reduced. However, they had not increased the staffing levels when numbers had increased. This meant they had not kept staffing levels under review and placed people at risk of not having their needs met in a safe and timely way.

Failure to ensure there are sufficient numbers of staff on duty at all times is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the second and third days of the inspection we found staffing levels had increased and there were four care staff on duty with one staff member present in the lounge at all times. Staff told us these staffing levels had been introduced following the first day of our inspection. We saw staff had time to spend with people ensuring they could safely walk about the service. People were also able to go out into the garden. Staff spent time sitting and chatting with people. They told us they were far less rushed and were able to spend time with people on an individual basis when not providing personal care. The provider and manager agreed the service had a much calmer atmosphere and staff were less stressed. The provider agreed these staffing levels would continue and they would use agency staff until they were able to recruit permanent staff.

People were not always protected from the risks associated with the employment of staff who may be unsuitable to work with people requiring help with their care needs. We looked at three staff files and saw they contained the required pre-employment checks including application forms and references. They also contained Disclosure and Barring Service (DBS) checks. The DBS checks people's criminal history and their suitability to work with people who may be vulnerable due to their circumstances. However, we saw that one DBS check contained details of convictions. The provider had carried out a risk assessment prior to their employment, but this was not robust enough to ensure people living at the service were fully protected. The manager agreed to ensure a robust risk assessment was completed.

Failure to ensure recruitment procedures were operated effectively is a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risks of abuse because staff had a good understanding of different types of abuse. They were able to tell us about how they would recognise if abuse was occurring and what they would do if they suspected any abuse had taken place. Staff told us they would report any suspicions to the manager or provider and felt confident action would be taken. One member of staff was unsure who to report any suspicions to outside of the service. However, we saw information displayed around the service that contained contact details for the local safeguarding team.

People were supported to receive their medicines safely and on time. Medicine Administration Records (MAR) indicated people received their medicines on time and as prescribed by their GP. During the inspection we observed staff offering people their medicines at the specified times, explaining to them what their medicines were for and ensuring they had a drink available to take with their medicines. Medicines were stored safely in a locked trolley in a locked cupboard. Only staff who had received training administered medicines. Audits of medicines were undertaken on a monthly basis and records were kept of any medicines returned to the pharmacy. One audit had identified a discrepancy in quantities recorded and held of one medicine. An incident form had been completed and it was identified that the discrepancy related to a medicine that had been returned to the pharmacy as it was out of date. The return had not been noted in the records, which had led to the discrepancy. The staff member involved had received further training.

Some people had been prescribed medicine to be taken when required (PRN) for pain relief or anxiety. Where PRN medicine was prescribed to help manage people's anxiety there were no guidelines within their MAR or care plan as to when the medicines should be administered. There was no indication of how staff would recognise when people were beginning to become anxious, or if alternative interventions should be used before the medicine was given. However, we saw that this medicine was not being given on a regular basis. We discussed this with the provider and manager who agreed to ensure this information would be recorded on people's MARs and care plans.

Requires Improvement

Is the service effective?

Our findings

People's needs were not being met effectively because staff did not receive sufficient induction and supervision. People living at Ashbourne House had needs relating to living with dementia and physical needs.

Staff did not receive sufficient induction and supervision to ensure they effectively carried out their role. We spoke with one staff member who was working only their second shift. Although they were an experienced carer they had been told they would be 'shadowing' an experienced staff member. This was because they did not know the service or the people living there. However, due to low staffing levels this shadowing had not happened and they were left to work alone for most of their shift. They had not received a thorough induction to the service and had not been shown around the service and told were fire exits were. They had been given a 'handover' sheet that contained brief details of people's needs, but this was out of date and did not contain the most up to date information on people's needs. They had not had time to read people's care plans due to the low staffing levels. One agency staff member who was new to care told us they had been told they would be shadowing an experienced staff member. However, they were frequently left to work on their ownThe manager told us that it was the team leader's responsibility to ensure new staff members received sufficient induction. They were not aware this had not been done and told us they would speak with the team leader to ensure it was done in future. However, the team leader was a member of the team directly providing care to people and would not have been in a position to provide this support. When we spoke with an agency staff member on our third day of inspection they told us they had not been shown where the fire exits were. This meant action had not been taken after we had raised our concerns.

The manager and provider told us they ensured staff were competent to meet people's needs through supervision and observation of their practice. We saw evidence that staff received regular supervision and discussions were held on some aspects of care practices. However, we saw that this system was not always effective. We heard one member of staff speaking sharply to people and telling them to sit down each time they got up from their chair. An agency member of staff told us they had concerns about the staff member's attitude and they had not heard them say please or thank you to anyone. We saw the staff member's supervision record completed by the provider in June 2017 highlighted other staff had concerns about the staff member's attitude towards people. The provider had not addressed this with the staff member. Following the inspection we received evidence the manager had spoken with the staff member about the way in which they spoke with people.

During our periods of observation we saw a staff member completing daily care records in the lounge and ignoring people who were calling out while they were completing the records. We discussed our concerns with the provider and manager who agreed to address these matters and ensure staff were competent in their role, attentive to people's requests for assistance and treated people with respect.

Failure to ensure staff received appropriate supervision is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records that indicated the manager conducted regular observations of staff to ensure they used appropriate hand washing techniques.

Staff received a variety of training including moving and transferring, medicines, first aid, safeguarding people, epilepsy and dementia awareness. The provider kept a matrix to ensure staff training was up to date. We saw staff using correct procedures when moving and transferring people.

The service was in need of redecoration and refurbishment. Some areas of the service including bedrooms, had a strong unpleasant odour, and a visiting professional told us there was a strong unpleasant smell around the service. The provider and manager told us that they were unaware of this and that they thought the service did not smell. They told us there was a regular cleaning programme in place to address this. However, throughout the inspection there continued to be a strong malodour.

Some areas of the service were dusty and needed cleaning. The housekeeper showed us their schedule for cleaning but said it was hard to keep up with the cleaning as they were the only person responsible for cleaning and the laundry. Rotas showed this staff member worked six hours each day Monday to Friday. This meant there were 30 hours available for cleaning a large adapted building and managing the laundry for up to 24 people. They told us they had been on leave for two weeks and care staff would have had to do any cleaning and laundry required. On the third day of inspection the service again smelled unpleasant and there was debris on the carpet in the lounge. The provider told us the housekeeper had not arrived for their shift and had been unable to contact them. They had not made any further provision for the service to be cleaned.

One bedroom in particular was in need of redecoration. The wallpaper was peeling away from the wall, there appeared to be damp patches on the walls and a hole in the carpet had been covered by tape. The relative of the person whose bedroom this was said they had requested several times the room be redecorated. The provider told us there had been a problem in the kitchen, which was next door to this bedroom which had had to be rectified and had caused damage to the bedroom. They told us they had arranged for the room to be decorated before the end of July 2017.

Several other areas of the service looked 'tired' and neglected, in particular the upstairs corridors were in need of redecoration as wallpaper was faded and paintwork was chipped. One staff member told us they thought the service needed redecoration and some pictures around the service as there was "nothing you could have a conversation about." The smaller 'quiet' lounge also had faded wallpaper and some of the seating was soiled. Half of the light bulbs in the light fitting needed replacing as they no longer worked. The provider told us they did not feel the service looked neglected. They told us they had planned some redecoration works in the lounge but the contractor had let them down. They said that they had also planned further redecorations throughout the service but due to the work needed on the fire system they had put plans back until the installation work had been completed.

Failure to ensure the premises were clean and properly maintained is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements to the environment had been made. The carpet in the lounge had been replaced and some people's bedrooms were personalised to reflect their interests. There was a stairlift fitted to help people get to the upstairs areas of the service. Some of the upstairs bedrooms had stairs to them that were not fitted with a stair lift. The provider told us that only people who could safely use the stairs would occupy those rooms. There was a large shower room downstairs and this was suitable to be used by people who

needed help from staff when showering. There was a raised toilet with a blue seat making it easier to see, which is good practice in relation to the environment for people living with dementia. This is because it helps people recognise a toilet more easily and may help with promoting independence. There were some signs around the building to help people with dementia find their way about. These included signs indicating toilets and bathrooms. However, there were no signs on bedroom doors that would help people find their bedroom unaided.

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 Mental Capacity Act (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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had a locked entrance door to protect those people who would be unsafe to leave the service unaccompanied. Because of the restriction on leaving the service the manager had made applications to the local authority to deprive nine people of their liberty in order to keep them safe. Due to the large number of applications being processed by the local authority no authorisations had been granted at the time of the inspection.

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

People who lived at Ashbourne House were able to make day to day decisions for themselves, but may not have the capacity to make more complex decisions about their health and welfare. We saw that seven staff had received training in the MCA and that other staff were due to receive training in August 2017. Staff displayed a good knowledge of the principles of the Act and knew that people were assumed to have capacity to make decisions for themselves unless assessed otherwise. Throughout the inspection we heard most staff applying the principles of the MCA. They asked people for their consent before they provided any care and frequently offered choices of food and drink.

The provider and manager did not have a full understanding of when people's capacity needed to be assessed. Capacity assessments only need to be completed where it is thought a person may lack capacity to make a specific decision at the time it needs to be made. Capacity assessments in relation to receiving medicines and leaving the service had been completed for everyone even when there had been no indication the person lacked capacity. Some assessment forms were completed incorrectly. For example, on one person's assessment of them leaving the service unaccompanied, the section on the form entitled 'what is the specific decision to be taken' did not state the specific decision to be made at that time. The section only contained the reasons why the person would be unsafe to leave the service unaccompanied. However, we saw that the form contained details of people involved in reaching a decision in the person's best interest. The form also showed that steps had been taken to ensure the person was given help in order to understand information during the assessment. We discussed this with the provider and manager who told us they would ensure capacity assessments were only completed for a specific decision and at the time they needed to be made.

We recommend the provider reviews the Mental Capacity Act 2005 Code of Practice.

Prior to the inspection we received concerns that the quality of food being provided by the service was poor. However, we found no evidence to support this and saw that people were supported to receive sufficient to eat and drink in order to maintain good health. We spoke with the chef who told us they always used fresh produce and we saw good stocks of food were kept. Meals presented to people looked appetising and were of a good quantity. People told us they were happy with the meals served to them and always had a choice of main meal. During the morning we heard staff asking people what they would like for their meals for the rest of the day. Throughout the inspection staff frequently offered people tea, coffee or cold drinks.

Some people needed their meals pureed or softened, and the chef was clear about what type of meals people required. We saw that where meals were pureed each ingredient had been pureed separately and was nicely presented. Some people who required assistance with eating were rushed and did not have a pleasant experience. These matters were addressed by the provider and manager.

People were supported to maintain good health and staff made referrals to healthcare services where required. Records showed people had seen their GPs and health and social care professionals as needed. However, we spoke with one person who had a sore eye and they told us staff had noticed it but hadn't done anything about it. We later spoke with the manager who told us the person had been seen by their GP and eye drops prescribed. A visiting healthcare professional told us that the service was very good at contacting them when required.

Inadequate

Is the service caring?

Our findings

People's needs were not always met in a kind caring and respectful manner and their privacy and dignity was not always respected. We heard staff speaking to each other about people in front of other people and in a manner that was not respectful. For example, we heard one person ask staff to take them to the toilet as they did not know where it was. Two staff members ignored the person saying to each other "She's a day care, she can go alone." We also heard one staff member say to a new member of staff "He knows you are new, he's playing you up," about a person who had dementia and was walking around the lounge.

Staff did not always use respectful language when speaking with us about people. We asked a staff member if the dining room was the only one as there was not enough room for everyone to eat at the same time. They replied "They do the feeders first and then the others come in." this told us the staff member did not respect the people they were caring for. We raised this matter with the manager who told us they would speak with the member of staff about the language they used.

We saw one person being assisted to eat in a manner that was disrespectful, undignified and did not display a caring attitude. They were continually 'fed' food by staff and not given time to finish one mouthful of food before having another put into their mouths. The staff member did not speak to the person at all. The person was not told what they were eating or asked if they would like it. We saw another staff member helping this person at another mealtime. The person ate their meal unaided by staff who sat by them in case they needed any assistance. This also showed us that not all staff encouraged people to be as independent as their abilities allowed.

The majority of bathrooms and toilets around the service did not have locks fitted. This meant people were denied their right to privacy. The provider told us they did not identify this as a problem. However, they agreed to fit locks to all bathrooms and toilets that needed them. We saw people's personal continence products were on full display in their rooms and anyone entering the room would know the person required help with their continence. We discussed this with the manager who told us that staff knew all continence products should either be kept in ensuites or wardrobes in order to protect people's privacy and dignity. They were surprised that the products were on display and this told us they did not regularly check people's rooms. They said they would remind staff to ensure the products were not on display.

One person did not want to move to a private area to be seen by a visiting healthcare professional, which meant the healthcare professional had to attend to them in the lounge area in front of other people. We also saw staff transferring people to and from chairs and wheelchairs using a hoist. While the transfers were made using appropriate techniques, people's dignity was not always protected by the lower half of their body being covered. We asked staff if there were any screens available to protect people's privacy and dignity during such times. They said there were no screens, but thought they would be a good idea. We discussed this with provider and manager and following the inspection they told us they had ordered two sets of screens.

Staff had received training in 'dementia awareness' but we did not see all staff putting this training into

practice. For example, staff did not always give people time to process information. We heard one staff member speaking in a very curt manner to people and did not say please or thank you to anyone. We also saw that when one person was calling for assistance, they were ignored by the same staff member. We heard one person say to a staff member "It's nice to see someone smiling." During our observations we saw other staff playing a ball game with people. However, they were told by this staff member to "go and get" a person who had left the lounge. One person got up to walk around the lounge and the staff member said to another "Will you put her back." One person described the staff member as "sharp." Following the inspection the manager sent us a supervision record that indicated they had addressed these matters with the staff member. However, these matters had not been addressed before the inspection.

Failing to treat people with respect and maintain people's privacy and dignity meant there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of good practice. For example, when one person was being transferred with the use of a hoist staff took care to cover their catheter bag and ensure other people could not see it.

We saw some good interactions between staff and people. On the second and third days of the inspection when there were four care staff on duty we saw staff taking time to chat with people and support them to go out into the garden. This showed us that when staffing levels were sufficient staff had more time to interact with people in a caring manner. Some visitors told us that they were happy with the care being provided to their relatives and felt the staff were kind and caring.

Some people were able to make choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. We spoke with one person who preferred to stay in their room. They told us they were very pleased they were not expected to go into the lounge area or dining room for their meals as they did not like mixing with other people.

People and their relatives were supported to be involved in planning their care when they wished to do so. Records showed that people's care plans had been discussed with either themselves or their relatives. Their wishes had been taken into account when care had been planned. For example, we saw one family had told staff that their relative had preferred to shower rather than bathe and we saw that the person was able to shower on a regular basis. One relative told us they had been involved in a meeting to discuss their relation's care plan the week before the inspection.

One person was receiving end of life care. There was a care plan in relation to the care they required during this time. This stated 'staff should communicate sensitively and professionally and to use their end of life training'. The plan did not contain details of when the person should be repositioned, the consistency of their food and fluid, pressure area care, oral care or how personal care should be given. However, when we visited the person in their room we saw these details there and the person looked well cared for.

Inadequate

Is the service responsive?

Our findings

People did not always receive person centred care that was responsive to their needs. Where people's personal and social care needs were identified in their care plans they were not always met. Staff did not interact and engage with people in a meaningful way. Care plans did not consider people's social care needs and there was little information on people's life histories. The provider and manager did not ensure people's records were up to date.

People did not always receive the care that had been recorded in their care plans. People's care plans were reviewed on a monthly basis. However, these reviews did not highlight that people did not always receive care as detailed in their care plans. For example, one person's care plan contained information about their mobility needs. This stated '[person's name] to move around and not sit down as much', and '[person's name] to move around and go for walks around the home to build mobility.' Throughout the first day of inspection this person was continually told to sit down each time they got up from their chair. When they did go for a walk because of lack of staff supervision, they were immediately brought back and told to sit down. When we discussed this with the provider and manager they told us staff should not be doing this and had been told if this person wanted to go for a walk they should be encouraged to do so and be accompanied to keep them safe. Staff told us this person's mobility had improved significantly since being admitted to the service. However, their risk assessment for mobility in the care plan had not been updated to reflect their improved mobility, but still required supervision to keep them safe.

The care plan for one newly admitted person stated they needed their temperature taking each day due to a health condition. However, there were no records indicating this had happened. We spoke with one member of staff who was unaware this should happen. We spoke with the manager who told us staff should know as it was in the person's care plan. They had not identified this was not happening until we brought it to their attention. They then introduced a document to enable staff to record the person's temperature.

People's care plans were large documents and it was not easy to find important information in them. Staff were given a 'handover' sheet that set out the main points of people's care plans. However, on the first day of inspection, one new staff member told us they had been given a handover sheet that was two days old and did not contain information about a newly admitted person. This meant they did not have the most up to date important information about people. We discussed this with the provider and manager who felt the staff member may have been given the wrong handover sheet as they kept all the old ones on the desk with the new ones. They told us they would shred the old ones to avoid confusion. On the second and third days of the inspection staff had the most recently prepared handover sheets. We also discussed the fact it was difficult to find important information in the care plans and that new staff had said they did not have time to read the full care plans. They told us they had taken advice from the local authority's Quality Assurance and Improvement Team who were guiding them with their care planning documentation. They said they would produce a summary of people's needs to place at the front of people's daily records so that all staff would be able to see important information more easily.

People were not supported by staff who demonstrated they understood the needs of people living with

dementia. Although staff had received dementia awareness training the practice of some staff showed that they were not following the principles of the training. For example, with the need to be aware of the impact of people's dementia on their ability to process information. People were directed to do things such as sit down, without any explanation of why they needed to do this. Some staff did not ensure they made and retained eye contact with people. Also they spoke quickly to people and did not give them time to process information given to them.

People were having their movement restricted within the service and this was not always in their best interest. One person was continually directed to sit down when they wished to walk around the service. The manager told us the person should have been able to walk about with supervision but we saw this did not always happen. People's mobility aids were all located together within the centre of the lounge. This meant people were not able to use their aids to move about independently without requesting help from staff. People were not able to go out in the garden or leave the service independently even when they had been assessed as being safe to do so. We discussed our concerns with the provider and manager who agreed to ensure people's movements were only restricted when they had been correctly assessed and appropriate supervision put in place to minimise any risks to people's safety. On the second and third days of the inspection we saw that one person, who had been assessed as safe to leave the service unaccompanied, had been given the exit code to the front door, but was unsure how to use it. Staff later gave them help on using the code.

People were not supported to engage in meaningful activities or social interaction. There were no activities designed for people living with dementia and no individual person-centred activities available to people. Where people's interests had been identified staff did not always support them with these. Social interaction and meaningful activities are important for people living with dementia as they provide mental stimulation which can reduce anxiety. The care plan for one person living with dementia stated they enjoyed listening to 'swing' music and singing and this helped calm them when they became anxious. On the first day of the inspection we heard the person getting increasingly anxious. They were ignored by staff and there was no attempt to play them music or sing with them. On the second and third days of the inspection due to increased staffing levels a staff member was present in the lounge at all times. This meant staff were able to interact in a more meaningful way. We heard music being played for the person who had become anxious and they were very happily singing along. Other people in the lounge were also enjoying the music and joining in. During the first day of the inspection we had discussed this person's needs with the manager. They told us the person enjoyed singing and other staff confirmed this. However, until the second and third days of inspection we did not see this happening.

One person's care plan stated they enjoyed listening to classical music and staff should ensure they were able to do this. We saw the person's TV in their bedroom was switched to a drama channel and they were unable to change the channel themselves. We discussed these matters with the provider and manager who had not identified this and they told us they would ensure staff made sure the person could listen to classical music.

We were told that one person's family had brought cars and a small garage for the person to interact with and that the person enjoyed doing this. On several occasions we saw that these items had been placed out of reach of the person and saw them struggling to get to them.

There was nothing of interest around the service for people to occupy themselves with. One person had a newspaper delivered, but none were available for other people to read. There were no magazines or books for people to look at. The provider told us they had 'fiddle' mats for people to touch and feel. These mats have been shown to provide comfort for some people, especially those living with dementia. However, they

told us that because visitors tended to use them as cushions they were kept in the office. After they had shown us the mats they put them back in the office and did not give them to people. They told us that night staff tidied away items such as magazines and that was why there were none on display. Our discussions took place late in the afternoon and we had not seen staff give people magazines or the fiddle mats during the day.

During our observations we saw the TV was tuned to the same channel all day and people told us they did not like what was on that channel. They told us staff were the only people that used the remote control. On the second day of inspection the TV was tuned to the same channel with the sound turned down. There was also a CD playing that kept getting stuck and making a noise. Staff did not notice this until we pointed it out to them, when they replaced the CD but did not turn off the TV. One person who was not living with dementia told us "I sit in this chair all day with nothing to do." One staff member said people looked at the same view (of the person sitting opposite them) every day without moving. This was because staff had no time to spend with people doing anything other than personal care tasks.

On the first day of inspection there was very little social engagement and the engagement we did see was not meaningful and consisted mostly of task orientated activities. For example, when people were being assisted with personal care. We saw only one activity taking place, a new staff member began to play a ball game with people who were really enjoying the activity. However, because of a lack of staffing they had to leave the game to attend to one person's care needs. The game did not continue.

There were several posters in the dining room saying 'Today's activity is….' However, they were placed high on the walls and did not say what day they related to. Two notice boards on the wall in the lounge contained information about which staff were on duty, what the weather was like and what activities were taking place. Neither of these was accurate. For example, one said the month was June when it was July.

Two people who wished to smoke needed to be accompanied by staff outside when they wished to smoke. However, we saw on several occasions they were not able to be accompanied by staff as staff were too busy. We heard one person asking to be taken for a cigarette several times and staff told them they would be back in a few minutes. However, we saw they did not return for over 30 minutes.

People were not able to access the garden independently even when assessed as safe to do so. On the first day of inspection the door to the garden in the lounge had a chair in front of it. Anyone wishing to use the garden had to ask staff to let them out of the front door and walk around to the garden at the rear or use the patio area. One relative told us they and their relative had been told not to go on the grass as it was uneven and therefore unsafe. They had sat on the patio which was not a pleasant area. There were only two dirty white plastic chairs for people to sit on and they were no flower pots to make it more cheerful. The relative told us they found the effort to get outside made the experience a "less than attractive one."

We discussed all our concerns with the provider. On the second day of inspection we saw the chair had been moved and people were supported to use the garden. Chairs had been moved on to the grass and staff helped people safely get to the chairs. The manager told us they would order more chairs and tables so people could enjoy the garden more.

People did not receive person centred care that was responsive to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second and third days of the inspection we did see some activities taking place including exercises and a sing-a-long which were organised by outside entertainers and funded by the provider. We were told

that weekly craft sessions were also funded and there were some pictures displayed around the service of people enjoying these. People told us there was trip out in the mini bus every Wednesday that they really enjoyed. However, we were also told that people who needed the support of staff to mobilise did not get off the bus. We saw pictures of places people had visited in the newsletter produced by the service on a regular basis. The provider told us there were also weekly visits from animals from Pet Therapy. Religious services were held where people requested these and were being held on a regular basis for one person.

We saw photographs of people enjoying birthday celebrations. The provider told us that for one person's birthday celebration a relative had funded a musical entertainer as that was something the person especially enjoyed.

On the second and third days of the inspection we saw that a member of staff was assigned to supervise the lounge area at all times. We saw that they spent time sitting chatting to people which they thoroughly enjoyed.

Complaints were not well managed. There was a complaints procedure displayed in the hallway. This contained incorrect details of the manager, who people were directed to complain to. We saw the complaints policy for the service contained incorrect contact details for CQC. The provider said they would amend these details. One visitor told us that when they had raised concerns they found the staff member they complained to, to be very defensive. However, staff told us they were always willing to discuss and address any concerns raised with them. Another visitor told us they were able to speak with the manager about anything and were always being asked if they were happy with the care being provided.

The concerns of people and their relatives were not always addressed. We saw that in a survey of visitors and professionals in January 2017 a relative had expressed concerns over staffing levels. There was no mention of this in the report produced showing the results of the survey. The provider told us they would have discussed it with the relative. The information we were provided with about how the service managed complaints did not contain any information about any concerns and there was no evidence the concerns raised about staffing levels had been recorded or dealt with. One survey completed by a person living at the service had said they were not very satisfied with the cleanliness of their room. The report said this would be discussed at the regular meetings held for people. There was no evidence this had been discussed directly at meetings. However, we did see people had been consulted over other issues such as outings, activities and the colour the lounge should be painted.

Failure to establish and operate effectively an accessible system for recording, handling and responding to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Ashbourne House is owned and run by Mrs Diana Dolorse Enilde Williamson (the provider). Until 17 March 2017 it was owned by Mr & Mrs R G Williamson. Mr & Mrs R G Williamson was a partnership, of which the current provider was a member. They had also been registered as manager during this time. Ashbourne House was rated inadequate following an inspection in September 2016 due to concerns about poor quality care being provided to people living there. Those concerns had not been resolved. The service remains rated as inadequate, for the same reasons it had been under the previous ownership arrangement. The provider was therefore aware of our concerns but had failed to make the required improvements.

As the provider is now registered as an individual there is no requirement for a separate manager to be registered with CQC. The provider employed a manager and deputy manager to assist them in managing the service.

During the inspection the provider did not demonstrate an understating of their legal requirements relating to their registration with the Care Quality Commission. They were not aware of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or the CQC document 'Guidance for providers on meeting the regulations'. This showed us the provider was unaware of the fundamental standards they were required to meet in order to ensure people received a safe and high quality service. This was of particular concern as the provider had previously been registered as a partner in the previous registration and also as manager of the service and should have been aware as the Act and guidance were in use at the time of the provider's registration as manager and partner.

This is a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection in September 2016 the provider sent us information on a monthly basis about improvements they were making. This included information on risk assessments, care plans, staffing levels and accidents and incidents. However, we found the information sent to us was not always accurate. For example, the information sent to us in June 2017 indicated fire escape routes had been risk assessed. However, on the first day of inspection we found one fire exit escape route blocked by a chair.

Visitors told us they rarely saw the provider and manager and they were not normally as prominent in the service as they were during the inspection. We found governance systems were not robust, and we identified a number of concerns relating to people's safety and welfare that the provider was not aware of. The provider had not established a robust system of governance to identify quality and risks at the service, or undertaken some checks necessary to manage potential risks. There was a lack of positive leadership and direction for staff. We identified that these areas impacted directly on people's care and the safety of the home. The provider and manager told us they worked in the service most days. The provider said they monitored the quality of care provided through discussions with the manager and deputy manager and by observations when walking around the service. They had not identified any of the safety issues we found during the inspection. Action was only taken to address the issues of people's safety and care as a direct

result of this inspection.

The local authority's Quality Assurance and Improvement Team (QAIT) had been working with the service for some time. They told us there had been some improvement to the care planning system, but had concerns over low staffing levels which were having an impact on the care being provided to people. We saw a document produced by the provider and manager that detailed improvements that had been made while working with QAIT. However, we saw that not all the improvements listed had been actioned. For example, the document stated that a new complaints notice had been displayed on the notice board. However, we found this notice to be inaccurate. This showed us the provider was not always providing accurate information about improvements made to the service. Following the inspection we spoke with the local authority commissioners and QAIT. They raised similar concerns as those identified in this report and took action to mitigate the risks identified.

There was a lack of ownership and accountability by the provider and manager. The provider, manager and deputy manager did not take responsibility for ensuring new and agency staff were provided with the induction they needed to keep people safe, or had time to read care plans to familiarise themselves with people's care needs. They blamed staff for not being aware of people's needs as recorded in their care plans and had not identified that staff would not have had time to do this due to the low staffing numbers. Concerns in relation to people's privacy and dignity and the fact not all staff displayed a caring attitude towards people had not been identified through competency checks or observations of practice. Observations of practice and environmental audits had not identified that call bells were not available or within reach of some people. The manager told us staff meetings had been stopped as staff did not turn up for them.

A tool had been used to calculate staffing levels and this indicated there were enough staff hours to meet people's needs. The provider had not identified the information used when calculating staffing levels was incorrect and they had not identified staff were unable to meet people's needs because there were not enough staff available to directly work with people. The correct time taken to meet people's needs would have required more staffing hours. The manager asked us to explain how the calculating tool worked as they did not understand it. This meant the provider had not ensured people's needs had been assessed correctly and that the manager understood how staffing hours were calculated. On the first day of inspection there were only two care staff on duty and people did not receive person centred care. On the second and third days of the inspection staffing levels had been increased to four care staff and the service had a more relaxed feel with people enjoying more staff engagement. However, people's care plans did not always reflect their needs and this meant their needs were not always met effectively. There were limited opportunities for people to occupy themselves or be involved with meaningful activities.

There had been a high turnover of staff at the service which had led to continual changes for people living there and this had impacted on the quality of care being provided, as new staff did not know people's needs. One visitor told us they thought staff were leaving because they were unhappy.

There was no systematic approach to collating and using information gathered or received to improve the quality of service for people or to reduce risks. Systems had been established in order to monitor the quality of care provided, but these were not effective. Systems used included monitoring accidents and incidents, reviewing staffing levels and reviewing risk assessments and care plans. However, they had not identified and addressed the issues we found during this inspection. Care plan and risk assessment reviews had not identified that staff were not following guidelines to ensure people were safe when drinking.

We identified breaches of regulation in relation to people's safety. The fire detection system and the

electrical installation were in need of attention. Records showed that in May 2011 the emergency lighting system had been identified as not complying with the British Standard set for emergency lighting systems. Following the inspection the provider wrote to us to tell us the remedial work had been completed. Although these matters were being dealt with, they had not originally been identified through the provider's systems. We saw that an undated (but due for review in October 2017) audit of the service indicated all portable appliances had been tested. The report from the fire officer in June 2017 indicated this was not the case. This meant people could not be assured electrical equipment was safe to use. We saw a planning document containing details of minor improvements to be made to the service. These included painting two bedrooms, handrails, doorframes, and skirting boards, to be completed in February 2017. The works had not been completed during this inspection and other issues we identified in relation to the environment were not shown as needing attention in the plan. The document indicated no major refurbishment works were planned for the service.

Risks to people's safety were not well managed and accidents and incidents were not thoroughly analysed for trends to reduce the risk of reoccurrence. Some carpets presented a trip hazard and the building was in need of redecoration. The provider told us they had delegated responsibility for several checks of the environment to be undertaken on a weekly and monthly basis. The checks had failed to identify several risks in the environment, including checks on water temperatures. The provider had not identified these risks themselves and had not ensured the delegated person was carrying out the required checks in order to keep the premises safe.

Each time we raised our concerns with the provider they accepted our concerns and said they would put measures in place to address each of our concerns. However, there was a lack of evidence that systems were being used to drive and improve the quality of care. This indicated the management of the service had a reactive rather than proactive approach to identifying issues.

Record keeping was disorganised. Records relating to the management of the service were not maintained securely. We asked several times for a copy of the electrical installation certificate for the service and for a copy of the letter from the visit of the fire officer. The provider told us they could not find them.

Records relating to the care and treatment of people were not accurate and contemporaneous. Care plan reviews had not identified these shortfalls in information. People's care plans and risk assessments had not always been updated to reflect their changing needs. No record was kept of a person's temperature, when their care plan said they should have their temperature checked daily due to a health condition. One person had been visited by a social care professional to assess their anxiety. They had requested that details of when the person became anxious, was recorded to help their assessment. We saw that records had not been kept of this as requested. The manager told us they would be able to get the information from the person's daily notes, but agreed staff should have completed the recordings and said they would remind staff to record the information correctly.

Failure to establish and operate effectively systems and processes for monitoring the quality of care being provided, risks to people's safety, evaluating and improving the practice of the registered person and maintaining accurate and complete records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC had not been notified in a timely way of all significant events that had occurred in the service. We asked why we had not been notified of an incident when a person had fallen and broken a bone. The provider and manager told us they had been going to complete the notification but had both had to attend a meeting. They told us they would send a notification straight away. At the time of writing the report, some twelve

working days following the inspection, we had still not been notified of the incident.

Failure to notify the commission of a serious injury, without delay is a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

Staff did not receive information and guidance on the ethos of the service and how this would help them to provide quality care to people. We asked two members of staff what the ethos and values of the service were. One shrugged their shoulders and said they did not know. Another staff member told us they did not understand our question, but would describe the home as "happy." This told us the management did not communicate the ethos and values of the service to staff in order to ensure they understood their role in providing quality care to people.

Some relatives expressed satisfaction with the quality of care provided and told us they had never had to raise any concerns. We saw details of a quality assurance survey produced in January 2017. In the survey people and visitors had been asked to rate catering, care, daily living, the premises and management. A high level of satisfaction had been indicated in all areas by the 22 respondents. Of the 22 respondents four were visiting professionals and the remainder people or their relatives. One staff member described the service as "One big happy family" and told us they enjoyed working at the service as they knew all the people and visiting professionals.

Under the previous registration the service had received an 'Enter and View' inspection from Healthwatch Torbay in January 2017. The service was rated by Healthwatch Torbay as 4.5 stars out of five. People expressed a high level of satisfaction with the service. However, people also said they would like more variety in activities and more social engagement with staff. We did not see there had been any action taken by the provider to respond to this.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC, without delay of all relevant incidents which occurred at the service.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 8 HSCA RA Regulations 2014 General The provider had failed to comply with regulations 9 to 20A of the HSCA 2008 (Regulated Activities) Regulations 2014 in carrying on a regulated activity.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure service users received care and treatment that was appropriate, met their needs and reflected their preferences.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure service users privacy and that they were treated with dignity and respect.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure service users received safe care and treatment.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure all premises and equipment used by service users was clean and properly maintained.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effectively an accessible system for recording, handling and responding to complaints

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively operate systems that had been established to ensure compliance with the regulations of the HSCA 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effectively recruitment procedures to ensure only suitable people were employed.

The enforcement action we took:

None due to provider voluntarily de-registering

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of service users. Regulation 18 (1) The provider had failed to ensure persons employed by them received appropriate support and supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)

The enforcement action we took:

None due to provider voluntarily de-registering