Mrs I Austen

Lebrun House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Lebrun House on the 20 July 2014 where we found the provider had not met the regulations in relation to the safe management of medicines and records. A further unannounced inspection and took place on 3, 4 and 5 February 2015 where we found improvements were still required in relation to medicines and records. We also found improvements were required in relation to consent, quality assurance and notifying the commission of the absence of a registered manager. A notification is information about important events which the provider is required to tell us about by law. The provider sent us an action plan and told us they would address these issues by June 2015. We undertook an inspection on 18 and 20 April 2016 to check that the provider had made improvements and to confirm that legal requirements had been met.

At this inspection we found some improvements had been made however not all legal requirements had been met.

Lebrun House is a care home that provides accommodation for up to 20 older people who require a range of care and support related to living with a dementia type illness and behaviours that may challenge. On the day of the inspection 20 people lived there. There is a registered manager at the home. 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.

Staff knew people well and had a good understanding of their individual needs and choices. However, risks were not always safely managed and care plans did not reflect the care and support people. We found that people with behaviours that may challenge others or themselves did not have sufficient guidance in place for staff to deliver the support they needed. Not everyone who required them had risk assessments in place that guided staff to promote people's comfort, nutrition, and the prevention of pressure damage.

On occasions people were not treated with respect and language within care plans was not always respectful. Despite this we observed staff were kind and caring and enjoyed looking after people who lived at the home.

There was not enough for people to do throughout the day. We saw one group activity during the inspection but for those who chose not to or were unable to take part there were no one to one activities or stimulation.

Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards however; there was no information about how people were able to make choices or decisions. Staff had a good understanding of abuse and how to protect people from the risks associated with abuse.

People were given choice about what they wanted to eat and drink and received food that they enjoyed. However, mealtimes were sometimes disorganised and people did not always receive support in a timely way.

Staff received regular training and supervision. However, there was a lack of competency assessments and supervision. This had not ensured good practice was embedded into care delivery.

The audit systems had not ensured that actions identified at the last inspection had been addressed. The systems to assess the quality of the service provided were not always effective and had not identified the shortfalls we found.

Staffing levels had impacted on people receiving the support required to ensure their social needs were met. Recruitment checks took place to ensure as far as possible staff were suitable to work at the home. However, criminal record checks were not always completed before staff commenced work.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

There were systems in place to ensure medicines were stored, administered and disposed of safely.

People were supported to maintain good health and had access to on-going healthcare support.

There were a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Lebrun House was not consistently safe.

Risk assessments were not in place for all risks and not include all the information required to ensure risks were managed safely

There were not always enough staff to meet the social needs of people.

Recruitment records evidenced there were systems in place that helped ensure staff were suitable to work at the home. However, criminal record checks were not always in place before staff commenced work.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

Systems were in place to ensure medicines were stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

Lebrun House was not consistently effective.

There was a training and supervision programme in place. However, there was no evidence that staff competencies were assessed following training to ensure staff had understood the principles of what they had learnt.

Mealtimes were not consistently organised and did not always provide a pleasurable eating experience for people. People did not always receive the support they required.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and referrals had been made. However, there was no guidance about how this affected people on a day to day basis.

People were supported to have access to healthcare services this included the GP, district and chiropodist.

Is the service caring?

Requires Improvement

Lebrun House was not consistently caring.

We observed occasions where people were not treated with respect.

However, in general people were treated with kindness and patience by staff who knew them well.

Is the service responsive?

Requires Improvement

Lebrun House consistently responsive.

Care plans had not always been updated to show the current information on people's needs, preferences and risks to their care.

There was a lack of stimulation for people throughout the day.

A complaints policy was in place and complaints were handled appropriately.

Is the service well-led?

Inadequate

Lebrun House was not well led.

The provider's systems for audit had not ensured identified actions from the last inspection had been addressed.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

Lebrun 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 20 February 2016 and was unannounced. The inspection was carried out by two inspectors.

We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records including staff recruitment, training and supervision records, medicine administration records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We looked at six care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

People who lived at Lebrun were unable to verbally share with us all their experiences of life at the home because of their dementia needs. Therefore the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watched how people were being cared for by staff in communal areas. This included the lunchtime meals. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with people who lived at the home, three visiting relatives, and nine staff members plus the registered manager and provider. We also spoke with three health and social care professionals who visit the service.

Requires Improvement

Is the service safe?

Our findings

We carried out an inspection on 20 July 2014 where we found the provider had not met the regulations in relation to the safe management of medicines. At our last inspection of 3, 4 and 5 February 2015 the provider remained in breach of Regulation 12 12(1)(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no photographs in place for staff to correctly identify people and staff did not follow their own medicine policy in relation to homely remedies. An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2015. At this inspection we found improvements had been made and the provider is now meeting the requirements of this part of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, however we identified concerns in other parts of the regulation.

We observed people approaching staff freely and appeared relaxed in their presence. Visitors we spoke with told us their relatives were safe in the home. One visitor said, "When we leave we know my relative is safe." However, we found aspects of the service were not consistently safe.

There were a range of risk assessments in place for example in relation to people's mobility, risk of falls and nutrition. However, these were not in place for all risks and did not include all the information required to ensure risks were managed safely. One person required a specialised diet due to their risk of choking, this had been identified in the pre-admission assessment. There was information from the speech and language therapist in the care plan. However, there was no risk assessment in place to guide staff and no information of what steps to take if the person began to choke. This person required thickened fluids and guidance stated one scoop of powder per drink but did not include the volume of fluid. Staff were aware one scoop should be used but were unsure as to the volume of fluid it should be mixed with. If the incorrect ratio of powder to fluid was used the drink may be not at the correct consistency which could leave the person at risk of choking. Another person required a soft diet and their care plan stated this was to prevent the person choking. However, there was no choking risk assessment in place. One person had recently had a seizure, all staff were aware of this but there was no care plan or risk assessment in place for staff to ensure they knew what actions to take should this happen again. There was no clear guidance in place for assessing risks to people or developing risk management plans, where people displayed behaviours which may challenge. For example one person's care plan informed staff to leave the person alone and their risk assessment informed staff to move other people if the person displayed behaviours which may challenge. This information was contradictory and meant staff did not provide support to this person in a consistent way. We observed the registered manager had put risk assessments in place for people we had highlighted to her during the inspection.

Accidents and incidents had been documented with the immediate actions taken. However there was a lack of follow up or actions taken as a result of accidents and incidents. For people who had fallen and had been unwitnessed by staff there was no record of an investigation or a plan to prevent further falls. This meant that there were no preventative measures in place to prevent a re-occurrence and protect the person from harm.

The registered manager and staff were able to identify some of the risks to people's safety however, they did not make the link between identifying the risk and putting plans in place to minimise the risk as much as possible. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff to meet people's individual needs. However, staff told us, "We have enough time to look after people but not to do activities with them, or take them out." There were three care staff working each day and two at night. The manager worked five days a week. There was a head of care who provided care three days a week and undertook managerial and administration duties a further two days. There was a cook and housekeeping staff working each day. The registered manager told us there was currently no activities co-ordinator in post but she was planning to recruit for the post. We observed staff were busy throughout the day and whilst they attended to people's care needs they did not spend time engaging people in activities throughout the day.

Recruitment records included application forms, identification, references and a full employment history. Before commencing their induction checks were made to ensure staff were not barred from working with adults. The registered manager assured us people would not provide care to people or work at the home unsupervised until disclosure and barring checks (DBS) had been obtained. These checks identify if prospective staff had a criminal record or were barred from working with children or adults.

There were systems in place to manage medicines safely. All staff who administered medicines had received training before doing so. Medicine administration record (MAR) charts stated the medicines people had been prescribed and when they should be taken. MAR charts included people's photographs, and any allergies. They were up to date, completed and signed by staff. Medicines were given to people individually and staff signed the MAR only when people had taken the medicine. If people did not take their medicines when they were offered they were removed by staff and not left for people to take later. Staff had a good understanding of people and the medicines they required. Whilst giving people their medicines staff explained to people what their medicines were for. For example we heard a staff member saying, "This is your pain killer, would you like to take it." Medicines were stored securely and appropriately, fridge temperatures were recorded twice a day and were within normal limits. There was only one medicine which had been prescribed as "PRN." PRN medicines are only given when people require them and not given routinely for example medicines for pain relief or anxiety. There was guidance in the MAR charts and staff had a good understanding of when the medicine was required. Nobody was receiving covert or crushed medicines. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them., for example, in food or in a drink. Crushing medicines may alter the way they work and reduce their effectiveness. Staff told us the policy was not to crush medicines or give them covertly. One staff member said, "That is something we would never do." The registered manager told us if this was necessary then appropriate permissions would be sought including discussions with the person's GP. Medicine audits took place regularly to identify any shortfalls and address these as necessary.

Staff had received safeguarding training and had an understanding of their responsibilities in order to protect people from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report to the registered manager or the most senior person on duty at the time. They told us if that was not appropriate they would refer to external organisations such as the local safeguarding team or CQC. There was safeguarding information on display in the registered manager's office and this included the relevant contact numbers. Where concerns had been identified these had been referred appropriately to the safeguarding team for review.

The home was clean, tidy and well maintained throughout. There were regular servicing contracts in place for example the gas and electrical appliances. There was guidance for staff on what action to take in case of an emergency and each person had their own personal evacuation and emergency plan. The home was staffed 24 hours a day and there were local arrangements in the event the home had to be evacuated.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 3, 4 and 5 February 2015 the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2015. At this inspection we found although the provider was now acting in accordance with the legal requirements about consent further improvements were still required.

Visitors told us their relatives were well looked after and staff knew them well. They told us their relatives enjoyed the food. People who were able told us they enjoyed the food. One person said, "It's lovely, but I do eat anything." Visitors told us staff ensured their relative received appropriate healthcare support when they needed it. One visitor said, "X has regular blood tests, the staff sort that out." However, we found aspects of the service were not consistently effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had submitted DoLS applications for people who did not have capacity and were under constant supervision by staff.

There was a copy of the DoLS application and mental capacity assessment in people's care plans. However, there were no mental capacity care plans or information in other care plans about how people who lacked capacity were able to make decisions or how restrictions may affect them. For example staff told us some people liked to go out for walks and were unable to do this unsupervised. There was no guidance for staff to ensure they knew how to support people to go out. Training schedules showed us that staff had received Deprivation of Liberty Safeguards (DoLS) training or MCA 2005 training. Some care staff we spoke with had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, "We give them a choice of what they can wear, I show them a choice of clothing." However, another staff member said, "If they can't make day to day choices I decide for them."

We saw some best interest decisions had been made in relation to people receiving care and support. This had been discussed with the person and their representative. Some people's bedroom doors were locked during the day. We saw previously people's representatives had signed to show they consented with the decision to lock people's bedroom doors during the day and for people to have their photograph taken. However, best interest decisions had not taken place to identify if this was the individuals choice. We discussed this with the registered manager as an area that needs to be improved.

There was a training and supervision programme in place. Staff received training in line with the provider's policy which required staff to receive training updates every two years. Training included moving and handling, skin pressure area care, managing challenging behaviour and continence. However, there was no evidence that staff competencies were assessed following training to ensure they had understood the principles of what they had learnt. Or to ensure competence had been maintained. For example we observed staff assisting people to stand by holding people under their arms. This is not a safe way of supporting people and can lead to pain or injury to a person's shoulders.

When staff started work at the home they received a period of induction which introduced then to the running of the home and people who lived there. For staff recently employed the induction programme was based on the Care Certificate. The Care Certificate is a set of 15 standards that health and social care workers follow. The Care Certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The registered manager supervised the new staff member in relation to their learning and to determine whether the staff member demonstrated good written understanding of what they had learnt.

Although staff received training the provider had not ensured staff had the appropriate knowledge and skills to meet the needs of people who lived at the home. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an ongoing programme of supervision and staff told us they received supervision. This included reminders of good practice for example in relation to safeguarding procedures and the Mental Capacity Act. Staff told us about some recent training received in relation to what to do in the event of an unexpected death. Staff told us the training was clear and it had identified what actions they should take. One staff member told us, "It's really told me what I need to know." Another staff member said, "It's the best training I have ever had."

The mealtime experience varied. We observed people were supported to sit at the dining table 40 minutes before lunch was served. A pictorial menu was on display the first day of the inspection but not on the second day. Staff did not engage with people or chat about the meal they were about to eat. However, where people displayed behaviour that may challenge others this was not always managed effectively and had an impact on other people who were eating their meals. For example one person took food from another person's plate. Although the meal was replaced this person's mealtime had been interrupted and did not provide a relaxed, enjoyable or social occasion for this person. One person was observed pulling the tablecloth whilst waiting for their meal. On one day the person was offered a soft toy which they appeared to enjoy holding and touching. On the second day the tablecloth was removed and no alternative was offered.

Some people required prompting and encouragement and others required more support. Again, the staff approach to this varied. We observed some people being supported appropriately by staff, giving them eye contact, engaging with them and working in an unhurried manner. However, we also observed a staff member supporting two people which did not help to provide these people with a pleasant mealtime experience. People were provided with a selection of hot and cold drinks throughout the day.

Most people were weighed monthly so staff could identify if they were at risk of weight loss or malnutrition. People were weighed regularly however their body mass index (BMI) had not been recorded so staff could not ensure people were the correct weight for their height. We identified this to the registered manager as an area that needed to be improved.

People had nutritional assessments which showed if they were at risk of malnutrition or dehydration. This

included the type of diet people required for example soft or pureed. There was information about people's dietary likes, dislikes and allergies and what support people required. For example one person who was able to eat their meals independently but this could take a long time. There was information within the care plan to guide staff.

Where required, records were in place to monitor the intake of people who were at risk of not eating or drinking adequate amounts. People's dietary needs and preferences were recorded in the kitchen and in their care plans. The cook and staff had a good understanding of people's likes, dislikes and portion size and food was offered accordingly. Hot and cold drinks and snacks were served throughout the day. There was one main meal served at lunchtime however, if people did not like the meal they were offered an alternative. These choices were often based on staff knowledge of people.

People were supported to maintain good health and received on-going healthcare support. Records confirmed that staff liaised with health care professionals when required. This included the community nurse, continence service, GP and chiropodist. One healthcare professional told us staff had followed their guidance in relation to managing one person's skin pressure areas. This meant systems were in place to ensure people received care and treatment from the appropriate healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Visitors told us staff were caring. One visitor said, "They're very caring, you never hear a cross word." Another visitor told us, "Staff seem to know who my relative is, they know the person." We observed people approach staff freely and appeared reassured in their company. Despite this we found aspects of the service were not always caring.

Whilst we observed staff engaging with people in a kind and caring way, people were not always treated with the respect and dignity they deserved. For example we observed a staff member applying cream to a person's knee at the dining table whilst they were eating their meal. Another person was given medicine with their main meal. The staff member said, "Here's your sweet medicine." However, this was given while the person was eating their savoury course. Some people wore clothes protectors during their meal. We observed staff putting these on people without asking if they would like to wear them. The hairdresser was at the home. We observed a staff member speaking to a person stating, "The hairdresser wants to trim your hair." After repeating this a number of times the staff member did add, "If that's ok." When people were offered hot drinks the staff approach to this varied. Some staff offered people a choice, others said "Here's your tea." This did not show respect or ensure people's dignity as they had not been involved in making decisions about the support they received. We saw wording within people's care records was not always respectful. For example one entry in the daily notes stated the person, "Slid on their bum." Another person's records stated "Will only co-operate if mood suits." We discussed these issues with the registered manager as areas that need to be improved.

Despite this we also observed staff supporting people with care and kindness. We saw conversations between staff and people were positive and there was friendly chat and good humour between them. Staff made time to talk to people whilst going about their day to day work. Staff were frequently asking people, "Are you alright?" It was clear staff knew people well but equally people were familiar with staff and happy to approach them if they had concerns or worries. One staff member was filing a person's finger nails, they were chatting together in a relaxed and friendly manner. The staff member then involved other people in the conversation. One person was distressed and a staff member asked if they would like to go outside for a while. The person responded no, the staff member asked again later and reminded the person they could if they wished. When people appeared unsettled we observed staff approaching them, asking if they were alright and saying, "Would you like a nice cup of tea?"

Staff spoke to people with kindness and patience; they were able to tell us about people's personal histories, care needs, likes, dislikes, individual choices and preferences. We observed staff talking to people using their preferred names and speaking with real affection. They told us, and we observed, how they communicated with people who were less able to express themselves verbally. This included observing how people responded to questions and gestures. A visitor told us, "Staff go out of their way to make people happy."

Staff prompted people to retain their independence. For example at meal times, we observed some people's meals were served in bowls, staff told us this enable people to eat their own meals with minimal support.

People's bedrooms had been personalised with people's own belongings such as photographs and ornaments. People were well presented in clothes that had been nicely laundered.

Visitors were welcome at the home and we observed people visiting the home throughout the inspection. One visitor told us, "I come in at all times of the day, I'm always welcome." Another visitor said, "Staff always offer me a cup of tea."

Requires Improvement

Is the service responsive?

Our findings

Visitors told us they were kept informed about changes in their relatives care and support needs. One visitor said, "They will always contact us if anything is wrong." Visitors told us they had been involved in the development of their relatives care plans. However, we found aspects of the service were not always responsive.

Pre-assessments took place before people moving into the home to ensure people's needs could be met. People and where appropriate their representatives were involved in developing their care plans. They included people's views and reflected some individual choices and preferences about the way they wanted their care delivered. We observed people were offered choices throughout the day for example in relation to where they wanted to spend their day, or what they wanted to wear. However, people did not always receive the care they required. We observed people spent long periods of time sitting without having their position changed. The care plans for these people stated their positions should be changed every two hours. Two people did not have their position changed from 10am until 3.30pm. This meant people were at risk of developing pressure sores. We observed another person sleeping in an armchair with their head tilted back. Staff did not intervene or try and make the person more comfortable. When they woke up, this person complained of a stiff neck and staff remarked this was because the person had been asleep all morning.

Some people lived with behaviour that may challenge themselves or others. There was limited guidance in the care plans to inform staff what they should do. We observed two people exhibiting behaviour that caused distress to others. We saw people were clearly upset by the incidents. One person's care plan informed staff the person may become agitated and guidance stated to leave the person alone and they would then approach staff if they wanted anything. However, there was no guidance in place to ensure appropriate action was taken to prevent these behaviours impacting on other people. Care plans were not personalised to provide detailed guidance for staff. For example continence care plans informed staff to follow a routine but this was not detailed. Staff told us they took people to the toilet before each meal however there was no evidence this was the appropriate plan for each person.

There was a lack of stimulation for people throughout the day. Staff engaged with people and we observed staff talking to two people to determine what they would like to watch on the television. For most of the day people sat and dozed in their chairs with nothing to do. There were no books, magazines or puzzles for people to engage with. We saw some people had participated in colouring and this was displayed on the wall however this opportunity was not offered to people during the inspection. Although we observed one staff member offered to take a person into the garden we saw other people walking around the home but they were not offered the opportunity to walk outside. There was information about people's hobbies and interests but there was no evidence people were supported or encouraged to continue with these. One person's care plan stated they enjoyed soap operas but there was no evidence this person was enabled to watch them. On the second day of the inspection there was a visiting activity provider which some people participated in. However, for those who chose not to or were less able there was no stimulation or interaction. Staff told us due to their dementia type illnesses people were unable to engage in activities. This meant that people had not received person centred care that reflected their individual needs and

preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place. Visitors told us if they had any concerns or complaints they would discuss them with the registered manager or other staff. When previous complaints had been raised we saw actions had been taken to address and resolve them.

Inadequate

Is the service well-led?

Our findings

We carried out an unannounced comprehensive inspection at Lebrun House on the 20 July 2014 where we found the provider had not met the regulations in relation to accurate records. A further unannounced inspection and took place on 3, 4 and 5 February 2015 where we found improvements were still required. We also found improvements were required in relation to quality assurance and notifying the commission of the absence of a registered manager. An action plan was submitted by the provider that detailed how they would meet the legal requirements by June 2015.

At this inspection we found the provider was now acting in accordance with the legal requirements in relation to notifications. However, improvements were still required in relation to records and quality assurance. This was the second inspection where we identified breaches in the quality assurance systems at the home and the third time we had identified people's records were not always accurate.

The quality assurance system in place had not identified all the shortfalls we found. Areas of concern highlighted during the inspection had not been identified within any of the service's quality monitoring processes.

The provider and registered manager lacked oversight of how care was provided on a day to day basis and did not demonstrate understanding of how this could impact on people. They had not identified the shortfalls we found in staff knowledge for example we observed staff using inappropriate moving and handling practices. There was no information about how staff competencies were assessed to ensure care was provided appropriately.

The provider and registered manager did not follow current published guidelines or best practice with regard to providing care for people living with dementia. There was no evidence that activities were seen as an important part of people's wellbeing and may give purpose to people's days. There was a lack of stimulation and meaningful activities for people throughout the day. For example, we observed people sitting and sleeping in their chairs for most of the day. There were a range of policies in place. The registered manager told us she was in the process of updating these. There was a copy of the regulations in place but these were for the Care Standards Act 2000 not for the current Act. These had been signed as recently read by some of the staff. A copy of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was put in place by the registered manager during the inspection.

The provider's audit systems had not identified people's risk assessments and care plans were not always accurate. Although staff knew people well care plans did not reflect people's current needs and were not updated to show when people's needs had changed for example one person required a pressure relieving mattress and this was in place. However, the care plan had not been updated to reflect this information. Another person was at risk of falling and had a 'falls mat' in place to alert staff if they got out of bed at night. However, this information was not recorded in their care plan. Care plans were not personalised, they did not include detail of how people liked or required their care to be provided. They did not include information about how to support people to retain their independence. Audits had not identified the use of

inappropriate language within the records. Daily notes included a brief overview of people's day but did not capture everything people had done, their mood or how they felt. Some care plans contained conflicting information. One person's care plan for aggression stated the person was rarely aggressive however, their violence and aggression risk assessment stated this person's behaviour was erratic and 'may lash out'.

Accidents and incidents were recorded within people's care plans, there was an audit but this did not include all the incidents recorded. They lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and was a continued breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt well supported by the registered manager and their colleagues. One staff member said, "It's a good team." Staff told us they could discuss any concerns with the registered manager and these would be dealt with appropriately and confidentially. The registered manager had good knowledge of people, their individual needs and the support they required. We saw the registered manager took appropriate action when the service was no longer able to support the physical needs of people living at the home.

Staff meetings were held and we saw staff had the opportunity to discuss any issues. Relative's feedback had been sought through a questionnaire. At the time of the inspection two questionnaires had been returned and these demonstrated relatives were satisfied with the service provided.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. (1)(a)(b)(c)(3)(b)

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 not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Although staff received training the provider had not ensured staff had the appropriate knowledge and skills to meet the needs of people who lived at the home. (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate records were not in place in relation to the care and treatment for all service users. The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning notice