Aryaa Care Limited

Ambleside Residential Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced comprehensive inspection was carried out on 10 and 18 January 2018.

Following the inspection in March 2017, the provider was in breach of a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and had an overall rating of Inadequate. We placed the service in 'Special Measures' and we asked the provider to complete an action plan. This was to tell us what they would do and by when to improve all key questions to at least good. We met with the provider to further set out the Care Quality Commission's expectations that they should provide a service that was consistently safe, effective, compassionate and of good quality. We also used our enforcement powers to impose a condition that required the provider to send us monthly reports showing what actions they were taking to make the required improvements.

This inspection was carried out to check if sustained improvements had been made. We found the provider had not made sufficient improvements to all the areas we had previously identified breaches of the Health and Social Care Act of 2008 (Regulated Activities) Regulations 2014. There were continuing breaches of Regulations 9, 10, 17 and 18, and new breaches of Regulations 7 and 8. We were still concerned about the level of the provider's willingness and ability to drive sustained improvements. This was the second consecutive inspection where the overall rating for the service was 'Inadequate'. This meant that the service remains in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

Ambleside Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 17 people in one adapted building. At the time of this inspection, 11 people were being supported by the service, some of whom were living with dementia.

There was a registered manager in post, who is also the provider of the service. 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.

The provider now had safe staff recruitment processes in place. However, there was not always sufficient numbers of staff to support people safely. The inconsistent staffing numbers had a wider impact on the overall quality of care people received. Systems in place to safeguard people from risk of possible harm or abuse had not been used effectively. People's individual risks were assessed to give guidance to staff on how these could be minimised.

There was still limited choice of food for people to maintain their health and wellbeing. People's needs had been assessed and they had care plans in place. People had been supported to access other health services when required. Staff had received training and supervision. Staff understood their roles and responsibilities to seek people's consent prior to care being provided. Staff worked in accordance with the requirements of the Mental Capacity Act 2005.

People were supported by caring, friendly and respectful staff, but inconsistent staffing numbers meant that they did not always have opportunities to have meaningful interactions with staff. The provider had failed to promote a caring and inclusive environment that put people at the core of everything they did. People's privacy and dignity was not always promoted. We have made a recommendation about improving this.

Staff had not been supported to develop care plans that took account of people's individuality, preferences and choices so that they consistently provided care in a person-centred way. People told us they were bored at the service. We were concerned about the continuing failures to adequately support them to pursue their hobbies and interests. People's complaints and concerns were managed appropriately.

The provider's systems to assess and monitor the quality of the service had not been used effectively to drive sustained improvements. There were continuing failures to provide a good quality service. As a result of these serious failures, we took enforcement action to cancel the provider and the registered manager's registrations, and this process was completed in June 2018. The service had already ceased to operate in April 2018 when the local authority supported people to find alternative care providers.

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 always safe.

Inconsistent staffing numbers and poor deployment of staff put people at risk of unsafe care.

The provider's safeguarding systems and processes were not being operated effectively to prevent abuse.

Improvements made to the cleanliness and infection prevention measures were not sustainable because of insufficient staffing.

People's medicines were being managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

There were still concerns about the quality and choice of the food provided to people.

Staff received training, supervision and support.

People's consent was sought prior to care and support being provided. The requirements of the Mental Capacity Act 2005 were being met.

Staff understood people's care needs and provided effective support.

Is the service caring?

Inadequate

The service was not caring.

The provider did not promote a caring environment that put people at the centre of everything they did.

Inconsistent staffing had a negative impact on all aspects of people's care.

Staff were kind, caring and friendly, but they had not been enabled to spend meaningful time with people.

People's privacy and dignity was not always promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not sufficiently supported to live active and fulfilled lives or to pursue their hobbies and interests.

Staff provided the care people required in a timely way, but the provider had not supported them to consistently provide this in a person-centred way.

People's complaints and concerns were dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

We continued to have concerns about the provider's willingness and commitment to driving sustainable improvements.

Any improvements made had not always been sustained so that people received consistently good care.

The provider's quality monitoring processes remained ineffective in assessing and identifying shortfalls with the quality of the service.

Prompt action was not always taken to rectify shortfalls.

Ambleside Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was prompted in part by information of concern we received in December 2017 about staffing levels, the service having no cook and people not being supported to pursue their hobbies and interests. The information shared with CQC indicated potential harm to people using the service because there was not always sufficient care staff to support them safely. Additionally, the absence of a cook raised concerns about the service's ability to provide people with nutritionally balanced meals. We shared these concerns with the main local authority that commissioned the service, and this inspection also examined those risks.

The inspection took place on 10 January 2018, and was unannounced. It was carried out by one inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people. The inspection was completed on 18 January 2018 when we received information we requested from the provider.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including the report of our previous inspection and notifications they had sent us. A notification is information about important events which the provider is required to send to us. We also received feedback from the main local authority that commissioned the service.

During the inspection, we spoke with two people using the service, two care staff, the cook and the registered manager, who is also the sole director of the provider organisation. We observed how staff interacted with people and how care was provided within communal areas of the service.

We looked at the care records for six people to review how their care was planned and managed. We looked at three staff files to review the provider's staff recruitment and supervision processes. We also reviewed training records for all staff employed by the service. We checked how medicines and complaints were being managed. We looked at information on how the quality of the service was assessed and monitored.

Inadequate

Is the service safe?

Our findings

When we inspected the service in March 2017, we identified continuing breaches of Regulations 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some areas of the service were still not being adequately cleaned, and this put people at risk of acquired infections. The provider had failed to ensure there was sufficient numbers of care staff to support people safely and consistently. Subsequently, people were sometimes left on their own in communal areas for periods of time without staff to interact with them. There was also a breach of Regulation 19 because safe staff recruitment practices had not been followed as outlined in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found there was still not sufficient numbers of staff to support people safely. On arrival at the service, we observed that there were four members of staff on duty. These were the cook, who had arrived at the same time as us; two care staff, one of whom was the deputy manager; an activities coordinator, who helped to support people from 8am to 9am, and also supported people with their meals at lunchtime.

Staff were reluctant to comment about staffing numbers, but one member of staff told us this was still an issue and not always consistent. They also said that on occasions when there had been three staff on shift and the activities coordinator, the registered manager always asked one of them to finish work early as they were not required. They further told us that the additional cleaning roles they were now expected to carry out took them away from interacting with people. Another member of staff said, "We have been given a sheet with cleaning duties on, as well as everything else we do." In the laundry room, we saw heaps of clothes to be washed and a basket full of wet clothes needing to be dried, and one member of staff told us that they were also responsible for ensuring that laundry was done. They said this meant that they had to support most people with personal care while they had the help of the activities coordinator, as it was not always possible to do this in a timely way with two staff.

We observed that the two staff providing care to people were busy throughout their shift and apart from brief moments when they came into the communal areas to support people, they hardly spent time in these areas. We were concerned that the additional cleaning tasks had further impacted on the amount of time staff could spend supporting people with their care needs. The provider had clearly not considered the impact of this on people's safety and meeting their needs.

We reviewed the staff rotas for that week, but these had not been updated to accurately reflect the staff on duty at the time. For example, some of the staff had swapped shifts and this information had not been added to the rota. The registered manager was on the rota from 07:45am to 6pm, but they did not arrive at the service until just after 10:35am. On the day of the inspection, only one staff was on the rota to work between 6pm and 8pm, when the night staff arrived. However, this was rectified by the registered manager who added the information on the rota and told us that the member of staff had swapped shifts. The provider now occasionally used agency staff to cover for sickness and leave if regular staff were unable to work additional shifts. This was to make up current numbers rather than to add to them. We were

concerned that the provider's formal system for assessing the required staffing numbers did not highlight that the current staffing numbers were not sufficient. Furthermore, the registered manager had not always followed the guidance on staffing numbers provided by the local authority in a meeting in January 2017. This advised them to ensure that there were always three members of staff during the day to provide care and support to people using the service. We found this omission continued to put people at potential risk of unsafe care.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the service. This included one person who said, "I'm safe enough (laughs). Well, I can't get out, so no one can get in. There are lots of people around me, I have no concerns." Another person said, "I'm safe here, the building is secure. I know what abuse is and I have never seen anything like that."

Staff had been trained on how to keep people safe, and they showed good understanding of safeguarding procedures and local reporting protocols. The provider had a system in place to safeguard people from abuse. However, they could not demonstrate that this was being used effectively to prevent potential abuse. This was because staff told us they were not always comfortable with using the whistleblowing process to report concerns. They said this was due to the repercussions of doing so. They then went on to tell us about their experiences of being 'quizzed' following our previous inspection. They said this was because the provider wanted to know who had made specific comments included in the report. We found this action had the potential to make staff afraid of the consequences of reporting concerns. This had the potential to put people at risk of unsafe care and abuse.

During this inspection, we found improvements had been made to the cleanliness and décor of the service. However, we were still concerned that sufficient time was not allocated to ensuring that the service was always cleaned to adequate standards. We noted that there was no longer a dedicated member of staff to do the cleaning and that the cook partly took on this role. We were concerned that it was not clear on the rota how they shared their time between the two roles. The registered manager told us that the member of staff did the cleaning for one and a half hours in the morning (8am to 09:30am), cooked until 1:30pm, and then cleaned again for one and a half hours in the afternoon. However, this had not been followed on the day of the inspection. Apart from other staff checking and cleaning toilet areas and other communal areas, no formal cleaning was done during our time at the service.

We discussed our concerns with the registered manager who told us that this was because the member of staff had hurt their back and was therefore unable to do any activities that required them to bend. We saw that night care staff did some of the cleaning duties. However, it was not sustainable to expect this to be done during the day because staffing levels were not enough to also meet people's needs in a timely way. This practice did not always promote a safe environment for people to live in, and had the potential to expose them to the risk of acquired infections. However, in order to protect people from risk of cross-infection, we saw that staff wore appropriate protective wear, such as disposable aprons and gloves. We also saw that hand washing facilities were available to encourage good hand hygiene.

The provider carried out other health and safety checks to ensure that the environment people lived in remained safe and free from hazards that could harm them. These included checks to ensure that the risk of a fire was low, and that gas and electrical appliances still functioned properly. The provider had a contingency plan to manage any foreseeable emergencies that could have an impact on the running of the service. The provider notified us of the fire in the laundry room caused by a build-up of lint in the tumble

dryer. We saw that the fire risk assessment had been reviewed by the fire officer following the fire and there were no outstanding actions for provider to complete. However, we were concerned that the provider had not reduced the risk of the fire by employing a dedicated member of staff who would have ensured that all laundry tasks were completed properly. This was further evidence that poor staff deployment put people at risk of harm.

Unlike during our previous inspection when parts of the service were cold, this time we found it was warm throughout the day we visited. We commented on this and a member of staff told us about the recent work to repair the heating system. However, we were concerned when we were told that this work had been done following repeated concerns raised by people and staff about the service being too cold. We had previously brought concerns about the temperature at the service to the attention of the provider, but nothing had been done at the time. We found their lack of pro-activeness in getting the heating system checked put people at risk of cold related health conditions. This also brought into question the provider's ability and willingness to ensure lessons were learned and improvements made when things went wrong in order to prevent the risk of re-occurrence. We therefore had no confidence in their ability to maintain a consistently safe and warm environment for people using the service and staff.

We found the provider had now improved their staff recruitment processes in order to ensure that only suitable staff were employed by the service. We reviewed the recruitment records of three staff who had been employed since our previous inspection and we noted that all appropriate pre-employment checks had been carried out in a robust way. These included confirming each member of staff's identity, employment history, qualifications and experience, obtaining references from previous employers, and completing Disclosure and Barring Service (DBS) checks.

Potential risks to people's health and wellbeing had been assessed, and each person had relevant risk assessments in place. These gave staff guidance on how risks could be minimised. Risk assessments included for risks associated with people being supported to move, falling, eating and drinking, pressure damage to their skin, the use of bedrails, behaviours that may challenge others, and specific health conditions. We noted that the risk assessments were reviewed monthly or updated when people's needs changed, and where necessary, appropriate preventative care was put in place.

People were happy with how their medicines were managed and given to them by staff. One person said, "I am on medication and I do get it regularly. They stand and watch me take it, but I don't know what I'm taking or what they are for." We saw that medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. We looked at the medicines administration records (MAR) and found these had been completed fully, with no unexplained gaps. The deputy manager completed regularly audits of the records and also ensured that appropriate stock levels were maintained so that people never ran out of medicines. Staff's competency to administer medicines safely was periodically checked and no concerns had been identified during the assessments.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in March 2017, we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure that people were provided with a variety of nutritionally balanced food.

During this inspection, we found continuing concerns about whether people were provided with suitable and nutritious food and hydration, which was adequate for them to sustain good health. Although people's comments about food were positive, staff had mixed views about the quality and variety of the food provided. One person who said, "Food is ok and I always clear my plate." Another person told us, "The food is ok. Recently people have been having a cooked breakfast. I have been offered this, but I prefer to stick to my [name of cereal]."

Staff told us that the number of hours the cook worked meant that there was limited choice of food for the evening meals. One member of staff told us, "Ideally, the cook should be here till at least 4pm to make sandwiches and maybe bake a cake for [evening meal]. When she and the activities staff have gone, afternoon staff have to go in the kitchen to make drinks and sandwiches for [evening meal]. If the cook worked longer hours, residents would have a hot evening meal more regularly rather than sandwiches most of the time." Another member of staff said, "The food served at lunchtime is okay, but [evening meal] could be improved. There is not much choice and I hope residents are not fed up of sandwiches and tinned soup." We asked the cook about how they ensured people had good food for the evening meal and they said, "I could stay on longer, but these are the hours I've been given. So I don't have time to prepare things for [evening meal] or bake. The afternoon staff give residents these fairy cakes (shop bought) and they will make sandwiches from ham or cheese. There are lots of packets in the freezer." The cook's time was further taken up because they had to wash all crockery and cutlery by hand. We asked them why they were not using what we thought was a dishwasher. They told us this had been broken for the six months they had taken over this role. We saw that it was also not suitable for use as it was in a very poor state of hygiene. The provider had failed to repair or replace this.

We checked with the cook about whether there was enough stock of food for them to cook a variety of meals for people. They told us that there were regular deliveries of food, with the most recent delivery being the day before our visit. However, they told us that they did not always get the food items they put on the shopping list in a timely way. For example when we asked what they were cooking for lunch that day, they told us that they would use the packet mashed potatoes because fresh potatoes had not been delivered. They said, "I have asked twice now, but I think [registered manager] likes to get them from somewhere else because the order came yesterday and they were not there. So I told her again, and she might bring some in with her." We observed that the registered manager brought a large bag of potatoes when they arrived. However, our history of involvement with the provider left us with no confidence that they would have bought the potatoes if we were not there. Although we saw that there was now fresh fruit which was in a bowl in the kitchen, we did not see this being offered to people during our visit. This was a missed opportunity to ensure that people ate more fruits and vegetables in accordance with the '5 a day' guidance issued by the NHS.

People we spoke with told us that their care needs were met and they were happy with how staff supported them. One person said, "I think I am well looked after." We saw that people's needs had been assessed prior to them moving to the service. This information had been used to develop care plans that took into account of people's needs, choices, views and preferences. These identified what support people needed in relation to various areas including mobility; medicines; nutrition and dietary intake; personal care; and specific health conditions. We found care plans provided clear information for staff to know how to support each person in a way that met their care needs. Staff told us that they got opportunities to read the care plans and that there was enough information in them to enable them to provide the care people required.

We observed that people appeared to be supported well with their personal care. The provider told us that the support provided by staff meant that pressure ulcers some people had been admitted to the service with, had now healed. One member of staff also told us that their main aim was to ensure that people always received good care. They added, "That's what we are here for. It's because of the residents that I'm still doing this work. They deserve good care." However, staff were not confident about the provider's willingness to invest in sufficient resources that would enable them to provide consistently good care.

Staff were happy with the level of the training and support they received through regular supervision and annual appraisals. Staff records showed that supervision was carried out regularly and staff we spoke with confirmed this. Supervision was mainly provided by the deputy manager and staff found them approachable and very supportive. We saw that the provider had a training programme and all staff were up to date with their mandatory training. We discussed with the registered manager how they could improve the way they presented their training log so that it was much easier to see when refresher training was due. They said they would find time to do this as they found it to be helpful. We saw that staff competence assessments were now carried out more regularly, and this was confirmed by a member of staff. They told us that they had been assessed to ensure that they administered people's medicines properly.

Staff worked closely with people, their relatives and professionals to ensure that the care provided to people was appropriate and continued to meet their needs. One person told us, "I see a doctor if I need to and I get my feet done by someone that comes here to do it." We saw that where required, various professionals had been consulted, and visited the service to assess people and provide advice on the most effective care and treatment. For example on the day of the inspection, opticians visited to carry out annual eye tests. A phlebotomist also visited to take a blood sample from a person who required regular monitoring because of the medicines they were taking. We saw that people received regular foot care from chiropodists. There were also seen by dietitians if there were concerns about their dietary intake, and were seen by their GPs regularly for other health concerns. Some people were also receiving specialist hospital care and the registered manager ensured that they were supported to attend their appointments. We found the service continued to work collaboratively with professionals to ensure that people consistently received effective care, support and treatment.

Of the recent refurbishment of the service, one person said, "I have seen some improvements recently and I think some areas have been decorated." A visiting professional also complimented the registered manager about the improvements to the décor and the new furniture in the conservatory.

The 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 lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for

this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The requirements of the Mental Capacity Act 2005 (MCA) were met because care records showed that where necessary, people's capacity to make decisions about their care had been assessed. The registered manager had also sent referrals to relevant local authorities to ensure that any restrictive care was lawful. Staff had been trained on the MCA and they showed good knowledge of the processes they needed to take to ensure that people's rights and choices were protected.

We saw that some people were able to give verbal consent to their care and support, and staff told us that they always asked for people's consent before care and support was provided. We observed this during the inspection. For example before lunch, we saw a member of staff approach a person and said, "Can I put this apron on you to keep you clothes clean [name]?" Also, when a person needed support to cut their food into smaller chunks, a member of staff asked first if they could do this for them. They said, "Would you like me to cut that up smaller for you?" They only proceeded to do so when the person had confirmed that was what they wanted.

Inadequate

Is the service caring?

Our findings

When we inspected the service in March 2017, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's privacy and dignity was not always protected.

During this inspection, people told us that their privacy and dignity were respected. We observed that staff were discreet when they asked people if they needed support with personal care so that this was not overhead by others in the room. However, we were concerned that the conservatory was still being used for external professionals to provide care and other interventions to people they visited. This was because the phlebotomist used this area to take a sample of someone's blood. There were no screens used to maintain the person's privacy during this procedure. Our concerns were that this area is adjacent to the lounge and people sitting in there could always see what was happening in the conservatory. This did not promote people's rights to be seen by professionals in private.

This was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were supported by kind, caring and friendly staff. One person told us, "The girls are very caring." Staff told us that they always aimed to promote a caring and happy environment within the service, but their busy schedules meant that they did not spend as much time with people as they would like. One member of staff said, "We don't have time to sit and talk to the residents. We also don't always get breaks." We observed that care staff were busy throughout our inspection and they hardly spent time in the communal areas unless they were providing specific support to people. For most of the time, we observed people just sitting in the communal areas and were disengaged from the activities around them. They had little to do and consequently, were lethargic and disinterested. People were keen to have opportunities to do the things that interested them, such as going out for a walk or visiting the local shops, but there was a lack of interest in the service to provide the facilities to do this. This has been a recurring concern over our previous two inspections of the service, and whilst staff did their best, the overall management of the service did not promote a caring and inclusive culture within the service that took into account people's preferences. There was a lack of opportunities for staff to have meaningful conversations with people that could result in them developing mutually respectful and trusting relationships. When we asked one member of staff how this could be improved they said, "Consistent staffing numbers would help."

There was now an activities coordinator to support people to positively occupy their time. However, this provision was still sporadic. One person told us that they were sometimes bored. They added, "I like to chat. Some of the people chat with me, but not always." At the last inspection, we raised concerns with the provider about how insufficient staffing could lead to people becoming socially isolated and lonely. We found this had not improved and people remained at risk of not enjoying happy and fulfilled lives.

We had no confidence that the provider had put effective systems in place to ensure that they consistently provided a service that was compassionate and that had people's best interest at its core. For example, we

found it uncaring that the provider bought packet mashed potatoes to use for people's meals when this could be easily prepared from fresh potatoes. Also, we noted an example of when people were not always provided the food they would like to eat. When one person told us that they would like some steak, we asked the registered manager if this could be facilitated. Their response did not take into account the person's choice and preferences when they told us that they would not provide this, as they 'did not eat it and would not know how to cook it'.

Additionally, we saw that one of the three frozen loaves of bread that had been left out to defrost had thawed, but the crusts were hard as if it was already stale when it was put in the freezer in November 2017. We asked the cook what the three loaves of bread were for and they said, "Well, that is what they will use for sandwiches and breakfast." When we pointed out that one of the loaves' crusts appeared hard and stale they said, "I understand it's good to have a couple of loaves in the freezer as backup, but there are so many we are using November's in January. I don't agree personally with this as we could have fresh bread delivered weekly with our other supplies, but it's not up to me." We saw that there were other loaves of bread in the freezer and it was not clear whether there was a system to ensure that the older bread was used first. We did not find it caring for people to be served this kind of food and had previously asked the registered manager why they could not buy fresh bread every week. We did not get a satisfactory response at the time.

The local authority told us that due to their level of concerns, they had carried out a visit to the service on Christmas day because they had no confidence that the provider would put sufficient staffing resources in place as agreed with them the previous week. They shared with us their concerns about the poor state of the meal served to people on that day. They found this and the general feel at the service did not promote a jovial and festive atmosphere. This was of particular concern for people who had no opportunity to enjoy this celebratory time of the year with friends and family members. There was a lack of festivities which had the potential to make people feel lonely, depressed and hopeless. The provider had failed to take the opportunity to make this a pleasant celebratory time for them.

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

Staff told us that they always supported people to make decisions and choices about their care. They further told us that they respected people's individuality and preferences. One member of staff told us that they always asked if people were happy with their care and if not, they would find out how they wanted things done differently.

Staff told us people were supported to maintain close relationships with their relatives or friends because they could visit whenever they wanted. The two people we spoke with did not have regular visitors and relied on staff to support them to develop social networks. This need was however, not always met.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in May 2017, the provider continued to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result of people not always being supported to pursue a variety of interests and hobbies.

During this inspection, we found people were still not appropriately supported to take part in a variety of activities they enjoyed. Furthermore, there were still only limited opportunities for people to pursue their individual interests and hobbies. People told us they would like to go out more often, but this was not facilitated regularly. There was a new activities coordinator who had only been at the service for two days at the time of the inspection. We observed how they interacted with people throughout our time at the service and we found they needed guidance and support to ensure that people were given choices and involved in making decisions about what they wanted to do. This was because on two occasions, we observed them changing music CDs without asking people. Also in the afternoon, they put a DVD on for people to watch without asking everyone if they wanted to watch it.

When we asked people if there was enough for them to do, one person said, "No, I would like to go out more often. It's been a while since I left this building you know and I would like to go to the shops. That would be nice, but I'm not going to run off." Another person was happy to occupy their time reading in their bedroom. Staff told us that further improvements were required to support people to live active lives. One member of staff said, "There is a new activities coordinator, but she needs a little bit of help with organising activities. It's the same old jigsaws and throw a hoop. Quizzes would be good, but we don't have any material on that I don't think. People would like to be taken out one to one, but we don't have the staff and resources."

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

We saw that where possible, people remained at the service at the end of their lives as long as they did not require specialist care that could only be provided at by another service. However, people's views and preferences about their care at the end of their life had not been sought. This meant that there were no care plans to give staff information to enable them to provide person-centred end of life care. We discussed this with registered manager who told us that they would put these in place as soon as possible. Where people had forms stating that they should not have cardiopulmonary resuscitation if they suffered cardiac arrest, we saw that the doctor who signed the form had made the decision with either the person or their relative. We found it would further empower people if these decisions were made in advance with them in the form of advance care plans. There is advice and guidance available to providers in relation to this.

People told us that their individual needs were met by the service and they were happy with how their care was managed. We observed that staff were responsive to people's needs and supported them quickly when they called out. Staff were observant and prompted people at risk of falling not to walk without their mobility aids or support. However, insufficient staffing numbers meant that staff were not always able to support people in a more personalised and person-centred way. Care staff had not had many opportunities

to speak with people, get to know them really well in order to fully understand their diverse needs, individual interests and preferences.

We saw that care plans had clear instructions on how staff should support people with their various care needs. These records however did not fully reflect people's care needs in a holistic way. This was because staff did not always spend time talking with people in order to get detailed information about their lives prior to moving to the service. This was a missed opportunity to get to know people well so that staff could provide care in a more person-centred way. We saw that some of this information was being collected using the provider's 'let's talk activities' form, but further work was necessary to ensure that the care provided to people was appropriate, consistently met their individual needs and reflected their preferences.

The provider had a complaints policy and procedure which gave people information on how to raise concerns and complaints they might have about the service. People told us they were happy with how staff supported them and they did not have any complaints. We reviewed the complaints records and saw that these had been dealt with appropriately.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in March 2017, we identified a number of breaches of regulations, with continuing breaches of Regulations 9, 15, 17 and 18 from the inspection we carried out in August 2016. The overall rating was inadequate and the service was placed in 'Special Measures'. We met with the provider to further set out the Care Quality Commission's expectations that providers should consistently provide a service that was safe, effective, compassionate and of good quality. They were supported by a consultant during this meeting. We also imposed a condition on the provider's registration asking them to send us monthly reports showing what actions they were taking to make the required improvements. These were in relation to: cleanliness and infection prevention measures; provision of opportunities for people to live active lives, and pursue their hobbies and interests; staffing numbers; catering and nutrition.

Prior to the inspection, we reviewed the monthly reports the provider sent to us. We found these were not always detailed and we had to ask the provider for further information. Following receiving the report in December 2017, we were concerned that this showed that only negligible improvements had been made. We wrote to the provider setting out our concerns that despite some initial improvements, the information they provided showed that the provision of activities to occupy people was back to the levels we observed in March 2017. Furthermore, a care worker had taken on the role of a cook and we were concerned about their level of understanding of nutritional guidance for older people. Their response did not give us confidence that the current arrangements in place were robust enough to ensure that people received a consistently good service.

We followed up on these issues during this inspection. We found the provider had not made sufficient improvements to improve their rating in all areas. Some improvements had been made to the provider's quality monitoring and audit systems, but these were not robust enough to identify shortfalls we found during this inspection. Additionally, these had not been used effectively to drive sustained improvements. It was of great concern that we continued to identify breaches of regulations in relation to staffing numbers, which had wider negative impact on the quality of the care people received. Also, people were still not being appropriately supported to pursue their hobbies and interests; the choice of food was limited; people's privacy and dignity was not always promoted.

At this inspection, we also identified new breaches of regulations because the provider's safeguarding systems and processes were not being operated effectively to prevent abuse. This was because staff felt uncomfortable with using the whistleblowing process to report concerns. They told us this was as a result of the provider quizzing them when they had reported issues to external agencies. The provider was unable to demonstrate to us that they had put robust systems in place to fully embed and sustain the improvements they had previously made. Neither could they demonstrate the willingness to improve the service in a sustainable way as evidenced by us finding recurring concerns over three consecutive inspections. It was clear that the provider did not act on the advice and guidance given to them as the service had a history of not embedding and sustaining good quality care. We found the provider tended to be more reactive to shortfalls identified by others rather than them using their own systems to identify these and make the required improvements.

We spoke with the provider about their vision for the service and how they saw the service moving forward. They had little to say about how they were actively working to a plan of improvement and sustainability. We raised with them the need for a focus on managing the service and delivering the registered manager functions so that the service improved rather than being involved in the day-to-day care delivery. They acknowledged the need to do this. When we discussed staffing levels, they felt that the level of two care staff was sufficient, the deployment of additional resources to cooking and cleaning duties was not necessary, and disputed the need for additional staff at the service. They felt that the current arrangements met the needs of people using the service and saw no reason for there to be a third member of care staff, a cleaner and a cook. They did not agree that the levels agreed previously with the local authority were necessary.

There was lack of transparency in the way the provider, who is also the registered manager conducted the home, and reasons for the shortfalls were rationalised away. They lacked candour and explanations for their actions were inconsistent. For example in relation to the lack of sufficient staff on Christmas day, the local authority officer who visited was told by the provider that they had been at the home and had put the lunchtime meal on to cook and then popped home to collect some milk. This was a journey of approximately 40 minutes round trip from Luton to the provider's residence in another town. The officer noted that there was plenty supplies of milk at the service at the time of their visit. The staff informed us during the inspection that the provider had prepared the Christmas lunch and then had left the home for the day leaving just two staff to support everyone, as well as serve the lunch. They had only returned when the local authority officer had visited the service because they were not meeting the staffing levels of three care staff on duty agreed with the local authority. The provider told us at the inspection they had popped home to deal with a personal issue. On the day we inspected, the provider was also on the rota to be part of the care team on duty from 7.45am, but did not actually arrive until 10.35 am after they were made aware of our visit. This failure to arrive early left just two care staff and a new activities coordinator to provide personal care to people at a busy time of the day. There had been repeated concerns raised with the provider about this agreed staffing level. It was concerning that they continued to produce a rota with their hours on it as part of the care staff, but then do not arrive on time, leave early or do not support people with personal care which left staffing levels low, and staff and people using the service unsupported.

Following our previous inspection, the provider sought the help of a consultant to help them improve the service. However, the history of our involvement with the provider showed that they had not used this support to learn and put in place systems that would bring about lasting improvements. We acknowledge that some positive steps had now been taken to carry out some audits with the assistance of the deputy manager including checking medicine stocks and medicines administration records. They now also completed regular health and safety checks to ensure that the environment was safe for people to live in. However, these checks were not always used effectively to ensure that all aspects of the service met the regulations. We remained concerned about the provider's willingness to make sustainable improvements.

The main local authority that commissioned the service also shared with us their concerns about the continuous failures by the provider to sustain any improvements made following interventions by both them and the Care Quality Commission. The local authority shared evidence that they had supported the service regularly in the past two years, but they found improvements to be slow and sporadic. There had been concerns about the level of the provider's involvement in leading the required improvements, with evidence of their over-reliance on others to identify shortfalls within the service. Also, concerns about insufficient staffing and cooking arrangements on Christmas day called into question the provider's openness and integrity. This was because they had not put in place the staffing numbers they had agreed with the local authority.

This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. We found these issues also brought into question the registered person's ability to effectively carry out their provider and registered manager roles. As a result, there were also breaches of regulations 7 and 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence that the provider sought feedback from people using the service, relatives and staff by way of occasional meetings and surveys. The results of the most recent survey showed that people were happy with the service. We saw that closed questions were used on one of the surveys which did not allow people to add comments or suggestions. However, the provider had already identified this as an area of improvement. We noted that some people's health had deteriorated since our last inspection and were therefore not able to give feedback about the service. It was for this reason that we were only able to speak with two people during this inspection.

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 8 HSCA RA Regulations 2014 General The provider and registered manager did not comply with all regulations to ensure that they provided a consistently safe, effective, compassionate, and good quality service. 8(1)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's privacy and dignity had not been always promoted. 10(1)(2)(a)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care was not consistently provided in a person-centred way. People were still not being adequately supported to pursue their hobbies and interests. 9(1)(2)(3)(a)(b)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor the quality of the service. There were continuing failures to make sustained improvements to areas where shortfalls had been previously identified. 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not have the right skills and experience to effectively manage the service. 7(2)(b)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient numbers of staff to support people safely. This also had a wider impact on the quality of the care people received. 18(1)

The enforcement action we took:

NOD to cancel the provider's and registered manager's registrations.