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Oak House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over two days on 15 August 2017 and 13 September 2017 and was unannounced.

Oak House Residential Home is the only home owned by the provider. It provides accommodation for up to 14 people living with dementia, learning disabilities and autistic spectrum conditions. On the day first of the inspection there were nine people living at the home, on the second day of the inspection there were eight people living at the home. The home is a large property spread over three floors with two communal lounges, a dining room and a garden.

There have been two comprehensive inspections since October 2015. We carried out an unannounced comprehensive inspection on 19 October 2015. Breaches of legal requirements were found. We carried out another unannounced comprehensive inspection on 3 January 2017. The previous registered manager was no longer in employment and the deputy manager had become the acting manager. They had been in post as manager for 12 months and had started the process of applying to become registered manager. However, they had not taken reasonable steps to complete this process in a timely manner and the home had been without a registered manager for 12 months. Part of the provider's condition of registration states that a registered manager must be in place, therefore the provider was in breach of their registration. We also identified breaches of legal requirements in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), a lack of quality monitoring processes, failure to notify CQC of reportable incidents, inflexible staffing, insufficient management of risks and a lack of records to inform staffs' practice. Practices that needed to improve related to peoples' dining experiences, a lack of reviews to ensure that peoples' care was meeting their current needs and a lack of activities and meaningful occupation for people. The home received an overall rating of 'Requires Improvement' and we took enforcement action against the provider. After our inspection in January 2017, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

We carried out this unannounced comprehensive inspection on 15 August 2017 and 13 September 2017. At this inspection, although some improvements had been made, in relation to the concerns found at the previous inspection, there were continued and further breaches of legal requirements. The overall rating for this service is 'Inadequate' and the service is therefore placed in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take

action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in 'special measures'.

The manager was still in the process of applying to become the registered manager. 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. Therefore the home had been without a registered manager for 19 months and the provider was in continued breach of their registration.

The manager had been responsible for the day-to-day management of the home. Although some minor improvements had been made since the previous inspection, these were not sufficient and there were continued concerns with regards to the management of the home and the provider's failure to improve the service people were provided with. The home is the only home owned by the provider. When the manager was asked what improvements had been made by the provider since the last inspection, they told us that the provider showed much more of an interest in the service and was always available to contact should the manager have any concerns or queries. However, there was no evidence to support this. The provider had not provided guidance to the manager in order to provide support during the manager's development. Neither had they had oversight of the home during a time that required concentrated managerial oversight to address the shortfalls and breaches that had been identified in the previous two inspections. As a result there was inadequate leadership and management of the home.

Despite the multiple breaches that had occurred during the past two inspections, neither the manager nor the provider had taken sufficient action to identify and adequately address the shortfalls of the systems and processes to make sure that they were providing people with a safe environment and good quality care. Following the previous inspection the provider could not demonstrate that they had maintained an oversight of the home or taken action to address the shortfalls and concerns that were found. There was a lack of action, effective governance, including assurance and auditing systems and processes, to assess, monitor and drive improvement in the quality and health and safety of the service provided. Neither the manager nor the provider had conducted any audits of the systems and processes to enable them to have oversight of them and to ensure that any improvements that were required, were made. The provider has a responsibility to ensure that this happens at all times to ensure that they are responding to the changing needs of people and that the service is continuously improved.

The lack of quality monitoring by both the manager and the provider meant that shortfalls in some of the systems in place had not been recognised. For example, the lack of audits meant that the provider had not recognised that medication management systems were not sufficient, that essential health and safety checks had not all been completed, that peoples' mental capacity had not been assessed, nor conditions on any DoLS implemented. In addition they had not recognised that people were not always involved in their care, that they were not always afforded choice within their lives, nor their independence promoted and that there was a lack of person-centred planning, implementation and review. Other shortfalls in peoples' care related to peoples' poor dining experience and the lack of access to stimulation, meaningful occupation and activities. Neither had the provider reviewed staffing levels in response to peoples' changing needs to ensure that these were sufficient.

The culture within the home was not always person-centred or empowering. It was not clear how people

were involved in decisions that affected their lives and the care they received. Peoples' independence was not always promoted and staff did not always encourage people to retain the skills they had or to develop new ones. Peoples' care records were not always person-centred and it was sometimes difficult to see 'the person' within them. Staff knew people well, however, their knowledge of peoples' preferences and life histories were not documented and therefore it was not evident if peoples' aspirations and goals had been encouraged. Reviews of peoples' care had not been undertaken and therefore there was a risk that the care they were provided with, was not current. People did not always have access to activities, meaningful occupation or stimulation. There were missed opportunities for daily engagement in activities to promote peoples' self-esteem and confidence.

People were cared for by staff that had undergone appropriate checks to ensure they were safe to work within the health and social care sector. Staff had access to training and development, however, had not always completed courses that were specific to peoples' individual conditions, to ensure that their knowledge and skills were appropriate to enable them to meet peoples' needs. People were asked for their consent when being supported in day-to-day activities, however, their mental capacity had not been assessed with regards to specific decisions that affected their lives and the care provided. Some restrictive practices were used, such as the withholding and limitation of sweets, crisps and certain lifestyle choices, to promote a healthier lifestyle for people. However, it was unclear if people had been involved in this decision or if their mental capacity had been assessed in relation to this before best interests decisions were made. People had Deprivation of Liberty Safeguards (DoLS) in place which had been authorised by the local authority. However, some of these DoLS had conditions associated to them. These conditions had not been met and therefore the provider was not complying with the DoLS authorisations.

People had access to healthcare professionals when required, however, observations and records showed that advice provided by healthcare professionals was not always followed. People had access to medicines; however, there were concerns with regards to medicines management. Records to inform and provide guidance to staff were not always completed and therefore staff were not always provided with appropriate information to inform their practice and ensure people had access to medicines when they required them.

People told us they were happy with the food. However, observations showed people to have a poor dining experience. It was unclear what choice people had been provided with in regards to the food that they ate. One person told us, "You never know what it will be, it just comes, but it's all right".

There were practices in place to help protect people from harm and abuse. However, risks to peoples' safety were not always assessed or managed appropriately according to their needs or abilities. Observations demonstrated a culture that was risk averse and people were not always able or encouraged to take risks to enable them to develop new skills or retain the ones they had. Environmental risks had not always been assessed and health and safety checks, such as checks to ensure that water temperatures were safe, were not carried out. Staffing levels were not always sufficient or flexible to meet peoples' changing needs and there had been a reliance on external healthcare professionals to visit the home to ensure sufficient staffing to meet peoples' needs during the night.

People were not provided with an up-to-date policy informing them of how to raise a complaint. When this was raised with the manager they told us that people knew to come to them, the local authority or CQC if they had any concerns. However this did not provide people with clear, detailed or appropriate guidance.

People told us that they liked staff and it was evident that people enjoyed their interaction with staff as observations showed people smiling and laughing when staff engaged with them. When asked what people liked about the home, one person told us, "All the staff, especially one, they're special". Peoples' privacy and

dignity was promoted and maintained and people told us that staff respected their right to privacy at all times. People received end of life care that was appropriate to their needs. They were able to stay at the home until the end of their lives and staff ensured that they were comfortable and well-cared for.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not safe.

Risks associated with the safety of the environment and to ensure peoples' safety were not assessed nor appropriate measures implemented.

Despite changes in the needs of people, staffing levels lacked flexibility to ensure that there was sufficient staff to meet peoples' changing needs.

People were supported to take their medicines by staff who had received training. However, there were concerns with regards to the safe management of medicines.

People were protected from abuse as they were cared for by staff that had undertaken relevant training and knew what to do if they had concerns.

Is the service effective?

Inadequate

The home was not consistently effective.

People were asked their consent before being supported. However, peoples' capacity had not been assessed in relation to specific decisions. Appropriate applications to deprive people of their liberty had been made; however, conditions associated with these had not always been met.

People were able to choose what they had to drink; however, they did not have a pleasant dining experience.

Staff had access to training and supervision and were supported within their roles. However, had not always received training for peoples' specific health conditions. Peoples' health care needs were met and they had access to relevant healthcare professionals.

Is the service caring?

Requires Improvement

The home was not consistently caring.

Peoples' independence, with regards to undertaking and maintaining their daily living skills, was not encouraged or promoted.

People were not always involved in day-to-day decisions that affected their lives.

People were supported by staff that were kind, caring and compassionate. Relationships had developed between people and staff.

Peoples' privacy and dignity was maintained and people were supported to have good end of life care.

Is the service responsive?

Inadequate

The home was not responsive.

Some people had access to external clubs and activities to meet their social needs. However, there was a lack of meaningful activities or stimulation for all people.

Care plans did not always document peoples' individual social, emotional and health needs and lacked detail. They had not been reviewed or updated to reflect peoples' current needs and to ensure that staff were provided with the most up-to-date information to enable them to meet peoples' needs.

People and their relatives' were not provided with up-to-date guidance to inform them of their right to complain.

Is the service well-led?

Inadequate

The home was not well-led.

The home did not have a registered manager.

There was a lack of quality assurance processes, oversight and actions by both the manager and the provider.

There was a failure to improve and instigate changes to ensure the delivery of high quality care, to drive improvement and to ensure peoples' experiences improved.

Oak House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over two days. The first day of the inspection took place on the 15 August 2017. The inspection team consisted of two inspectors 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. The second day of the inspection took place on 13 September 2017 and was carried out by one inspector. Both inspections were unannounced. The second day of inspection took place to ensure that some actions, to address risks that had been identified during the first day of the inspection, had been carried out. The home was last inspected in January 2017, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. Prior to the inspection we looked at the previous inspection report and information that had been shared with us by the local authority. We also checked the information that we held about the home as well as the provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to send us by law. We used all of this information to decide which areas to focus on during our inspection.

Prior to the inspection we contacted a professional from the local authority to obtain their feedback. During the inspection we spoke with four people, two care staff, the manager and a visiting healthcare professional. Following the inspection we contacted two healthcare professionals for their feedback. Some people had

complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experiences of people who could not talk with us. We reviewed a range of records about peoples' care and how the service was managed. These included the care records for six people, medicine administration record (MAR) sheets, three staff training, support and employment records and records relating to the management of the home. We observed care and support in the communal lounges and dining room during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

Inadequate

Is the service safe?

Our findings

At the previous comprehensive inspection on 3 January 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to a lack of risk assessments for staff who worked alone during the night and for people who were unable to use the call bell system. Other concerns related to insufficient health and safety systems and checks within the environment to assure peoples' safety, a lack of recording of accidents and incidents and a lack of guidance for staff when supporting people with 'as and when required' medicines. Further concerns related to unplanned for, and unexplained weight loss going unrecognised for some people and insufficient and inflexible staffing levels. Following the inspection the provider wrote to us to inform us of how they were going to address the shortfalls and ensure compliance. At this inspection, although minor improvements had been implemented, the provider was found to be in continued breach of this regulation.

At the inspection on 3 January 2017, although people could independently mobilise, there were concerns with regards to peoples' cognitive abilities and their understanding of how to use a call bell should they need to summon staff assistance. The building is spread over three floors and there is one member of staff working during the night. There were no assessments in place to identify how this would be managed or to identify and mitigate any risks. There was no guidance for staff to follow in relation to ensuring that people, when in their rooms, were safe. When this was raised with the manager they explained that staff who worked during the night undertook regular checks to ensure peoples' safety, however, the manager explained that there was no record of this to demonstrate how risk was managed. At this inspection improvements had been made, however, these were not always sufficient to ensure that each person's needs had been fully risk assessed and appropriate plans and guidance in place for staff to follow to ensure peoples' safety. For example, the manager had implemented a lone working risk assessment for staff who worked during the night. A call bell protocol had also been introduced that named each person who was unable to use their call bell due to their cognitive abilities. It stated, 'Staff are informed at each handover if a resident is unwell and will automatically ensure that they are checked at regular intervals through the day and night if it is deemed that they cannot summon assistance. These checks will be carried out, documented and evidenced'. However, there was no evidence of risk assessments for each of the people listed that identified the risk of not being able to use the call bell or informed staff of how frequently the checks should take place. Neither was there any evidence of checks that had been conducted by staff to confirm that this process to manage risk was being undertaken. Conversations with staff raised further concerns with regards to staffs' knowledge about which people were not able to use their call bells and the checks that staff should be undertaking. One member of staff told us, "They use the call bells". When asked if they were referring to all of the people, they told us, "I think so, yes".

At the previous inspection on 3 January 2017, risks associated with the safety of the environment and equipment were not always identified and managed appropriately. Regular checks to ensure peoples' safety had not always been undertaken. Including checks on the fire alarms, emergency lighting and hot and cold water temperatures, which had not been completed for four months. In addition an external safety check for the electrical wiring of the home had expired two years previously. At this inspection, some improvements

had been made. Records showed that the fire alarm, emergency lighting and the electrical wiring of the home had been checked. Subsequent to the previous inspection a fire audit had been conducted by an external contractor who had recommended that some fire detectors be replaced and that a system upgrade be considered. There was no action plan to show that these recommendations had been acted upon, planned for or addressed. However, on the second day of inspection, an external contractor was at the home replacing some fire detectors, smoke alarms and emergency lighting. Records also showed that an external fire consultant had visited the home following the first day of the inspection, they had conducted a fire risk assessment and an action plan had been devised which identified 22 actions that needed to be completed. The action plan identified those that needed to be actioned with immediate effect and those that needed to be completed within 1, 3 or 6 months. The manager and provider had completed some actions from the action plan and had contacted external contractors to complete others, however, one action, which had been identified as needing to be actioned immediately, had not been completed. The home has an external metal staircase that can be used as a means of escape in the event of an emergency. The risk assessment had identified that combustible materials and waste such as an old mattress had been stored underneath the fire escape stairs and therefore this had posed a risk. However, observations on the second day of inspection showed that this risk had not been mitigated. Items such as an old mattress and a disused commode were stored underneath the stair case. In addition, cigarette butts were found alongside these items, therefore increasing the fire risk that the items posed. When this was raised with the provider they took immediate action and the items were removed.

At the previous inspection personal emergency evacuation plans (PEEPS), which informed staff of how to support people to evacuate the building in the event of an emergency had not been completed for all people. At this inspection, although all people had a PEEP in place, some of these had not been updated to reflect the change in peoples' needs and therefore were not current. The home is spread over three floors, people had varying degrees of mobility and cognitive impairments and therefore would need support from staff in the event of an emergency. There was no fire risk assessment or current, clear plans for staff to follow. This posed a greater risk as there was only one member of staff who worked during the night and it was not clear, due to the lack of clear, updated guidance, how the member of staff would manage or ensure peoples' safely in the event of an emergency. On the second day of the inspection PEEPS had been reviewed for all people, providing staff with clear information as to how to safely support them in the event of an emergency.

An asbestos survey had been conducted by an external contractor one year prior to the inspection. They had identified that there were some higher risk items within the home and whilst acknowledging that these items were in good condition, had suggested to the provider that these areas be labelled and that on-going monitoring of them took place. The manager explained to us that they were yet to label the items or implement regular monitoring of them. Therefore there was a potential risk that people and staff could have come into contact with a product that had the potential to cause them harm.

A different external contractor had visited the home a year prior to the inspection to conduct a water safety test. They had identified that the hot water supply had been below temperature and that on-going management actions had been lacking. Regular testing of the water temperatures had still not been re-commenced by the manager or provider to ensure peoples' safety. This meant that the water temperatures had not been tested for 11 months. When this was raised with the manager, they told us that the water temperature checks had not been undertaken as they were waiting for the correct template and form to be sent to them by an external company before they re-commenced the checks. Subsequent to the inspection the manager was asked to test the temperature of the hot water to ensure that people were not at immediate risk of scalding, the results of which were found to be within an acceptable and safe range.

At the previous inspection, although treatment plans from external healthcare professionals had been implemented, such as the fortifying of food to increase peoples' calorie intake, people who were at risk of malnutrition were not always regularly weighed to ensure that they were not losing more weight. Records showed that where people had lost significant amounts of weight, this had gone unrecognised and unmonitored. At this inspection improvements had been made. Although some people had lost weight, records showed the possible reasons for this and referrals had been made to peoples' GP. One person's records showed that they had lost a large amount of weight over a period of time. When this was raised with the manager they told us that the person had been overweight and with support from staff, with regard to restricting the person's access to certain types of food, as well as monitoring what the person had to eat and avoiding so much unhealthy food, the person had lost weight. However, other records to show that this was something the person had consented to and worked towards, were not in place.

At the previous inspection observations showed that cleaning products were stored in a dis-used shower, in a bathroom that people used. Further observations showed that other cleaning products, that were stored in the COSHH (Care of Substances Hazardous to Health) cupboard, were not locked away. At this inspection most cleaning products had been stored correctly. However, observations showed that one, commercial grade chemical, had been left unattended in the main communal bathroom. This meant that people continued to be at risk of coming into contact with chemicals that had the potential to cause them harm. There were further concerns with regard to the lack of risk assessments and relevant information held with regard to the hazards and risks that certain chemicals could cause should people or staff come into contact with them. This had also been recognised within an audit conducted by the local authority four months prior to the inspection but was yet to be rectified and appropriate risk assessments had not been devised to assure peoples' and staffs' safety.

People were assisted to take their medicines by staff who had been trained and assessed as competent to administer medicines. However, observations of medicines being dispensed showed that the appropriate checks, before administering medication, were not all completed. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that staff should follow the six R's when administering medication. These include – right resident, right medicine, right route, rights dose, right time and a resident's right to refuse. Observations showed that medicine was dispensed from the person's medication pack without checking that the medicines contained in this, corresponded with the person's medicine administration record (MAR) charts and therefore correct checks had not been undertaken to ensure that the correct medicine was being dispensed.

At the previous inspection there were concerns with regard to the guidance provided to staff for 'as and when required' medicines. At this inspection no improvements had been made and therefore people remained at potential risk of not receiving their prescribed medicines. Records showed that people had received their medicines in a timely manner and that when they required additional medicine, on an 'as and when required' basis that this had been offered by staff. However, there were continued concerns with regards to guidance that was provided to staff in relation to these types of medicines. The NICE guidance recommends that care homes' policies should include clear reasons for giving 'as and when required' medicine, minimum time between doses, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'as and when required' medicines in peoples' care plans. Prescribing instructions for one person, who was prescribed medicine to manage their anxiety, stated that the person could be given one to two tablets 'as and when required'. Staff had demonstrated good practice by recording when, how and why the medicine was given; however, they had not been informed when and why they should offer one tablet or when they should offer two. There was a risk because of this that the person was not provided with their 'as and when required' medicines in a consistent way and as the prescriber had intended.

Records showed that most medicines had been entered on to the MAR electronically, by the person's pharmacy. However, some records had been entered in manually by one member of staff. The NICE guidance recommends that handwritten additions and changes to the MAR are checked for accuracy by a second, trained member of staff to reduce the risk of errors. This had not taken place.

People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example, hidden in their food or drink. The NICE guidance states that a best interests meeting should take place involving healthcare professionals, peoples' relatives or representatives, to discuss and agree if this is the correct option. It advises that guidance should be provided to staff stating how the medicine should be administered covertly. This had not been implemented in practice. One person was supported to have their medication given covertly. A letter had been obtained from their GP which stated, 'It is reasonable to crush tablets and for them to take them in their food as long as the prescribing rules are closely adhered to. They must be aware of why they need to take the medicines'. However, records and staff could not confirm that the person had been informed about taking their medicines in this way. There was no involvement from a pharmacist or associated guidance on how the medicine should be covertly administered in a safe way to avoid altering the structure of the medicines. There was a lack of involvement and guidance from healthcare professionals to ensure that the medicines were being administered in an appropriate way.
Checks to ensure that the medicines cabinet was at an acceptable temperature to store medicines appropriately, had been undertaken on a daily basis. However, there was no guidance for staff to follow so that they were aware of the correct temperature ranges, so that they could then identify if the temperature of the medicines cabinet was too cold or too warm. When this was raised with the manager they could not tell us the recommended temperature range that medicines should be stored at. Records for one person showed that a medicine that they had been prescribed needed to be stored below a certain temperature and away from excess heat. Therefore, although the temperature of the cabinet was within the normal recommended range, there was a risk that had it not been, staff would not have been aware and peoples' medicines might not have been stored safely.

The provider was not doing all that was reasonably practicable to mitigate risks. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection an area in need of improvement was noted with regards to the level and inflexibility of staffing when peoples' needs changed. At this inspection, this became a greater area of concern despite the occupancy levels decreasing by one since the previous inspection on 3 January 2017 and the staffing levels remaining the same. This was because one person's dependency needs had increased. For example, one person was receiving end of life care and staff were demonstrating good practice by ensuring that they spent time with the person during the day to meet their needs and to ensure that they were not alone. There was one member of staff who worked during the night. The person receiving end of life care required support to assist them to change position every two hours to minimise the risk of pressure wounds deteriorating. We were informed by a healthcare professional that due to there only being one member of staff during the night, external district nurses had been visiting the home every two hours, to provide support to the person who required assistance to move and position. Concerns had been raised with us about the level of staffing during the night and the fact that the provider had relied upon external healthcare professionals to safely and effectively meet peoples' changing needs. The provider had not ensured that the persons' needs were assessed in relation to staffing levels and as a result had not provided additional staffing to ensure that staffing levels remained sufficient during times of change and had instead relied upon external services to provide sufficient staff to meet the persons' needs.

Staff told us that they felt that the staffing levels were usually sufficient but that during times when peoples'

needs changed it could cause a strain on them. One member of staff told us, "Two on is ok, it works. But the situation with this person means we are limited at present. There is good continuity of staff, always one on who was on the previous day". Another member of staff told us, "Two on shift is fine, except now with end of life care we want to make sure they are not alone, so a lot of the time it's really one on shift".

The provider was not doing all they could to ensure that there were sufficient numbers of staff to meet peoples' needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I always feel safe". Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. Referrals to the local authority had been made when there were concerns over a person's safety. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Inadequate

Is the service effective?

Our findings

At the inspection on 3 January 2017, there was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were continued concerns with regards to the lack of mental capacity assessments for people who had been identified as not having capacity to make specific decisions. In addition, a DoLS authorisation had expired which meant that a person was potentially being deprived of their liberty unlawfully. Following the inspection the provider wrote to us to inform us of what they would do to ensure that they were meeting legal requirements. At this inspection, although DoLS applications had been made for people, there were further areas of concern and the provider continued to be in breach of the regulation.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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).

At this inspection we checked whether the provider was working within the principles of the MCA as well as ensuring that actions had been taken in response to the concerns that were found at the previous inspection. In addition, we checked that any conditions on authorisations to deprive a person of their liberty were being met. It was evident that some improvements had been made. Staff had undertaken MCA and DoLS training and people were asked their consent for day-to-day decisions and these were respected by staff. Due to peoples' cognitive abilities and the fact that they would be unable to leave the home unaccompanied, DoLS applications had been made for all people. One person had a lasting power of attorney (LPA) so that when the person lacked capacity to make certain decisions the LPA could make these on the person's behalf. The manager had demonstrated good practice as they had obtained a copy of the LPA to assure themselves that people, acting on behalf of the person, had a legal right to do so. Further good practice was demonstrated, in part, as best interests decision meetings had taken place with relevant professionals to ensure that decisions that were made on peoples' behalf were in their best interests. However, the manager had not ensured that peoples' mental capacity was assessed prior to this, to identify if people had capacity to make their own decisions or if they lacked capacity and therefore required the assistance of others to make decisions on their behalf. This related to specific decisions in relation to peoples' care such as the use of bed rails, covert medication and agreements when restrictive practices, such as the withholding and limitation of certain foods or items to support a person's lifestyle choice, were in place.

People may sometimes require support that involves restrictive practice or intervention. This could be physical restraint or use of devices, medication or seclusion. Records showed that several people had been subjected to restrictive practices with regards to the storage and access to certain types of food and lifestyle choices. For example, two people had restrictive practices in place whereby staff stored sweets and crisps in

the kitchen rather than these being kept in the persons' room, staff told us that this ensured that the people did not have excessive amounts of the food and also minimised the risk of them choking on these whilst in their room alone. Another restrictive practice related to a person's lifestyle choice, this meant that staff stored items on the person's behalf and limited the use of them. Although these restrictions were in place to promote a healthier lifestyle, peoples' capacity had not been assessed in relation to their ability to make these decisions. Records for one person stated that a best interests meeting had taken place with regards to a restrictive practice. However, only the person and the manager had been involved. When the manager was asked if the person had capacity to make the decision they told us they did not and therefore the manager had been the person making the decision. Best interests meetings had not taken place to ensure that these restrictions were in peoples' best interests.

Some peoples' DoLS authorisations had conditions associated to them. This meant that the local authority that authorised the DoLS, had only authorised the DoLS on the understanding that certain conditions were met. DoLS authorisations for two people showed that the conditions associated with their DoLS had not been met. One persons' DoLS stated that regular reviews of the person's mobility should take place. However, there were no care plans or risk assessments that had identified the person's mobility as being a need and therefore this had not been identified or reviewed. Observations of the person showed them to be unsteady on their feet when standing and accessing the stairs. However, this had not been considered and therefore the person's DoLS condition was not being met. Records for another person stated that the person's care should be regularly reviewed, that there should be clear guidelines in place for their 'as and when required' medicines and that they should have access to regular activities. None of these conditions had been met.

The provider had continued to not ensure that care and treatment was provided with the consent of the relevant person. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, an area identified as in need of improvement related to peoples' dining experience. At this inspection, no changes or improvements to their experience had been made. People had their main meal in the evening and a lighter lunch that consisted of sandwiches or a lighter meal, fruit, yoghurt, crisps or chocolate. People could choose where they had their lunch, most people chose to have their meals in the main dining room, others chose to have their meals in their rooms and this was respected by staff. People were provided with a degree of choice, observations showed people being asked what choice of drink they would like with their lunch; however it was unclear how much choice people had with regards to what they had to eat. One person told us, "You never know what it will be, it just comes but it's all right". The dining room did not create a pleasant atmosphere for people to eat their meals. The Alzheimer's Society suggests that as dementia progresses eating can become difficult for some people. It states that, 'The environment plays an important part in the eating and drinking experience. A good mealtime experience can have a positive impact on the person's health and well-being'. Within the tips provided to carers, it states, 'Make the environment as appealing to the senses as possible. Familiar sights such as tablecloths, flowers and playing soothing music at mealtimes can all help'. Observations showed that these were not in place for people and instead people ate their meals in silence with staff handing out food from a trolley in the dining room, whilst wearing disposable plastic gloves. This did not create a relaxing, sociable atmosphere and instead made the lunchtime experience people had, feel institutional.

People had access to regular healthcare. Records showed that people had been supported to access the GP, opticians, audiologists, district nurses and consultants to maintain their health and well-being. However, guidance provided by healthcare professionals had not always been followed. Records for one person showed that they had been assessed by a physiotherapist and guidance had been provided to enable staff

to effectively support the person to mobilise. Supported walking guidelines for the person, stated that they should be supported by staff walking beside the person, supporting the person's elbow and using a palm to palm technique to guide the person or by encouraging them to use a walking aid. However, observations, throughout the day, showed the person being guided by staff, who were standing directly in front of the person and walking backwards whilst guiding the person to walk. This raised concerns about the sharing of healthcare guidance with staff and staffs' understanding of this. When this was raised with the manager, subsequent to the inspection, they explained that the person's needs had changed and that they were waiting for a new assessment of the person's needs by a healthcare professional and that in the meantime staff had adapted the support they provided to the person with their mobility. However, care plan records for the person had not documented that the person's needs had changed and that staff had adapted their approach to meet changes in the person's needs.

The provider had not considered peoples' well-being when meeting peoples' nutritional and hydration needs. Neither had they ensured that people received person-centred care and treatment that was appropriate to meet their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) 2014.

Staff told us that they felt well-supported and could approach the manager or provider at any time if they had concerns or needed assistance. Staff told us and records confirmed that they were provided with regular, formal supervision to enable them to discuss their concerns and areas of development as well as to be provided with feedback on their practice by the manager. A majority of staff had worked at the home for several years. Newer staff had been supported to learn about the providers' policies and procedures as well as peoples' needs. Staff had completed training which the provider considered essential. There were links with external organisations to provide additional learning and development for staff, such as the local authority and the Care Home In-Reach Team (CHIRT). CHIRT provides advice, training and information for care homes that provide care to people living with dementia.

Some staff had achieved diplomas in health and social care. Staff told us that the training they had undertaken was useful and enabled them to support people effectively. However, staff had not always completed training for peoples' specific conditions. Records showed that staff had not completed training for a health condition that two people had. There was no guidance in these peoples' care plans as to what staff should do to deal with any emergencies resulting from their health condition, when asked, one member of staff told us that they would contact the emergency services immediately, whilst another explained that they may wait for a period of time to see if the episode passed. Therefore there was a risk that staff did not have the necessary knowledge or skills in relation to supporting these people consistently or effectively. Medication records for one of the people showed that they had been prescribed a particular medication to be used if a health emergency were to arise. When this was raised with the manager they told us that the medication had not yet been supplied as staff were waiting to receive training on its use. Therefore there was a risk that should the person require their medicines in the event of an emergency, staff would not have had these to administer as they had not had the relevant training in their use. Therefore some measures had been taken to ensure that staff were suitably skilled and trained to deal with certain conditions, however the provider had not ensured that staff were suitably skilled and trained to deal with all of the health conditions that people had. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, were living with various stages of dementia. Observations of one person showed them to be disorientated and confused when they came out of their room. The person was immediately supported by staff to navigate to a part of the home that they were familiar with so that they could access the communal areas to have a drink and to see other people. The Health and Social Care Institute for Excellence (SCIE)

state that simple changes to create a more dementia-friendly environment can have a positive impact on a person's emotional well-being and independence. The provider had taken this into consideration in part. There was clear signage on the toilet and bathroom door. However other doors were painted white with white or pale wall colours surrounding them. Observations showed that this affected one person's' ability to freely orientate themselves and move around the home. SCIE states that the use of colour and contrast can be helpful for people living with dementia. We recommend that the provider access guidance from a reputable source to ensure that the environment meets peoples' needs.

There was effective communication amongst the staff team. Day and night records detailed staffs' actions and peoples' conditions and ensured that information was passed from one member of staff to another. Observations demonstrated that there was effective verbal communication between people and staff, with staff using simple hand gestures to aid their communication with one person. Staff enabled people to communicate their needs and it was apparent that they knew peoples' communication style well. However, there was no adapted written communication for people to access. Peoples' care records were in written form as was information that was displayed on the notice board, such as safeguarding and complaints procedures, this meant that people were not always provided with information in a format that they could easily understand and therefore relied on staff to communicate this information to them. It was not apparent in peoples' records that this had happened. The manager explained that people used to use Makaton to enable them to communicate more effectively, however, as staff knew peoples' needs this was now not used in practice. Makaton is a language programme using signs and symbols to help people communicate. Therefore the adaptation of information, to ensure that it is accessible to all people, is an area of practice in need of improvement.

Requires Improvement

Is the service caring?

Our findings

People told us that they liked the staff and that they were well cared for. One person told us, "It's a nice place to live, of course some staff are better than others but we all get along together". When asked about what a person liked about living at the home, they told us, "All the staff, especially one, they're special". People responded well to staffs' approach, staff appeared to know people well and enjoyed providing support to people in a relaxed and comfortable way. There was a relaxed and welcoming atmosphere. Observations demonstrated that people enjoyed the interaction they had with staff, there were lots of smiles, laughter and banter and people appeared to be very happy in the presence of staff. However, despite this, we found areas of practice that required improvement.

Peoples' independence was not promoted and staff did not always encourage people to retain the skills they had or to develop new ones. Staff were responsible for cleaning peoples' rooms, tending to most peoples' washing and cooking and preparing peoples' meals. Not all staff showed an awareness of the importance of encouraging independence with daily living tasks. Observations of people when they were having their lunch, showed staff undertaking the simplest of tasks for people, such as peeling bananas and opening chocolate bars and serving people their prepared food and drink. Staff had not encouraged people to assist in the preparation of their lunch or the serving of drinks. When this was raised with the manager they explained that people did not want to engage in these activities of daily living and instead wanted staff to support them. Records for one person showed that prior to their admission to the home they had been assessed by the local authority, the assessment clearly stated that the person enjoyed and was able to make their own bed each day. However, there were no care plan records or documentation to inform staff of this. In addition records did not indicate if this was something the person was encouraged to undertake and therefore it was unclear if this was a skill they had retained. It was not apparent that peoples' independence and engagement in daily living skills had been encouraged or promoted. This did not support people to develop new skills or retain the ones they once had.

The provider had recognised that people might need additional support to be involved in their care; they had involved peoples' relatives when appropriate or their paid representative. People who are being deprived of their liberty in care homes have a statutory right to have a representative to support them to exercise their rights under the Mental Capacity Act 2005 (MCA). If there are no appropriate, willing or able friends or family to take on this role, then a paid representative will be appointed. This is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. There were no formal residents' meetings and it was unclear how people were kept informed about the care they received. For example, one person told us that they liked the food that was provided but that they never knew what they were having for their dinner. Menus were displayed in the kitchen to inform staff of what meals to cook, however, there was no evidence that people had been involved in devising the type of meals they liked or how they were then informed of what menu choices were available for the day. Subsequent to the inspection the manager explained that menus were designed around peoples' known preferences and that they had the opportunity to change their mind. Observations showed that people were asked their preferences with regards to the drinks they would like. However, other than simple decisions that related to day-to-day care, staff could not

demonstrate the extent of peoples' involvement in decisions that affected their lives or their care. Peoples' care records did not demonstrate that they had been involved with the development, planning and review of their care.

The provider had not ensured that the care and treatment of people was appropriate to meet their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a friendly atmosphere. It was evident that staff cared for the people they were supporting and relationships had developed. People were cared for by kind and caring staff who had worked at the home for a number of years and who knew their needs well. People were encouraged to maintain relationships with one another as well as with their family and friends. Some people accessed external clubs where they had made friends and socialised. People told us that they were able to have visitors' to the home and that they were welcomed.

Peoples' diversity, with regards to their preferences on how they spent their time, was respected, for example, some people preferred to spend their time in the communal areas of the home, whereas others preferred to spend time in their own room. Peoples' privacy was respected and maintained. Observations showed that when people required assistance from staff that staff did this in a discreet and sensitive way. For example, staff spoke in a low voice when asking people if they needed assistance to access bathroom facilities and had closed peoples' bedroom doors when supporting them with their personal care needs. People confirmed that they felt that staff respected their privacy and dignity as they knocked on their doors before entering their rooms. Some people held a key to their room so that they could lock their door to ensure that their privacy was maintained. Privacy, with regards to the information held about people, was promoted as records were stored in locked cabinets and offices.

Conversations with people, and their relatives, if this was appropriate, had taken place, and advanced care plans had been devised for some people. Peoples' rights had been respected if they had not wanted to discuss their end of life care needs. Staff had undertaken end of life care training and support and guidance had been sought from visiting healthcare professionals. People were able to remain at the home and were supported until the end of their lives. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. One person was receiving end of life care. Staff showed compassion and sensitivity to the persons' needs and ensured that a member of staff spent time with the person. The person received regular visits from healthcare professionals and these, as well as the support from staff, had ensured the person's comfort and well-being.

Inadequate

Is the service responsive?

Our findings

At the previous inspection on 3 January 2017, areas in need of improvement were identified in relation to peoples' access to activities, stimulation and meaningful occupation. Other areas in need of improvement related to the reviewing of peoples' needs and their care records. At this inspection, it was evident that measures had been taken to try to improve peoples' participation in activities. CHIRT had visited the home to provide staff with advice and support as to how to improve peoples' experiences. However, it was not apparent how this had been implemented in practice and consequently peoples' experience with regard to stimulation and access to activities had not improved.

The home is registered to provide support for older people, who are living with dementia as well as older people who have a learning disability. The British Institute for Learning Disabilities (BILD) provides guidance on how to support people to age successfully and to continue to lead a productive life, with access to stimulation and opportunities. It explains that when older people do not have these opportunities they are at a greater risk of depression as a result of social isolation and exclusion. This is echoed in relation to guidance provided by SCIE in relation to older people living with dementia. They state, 'Older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation'.

One person had their own electronic device that they could watch sport on, something which they had clearly been able to keep up-to-date with as they were able to tell us the most recent scores and sporting achievements. Despite the involvement of CHIRT, there was a continued lack of stimulation for some other people. There was a reliance on external services to occupy peoples' time. Some people had access to activities through local clubs, support groups and day services. One person had been supported by an external club to go on holiday and told us how much they had enjoyed this. However, not all people attended external clubs or day services.

One person spent their time in their room and observations showed staff going into the person's room to take them their drinks or meals. The manager explained that the person preferred to spend their time in their room and would seek support from staff when needed. Observations showed that the television was on in both communal lounges throughout the day; however it was not apparent if people enjoyed watching this. When the lack of meaningful activities and stimulation was raised with the manager they explained that people had a right to refuse to take part in activities and choose not to participate. However, there was no evidence that people had been provided with this choice, as there were no meaningful activities or sources of stimulation that people could choose to partake in. Records had been implemented that had been completed sporadically. These stated that activities had been offered but had been refused. However there was not always a description as to what activity had been offered so that this could be evaluated. The lack of activities raised concerns with regard to the staffing levels as current staffing levels would be insufficient to enable people to enjoy time out of the home if this was something they chose to do. This was confirmed by the manager, who said that they expected to be seen by external auditors, such as the local authority and CQC, as not providing enough activities, and told us, "That's all everyone says but the residents don't want them and we are limited what we can do with staffing as it is".

Staff told us that they had tried to engage in activities with people. One member of staff told us, "We've tried more activities, we offer puzzles, and we've tried keep-fit videos. Through the day centres they get parties and things outside to do. I don't believe they enjoy going out". However when asked if they spent time out of the home, one person told us, "I wouldn't mind if I could go out more. I can't do it unless someone comes with me to keep me safe". One member of staff told us, "We make sure they get sport on the TV when it's on, we check it out beforehand to make sure they don't miss it. We spend time with people in the lounge. One person uses their tablet on the home's Wi-Fi to keep up with the sports they want and can use headphones. Another likes going out and the day centres do that. I've taken one person for a coffee when we've been out anyway for an appointment, but they don't have any appointments now."

The home had a large, well-maintained garden. One person often accessed the garden, however, when another person was asked if they liked to go into the garden they told us they didn't go out on their own as they did not like the steps leading up to it, but told us, "I haven't been out yet today, I like to go out, I like to see the flowers". Observations, later in the day, showed that the person had followed a member of the inspection team into the garden and the person enjoyed talking about the birds and the different types of flowers. A member of staff told us, "In the garden, they like it if we are here; as soon as we go in, so do they". The manager told us about a raised flower bed that had been made in the garden to encourage one person to partake in some gardening. They told us that the person didn't use it. However, it was not evident how much encouragement people were given to participate in activities or meaningful occupation to occupy their time or how much staff actively supported people to engage and partake in activities to ignite their enthusiasm and enjoyment from it. There were missed opportunities for engagement in daily activities and access to stimulation. Care plan records made no reference as to how to support peoples' interests or to encourage stimulation. There were no resources available or on display to stimulate or occupy peoples' time. When one person was asked what they did at the day service they attended, they told us that they enjoyed playing skittles there. When asked if they ever did that at home, they told us "No, we don't do that here". When the person was asked if it was something they would like to do, they told us, "Yes, I'd like to". This comment was fed back to the manager at the end of the inspection.

Files that contained peoples' care records, contained outdated and generic information such as information sheets for staff to provide guidance as to what to do if a person died or if a DoLS application was required to be made. Older paperwork, such as DoLS applications, authorisations, risk assessments and care plans also remained in the files. This had been fed back to the manager at the previous inspection and through external audits that were carried out by the local authority, however files had remained unchanged. This made it difficult for staff to access the most current information that was important to the person. In the Government initiative, Valuing People - A new Strategy for Learning Disability for the 21st Century, it states, A person-centred approach to planning means that planning should start with the individual (not with services) and take account of their wishes and aspirations. One persons' care plan was more detailed than others, containing information on their likes, dislikes and hobbies. Whereas others did not contain this type of information and did not demonstrate 'the person' within their care records. Guidance had been sought from CHIRT, who had advised staff to develop life stories for people to enable their care to be more personalised. However there was no evidence that this had been implemented.

It was apparent that due to the small staff team, staff knew peoples' needs well; however this knowledge of peoples' individual needs was not supported by clear guidance to ensure consistent care. There were various generic care plans in place such as personal care and dementia, however, these were not sufficient or detailed enough to provide individual guidance for staff. For example, a dementia care plan for one person stated that the person's dementia had become more profound and they had been showing signs of dislike for other people and had been unkind to them. There were no plans in place as to what staff were doing to support the person during this period of change, or to effectively manage the situation.

Care records contained inconsistent information and guidance for staff. For example, one person's care plan advised staff that they did not want to be resuscitated; however there was no accompanying Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place. A DNACPR form is a medical document which informs others of the person's wishes with regards to resuscitation. Other peoples' care plans did not contain DNACPRS and these were stored in other files, which meant that in the event of a health emergency, they were not easily retrievable.

Records showed that people had access to external healthcare professionals when required. However, records did not show that peoples' heath had been assessed and effective plans put in place to promote good health and minimise the need for external medical intervention. Valuing People state, 'The Government expects each individual with a learning disability to be offered a personal Health Action Plan (HAP). The HAP will form part of the person-centred plan. The HAP is an action plan and will include details of the need for health interventions. There was no evidence in peoples' care records of HAPs, neither were there effective plans in place to identify peoples' heath needs and plan effectively for peoples' health or well-being.

At the previous inspection, an area identified as in need of improvement related to the reviewing of peoples' care to ensure that it was up-to-date and met their current needs. At this inspection, care records for one person had been reviewed, following a recommendation also made by the local authority within a best interests meeting, however other peoples' care records had not. There were no systems and processes for the reviewing of peoples' care records. This meant that there was the potential that peoples' current needs had not been identified or met.

People were supported to make day-to-day choices, such as what they would like to drink and what clothes they wanted to wear and peoples' rooms were decorated as they wished, with items and personal belongings that were important to them. However, people were not always afforded choice throughout other aspects of their lives or to maintain their own sense of identity. Observations of certain practices demonstrated a non-person-centred approach to supporting people. For example, people shared a communal bathroom. Toiletries in the bathroom were used by most people. When the manager was asked if people had their own toiletries, to promote a sense of identity, the manager told us that two people had their own toiletries whereas others shared the communal bottles. Other observations showed that the news was on the television. One person was sitting in the room whilst the television was on. They told us that they disliked the news and thought it was boring and when it was suggested by an Inspector that they could change the channel, they told us, "No, I'm not allowed to, they'll tell me off". This same statement was repeated to another member of the inspection team later on during the day. When this was fed back to the manager subsequent to the inspection they told us that this was a standard response from the person and that had the person been asked several more times, their response may have changed.

The provider had not ensured that people received care and treatment to meet their assessed needs or which reflected their preferences and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There had been no complaints since the previous inspection. The provider had recently engaged with an external organisation that had provided policies and procedures and updated the provider on changes to legislation and best practice guidance. One of these new policies related to the complaints policy. There was a comprehensive policy in place, however the manager's and staffs' awareness of this was not embedded in their practice and the previous complaints policy was still being displayed on the notice board within the hall for people and visitors to see. When the manager was asked how people and visitors would know how to complain, they told us that people knew to go to them if they were unhappy about anything and that,

"These days' people just know to go to social services or CQC don't they"? This meant that there was no clear, updated guidance for people or their visitors to access should they wish to make a complaint. The awareness of new policies that had been introduced and the accessibility of these to people and visitors, so that they were aware of how to make a complaint if they were unhappy about the care being provided, is an area of practice in need of improvement.

Inadequate

Is the service well-led?

Our findings

The provider has failed to ensure that there are systems and processes in place to continually review and improve the service. At the inspection on 19 October 2015, the provider was in breach of Regulations 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At the next comprehensive inspection on 3 January 2017 some improvements had been made, however, the provider had not addressed all of the previous concerns in relation to the lack of notifications submitted and insufficient audits to ensure that they were continually improving the service provided. In addition, there were concerns with regards to the lack of guidance to inform staffs' practice and the lack of a registered manager. As a result the provider was in continued breach of the regulations. At this inspection, although some improvements had been made the provider was still in breach of the regulation.

The provider has been without a registered manager for 19 months and therefore in breach of their registration conditions. This matter is being dealt with outside of the inspection process. The manager is currently undertaking the process to apply to become registered manager.

At the previous inspection on 3 January 2017 it was identified that the manager was still developing in their role and was yet to fully understand their role and responsibilities. At this inspection it was found that the manager was still developing in their role and although they had implemented some improvements, these were insufficient and they had not effectively planned or resolved the shortfalls that had been found at the previous inspections. There were links with external organisations to support the manager and staff to provide the most effective and appropriate care for people and to enable the manager and staff to learn from other sources of expertise. These included links with the local authority and CHIRT. The manager also worked closely with external health care professionals to ensure that peoples' needs were met and attended a practice development forum for managers. However, due to the lack of actions taken to address the concerns from previous inspections the impact of external support and involvement was not evident in improving practices. The manager often worked as a member of care staff and whilst this enabled them to monitor staff's practice, it meant that this had an impact on their abilities to fulfil their management duties.

The home is the only home owned by the provider. At the previous inspection is was noted that the provider had failed to oversee the running of the home during the time of transition of management and had not supported the development of the new manager. As a result the provider had not ensured that they operated effective systems and processes to make sure they assessed and monitored their service against the regulations. At this inspection no improvements, with regard to the provider's oversight and responsibility, as well as the support and development provided to the manager, had been implemented.

At the previous inspection no improvements had been made by the provider to address concerns around quality assurance. Therefore the provider remained in continuous breach of this regulation. At this inspection there remained no further improvements in ensuring the provider was meeting peoples' needs and that the service continually improved.

The lack of quality monitoring by both the manager and the provider meant that shortfalls in some of the systems in place had not been recognised. For example, the lack of audits meant that the provider had not recognised that medication management systems were not sufficient, that essential health and safety checks had not all been completed, that peoples' mental capacity had not been assessed, nor conditions on any DoLS implemented. In addition they had not recognised that people were not always involved in their care, that they were not always afforded choice within their lives, nor their independence promoted and that there was a lack of person-centred planning, implementation and review. Other shortfalls in peoples' care related to peoples' poor dining experience and the lack of access to stimulation, meaningful occupation and activities. The provider had not reviewed staffing levels in response to peoples' changing needs to ensure that these were sufficient.

At the inspection on 3 January 2017 shortfalls noted at the previous inspection in relation to outdated information being provided to staff, had started to be addressed. The manager was in the process of devising new organisational policies, to ensure that staff were provided with appropriate guidance and had plans to improve and extend these; however at the time these were not sustained or embedded in practice. At this inspection, the provider had engaged an external organisation to provide organisational policies and procedures and to inform them of any changes to legislation and best practice guidance. However, although these were seen within the home, there was no evidence that these had been read, understood or implemented in practice by either the manager or staff and therefore staff were not provided with appropriate guidance that related to their roles or the people they supported.

When the manager was asked what improvements had been made by the provider since the last inspection, they told us that the provider showed much more of an interest in the service and was always available to contact should the manager have any concerns or queries. However, there was no evidence to support this. The provider had not provided formal supervision to the manager in order to provide development, guidance and support during a time of the manager's development and had not maintained oversight of the home in order to address the continuing concerns. There was a lack of action, effective governance, including assurance and auditing systems and processes, to assess, monitor and drive improvement in the quality and health and safety of the service provided.

There remained inadequate processes for assessing and monitoring the quality and safety of the service provided for the purposes of continuing development. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 3 January 2017, there were no mechanisms in place to gain peoples' feedback with regard to the service they received. The manager had taken steps to improve this and had introduced the quality assurance questionnaires that were sent to people and visitors to gain their feedback.

At the inspection on 3 January 2017, records showed that there had been a safeguarding alert raised with the local authority. In addition to this there were several DoLS authorisations in place and a death that had occurred. The provider had failed to inform us of these events. Providers are required to inform CQC of these incidents to enable us to have oversight to help ensure that appropriate actions are being taken and to ensure peoples' safety. At this inspection improvements had been made. Notifications had been submitted to inform us of significant events that had occurred at the home to enable us to have oversight of them to ensure that people were provided with safe care.