Ashley House Care Limited

Ashley House

Inspection report

Ashley House Care Limited
Upper Moulsham Street
Chelmsford
Essex
CM2 9AQ

Tel: 01245494674

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Ashley House provides accommodation and personal care for up to 22 older people. On the day of our inspection there were 11 people using the service. Ashley House has 6 shared bedrooms and 10 single rooms. There is a communal area, which includes a sitting area and a quiet room along with a garden.

The overall rating for this service is 'Inadequate' and the service is 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 provider's found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this time frame so that there is still a rating of inadequate overall, we will take action in line with our enforcement procedures 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. The 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 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 questions it will no longer be in special measures.

The registered manager was present during our inspection. 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.

During our comprehensive inspection, 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.

Risk assessments were not personalised and relevant to the individual.

Information was not available for staff to know how to manage the risks and improve safety to people who swallowing or eating and drinking difficulties. Plans in place for managing risk were not detailed, informative, or specific to the individual. Therefore, staff did not have adequate information to guide them when a person's risk of choking had increased.

Staff did not have training in the wider risks relating to Dementia, including dysphagia. Dysphagia describes any difficulties or pain in eating, chewing, drinking, or swallowing. The provider did not have a robust or effective system in place for monitoring and improving the quality of care people received related to this condition.

The premises and equipment was not visibly clean and infection control audits were not carried out and call bells were not always responded to in the most responsive and timely way.

The registered manager and staff did not involve people to make decisions about the service they received. Staff did not understand people's needs and preferences well.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service.

Staff did not take an active part in meeting people's social wellbeing and people were not encouraged to take part in the activities they wanted to pursue.

The registered provider did not work within the principles of the Mental Capacity Act and did not always follow the requirements of the Deprivation of Liberty Safeguards.

The registered manager did not have adequate systems in place to continually review the quality of the service being offered to people.

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

This service was not safe.

Information was not available for staff to know how to manage the risks and improve safety to people who had swallowing or eating and drinking difficulties.

Risk assessments were not personalised, information did not include guidance for staff and plan for managing risk were not detailed informative or specific to the individual.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not always effective in helping them to carry out their jobs.

The registered manager and staff did not understand the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Inadequate

The service was not caring.

People did not always receive care that was centred on them.

People were not always treated in a dignified way.

Staff communicated with relatives to keep them involved.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always reflect people's needs and people did not have their needs reassessed when they had returned from hospital.

People's needs for social interaction were not met and there were very little activities for people to get involved in if they

wanted to.

People did not seem to know who to speak to about particular issues or requests, and did not know how to make a complaint.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have an effective governance system in place to assess and mitigate risks to people.

The registered manager did not look at ways the service could be continuously improved to make sure the service was safe and people's views about what needed to improve was taken on board.

The registered manager did not understand their registration requirements around notifying the commission of any significant events to help us monitor how the provider keeps people safe.

Ashley House

Detailed findings

Background to this inspection

The inspection of Ashley House commenced on 30 of January 2017 and was unannounced which meant that the provider did not know that we were coming.

The inspection of Ashley House took place on 30 January 2017 and was unannounced which meant that the provider did not know that we were coming. The inspection was carried out by one inspector 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 and specialises in dementia care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make, a PIR was returned to us. We looked at previous inspection records and intelligence we had received about the service and notifications. Notifications are information about specific important events the service is legally required to send to us.

Whilst most people who used the service were able to talk to us, some could not. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During our inspection we observed how the staff interacted with people and spent time observing the support and care provided to help us understand their experiences of living in the service. We observed care and support in the communal areas, the midday meal, and we also looked around the service.

We inspected the care plans of five people and looked at information about how the service was managed. These included medicine records, staff training, recruitment and supervision records, accidents and incidents, complaints, clinical governance, audits and policies and procedures.
Reviewing these records helped us to understand how the provider responded and acted on issues related to the care and welfare of people.

As part of the inspection we also spoke with the registered manager, nine people who use the service, six relatives, four members of staff and a visiting District Nurse.

Inadequate

Is the service safe?

Our findings

During our inspection we found this area of the service was inadequate. There had been a recent incident where someone had choked and needed hospital treatment. When this person had returned from hospital the registered manager had not carried out a risk assessment and did not provide staff with adequate guidance to reduce the risk of this occurrence happening in the future.

Whilst it is not possible to prevent all episodes of choking, we found the registered manager had not taken all reasonable action to improve the safety of individuals who had swallowing or eating and drinking difficulties. Staff and the registered manager told us they had not received training relating to people's ability to eat safely and the way Dementia and other diseases can affect the swallowing function of some people.

Tools for assessing risk to people in relation to eating and drinking safely were not carried out and the registered manager and staff did not consider all of the associated signs and symptoms that could indicate a swallowing problem. For example, changes may include but are not limited to; a change in voice, coughing during and after eating or drinking, taking a long time to swallow, or evidence of discomfort when swallowing.

Staff were unable to recognise the potential signs of dysphagia. For example, one person was receiving care in bed, and was making a gurgling sound from their chest. When we asked staff how they should support this person to eat safely they were unclear. One staff member said they would "probably mash it up a bit with the fork." We asked the GP to see this person following our inspection.

Care plans did not identify people who were at risk of choking and did not identify specific symptoms experienced by the individual, therefore staff did not have sufficient information to guide them so they were unable to recognise when people were worsening and were unable to identify an increase in risk. We asked to inspect the provider's policy and procedure but the registered manager told us these were not available for us to inspect.

People's information had been reviewed on a monthly basis, but the information recorded did not reflect people's changing needs. For example, people's information had not always been updated when someone's needs had changed and we found examples, where someone had been hospitalised following an accident or incident and this information had not been updated to reflect the change in the person care needs. When bed rails were being used, risk assessments had not been carried out to make sure that using this type of equipment was safe for the person and appropriate to use.

When an accident or incident had occurred, the registered manager did not maintain an oversight or complete a root cause analysis to look at the ways in which they could be reduced. When accident or incident happened the care plan and risk assessment had not always updated.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Safe care and treatment.

We received mixed feedback from people when we asked if they felt safe at Ashley House. One person said, "I can't complain about being here. I think I'm in safe hands." Another person said, "I've been here for three weeks, and I've seen three people taken out on a stretcher." Another person asked us to find out what had happened to someone who had recently been admitted to hospital. They asked us, "Could you find out what happened to [Name] who went to hospital? I worry about these people."

On the day of our inspection we found the certain areas of the premises and some of the equipment was not visibly clean and free from odours. Several people told us they did not observe much cleaning taking place. One person said, "I think they hoover every day in here [the lounge] but that's about it." Two other people speaking together told us, "We don't see much cleaning going on, but we think it is okay." A relative told us, "The room just smells sometimes, it's not nice." During the day we did not observe any cleaning taking place.

The registered manager had not carried out infection control audits to make sure the environment people were living was kept clean and free from odours. For example, one of the shower curtains had bodily fluids on it, and other areas of the home were dirty, with stained carpets and strong odours. In total, three people and two relatives said they thought the home was dirty and unclean. One relative, who was moving their relative to another home said, "It stinks and it's dirty, and I can't leave them here any longer."

People told us some areas of the service were too cold. One person said, "The water is hot, that's not a problem, but the room is very cold, it's not nice in there." Another person explained, "I'm not always keen to have a shower because it's so cold in there." On the day of the inspection we found the heating system had not been not working correctly, however we spoke with the registered manager about this and after the inspection they confirmed the heating system had been fixed.

The bath did not have a temperature monitoring valve (TMV) fitted to it. This is important because it reduced the possibility of someone having a bath that was either too cold or too hot. The registered manager explained the bath had been out of order and did not work, this meant people could only have a shower. Showers were offered to people on a rota basis a couple of times a week, two people told us they were not always given hot showers.

Risk assessments of the premises are not carried out to make sure the health and safety to people had been maintained. Some areas of the floor were very uneven and may have been a trip hazard. Wardrobes in a number of rooms were unstable and could have fallen on to people. Window restrictors had not been fitted to all windows, and fire doors had been wedged open. The registered manager had not assessed the risk to people. The premise did not ensure easy access to relevant facilities. For example, people told us they were unable to easily open doors to access other areas of the home such as their bedrooms or bathrooms.

These failings are a breach of Regulation 15 (a) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

We received mixed feedback from people about the availability of staff. Some people told us staff responded to them quickly, whilst others did not. One person said, "Sometimes I have to wait for staff, they say, "We haven't got three pairs of hands, you know." Other people told us they were responded to quickly, but we noted these people were mainly sat in the lounge area. Some people told us when they pressed their call bell, staff did not always respond quickly enough.

The district nurse told us they thought the home may benefit from having more staff on shift and so did one member of staff. The registered manager did not have way of assessing if there were enough staff on shift according to people's needs; however they assured us that following the inspection they would introduce a way of doing this.

We observed a lack of staff in the main lounge for significant periods of time during the inspection. We saw no staff sitting alongside people, or engaging in meaningful conversation with them. On two occasions we had to find staff to assist people to make sure they were safe.

These failings are a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff knew how to report any suspicions of abuse and had received training. Typical comments from staff were; "I would go to my manager and report it straight away or go to CQC." Staff knew how to whistle blow and they told us they would contact the CQC if they had concerns people were not being cared for in a safe way. Two days following the inspection we received a member of staff whistleblowing about the way people were being cared for.

Senior staff administered medicines and recorded the balance remaining on the MAR once the medicine had been given. Suitable arrangements were in place for obtaining, storing, administering, and disposing of medicines. Staff administering medicines had received appropriate training but had not had their competency assessed.

The Medication Administration Record (MAR) provides a record of which medicines were prescribed to a person and when they were given. At the front of each person's MAR was a document that described how people liked to take their medicines. Where medicines were prescribed on an as required basis, clear written guidance had not been put in place for staff to follow.

We inspected the way people were recruited and found this to be safe. Checks had been carried out before staff started work with the Disclosure and Barring Service (DBS) along with two references. The eligibility of people to work in the United Kingdom had been checked as part of the recruitment process.

Inadequate

Is the service effective?

Our findings

Most people told us they were not confident in the staff's abilities to care for them. One person said, "They're mainly ok, but I don't think the newer ones know as much, they've not got the experience, have they." Another person told us, "They don't know much about me. They haven't got the time to sit and talk to us like you're doing."

All of the staff told us they had been trained in the mandatory topics, but we found this was an area that required improvement. For example, staff had received training in the mental capacity act and deprivation of liberty (MCA and DoLS) but they were unable to explain how this could be applied in a day to day setting when caring for people who may lack capacity. Staff did not understand how to meet the needs of people who may be at risk of aspiration and they had not completed training in dignity and respect. We spoke with the registered manager and they assured us they would arrange for staff to have training in these areas following the inspection. Staff had been trained in medicine and manual handling, but observations had not been carried out by senior members of staff to make sure staff could apply what they had learned in practice.

We asked staff about what kind of supervision they received and they told us they had meetings with their manager which had been beneficial. Staff told us when they started work they had received an induction. No staff had completed the care certificate and the registered manager told us they were planning to introduce this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence these workers have the same introductory skills, knowledge, and behaviours to provide care and support.

The provider did not give consideration to individual requirements at meals times. For example, people told us if they wanted a cooked breakfast they did not think this was available to them. We spoke with the registered manager about this who told us that people only have to ask and it would be cooked for them.

People told us they had very little choice or flexibility about when they ate their meals. One person said, "I don't know what would happen if I got up late. Would I still be able to have breakfast? I always thought I would miss it." Another person said, "Breakfast is at 8 am, I have cereal and toast."

The registered manager did not offer people good alternatives when people who had specific dietary requirements. For example, one person was a vegetarian and they had been served a salad with chicken pie. They told the staff that they could not eat this, so it was taken away. No replacement given and no alternative to chicken pie was offered. They said, "I'm vegetarian, and they gave me the chicken pie. When they realised they took it away, and I ate the vegetables which were very nice."

If people wanted finger foods or snacks this was not easily available without them having to ask staff first. One person said, "Once I asked for a packet of crisps and I was told I could not have one, so I didn't bother asking again." People did not have the option to access drinks freely without asking staff first, and drinks

rounds were done routinely between each meal. On the day of the inspection the cup of tea round was half an hour late and one person repeatedly mentioned this loudly over and over again. Staff did not appear to hear and did not acknowledge or respond to their request.

We observed staff supporting people in the dining rooms during the lunchtime meal. The dinner looked appetising with fresh vegetables on offer and people told us it was tasty. Condiments were available on each table, and we observed people being offered extra sauces if they wanted them.
We inspected how people were supported when they were identified as being at risk of poor nutrition, and found this was ineffective. For example, people were routinely assessed against the risk of poor nutrition but this information had not been used to update risk assessments or make referrals to relevant health professionals.

The information we inspected showed the involvement of health professionals were not proactively pursued. For instance, the registered manager told us they thought once they had mentioned their concerns to their GP it became their responsibility. We recommended the provider was more proactive and followed up with health professionals when people required medical support and referrals.

Some people had risk assessments in place if they were at risk of malnutrition; however this information was inaccurate as their weight had not been taken, so the risk score could not be monitored. Whilst it was noted these people were unable to get up out of bed, the provider did not use an alternative way of monitoring them by taking key measurements or monitoring their clinical presentation.

These failings are a breach of Regulation (14) (1) (4) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Meeting nutritional needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in MCA and DoLS but they were unable to explain how these restrictions may be applied to or the support that people may needed as a consequence.

We checked whether the provider had been working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found when people may be subject to MCA that DoLs, applications had not been made and there was a lack of information and guidance for staff about the way in which care should be delivered to people. We spoke with the registered manager and staff and they were unable to explain they understood the implications of the act or when to make an application. At the time of the inspection the provider did not have clear policies or procedures, or recording systems in place when people were not able to make decisions about their care or support. After we spoke with the registered manager about this, a few days after the inspection they supplied us with a template policy. A member of staff told us that when they required policies and procedures to refer to none were available.

We found the provider had not been following the necessary requirements. For example, DoLS applications had not always been made to the supervisory body with the relevant authority. Decisions taken had not always been appropriately documented, for instance when bed rails had been used records did not include

information or guidance for staff about how to act in the person's best interests. Signed consent had not been routinely obtained as part of the assessment process and was not recorded within peoples' documents. When we spoke with the registered manager they did not appear to understand why they should obtain consent if people had capacity to give it. Policies and procedures around obtaining consent were not in place.

These failings are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Need for consent.

Health professionals were not always quickly involved if people needed it. We noted that two separate safeguarding concerns had been raised in the last eight months following concerns that people may not be receiving prompt medical attention when they needed it. We asked people if staff involved health professionals quickly enough if they needed it, and mixed feedback had been given. For example, one person explained they had been waiting for a long time for an operation and wondered whether this had been forgotten about. Another person said, "I've had a [health condition] for some time. I don't know if the staff know that I've got it. If they do they don't talk to me about it." However another person was more positive and said, "I'd tell them if I didn't feel well, and they'd call the doctor."

We had concerns about a person who appeared to be getting very little attention and appeared to be very unwell. Staff had not noticed this person, and had not contacted a GP. We requested a GP was called out to this person and medical advice was then obtained.

These failings are a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

Inadequate

Is the service caring?

Our findings

When we asked people if staff were kind and caring towards them we received mixed feedback. One person said, "The staff are fine, they have a little joke with me every now and then. I could not explain to them how I feel though." Another person said, "The staff are kind, caring and friendly, but they come and go, so that can be a bit unsettling." And another person said, "They tell me off if I do something wrong. They tell us the right things to do, and the wrong things to do."

People told us staff did not always treat them with respect. One person said, "I feel a bit left out, and I'd like a bit more human contact. " They went on to explain, "Staff sometimes rush, and when I call them they pretend not to hear me. This makes me feel sad. I wish they had a little more time to be a bit more personal. They only want to know if something needs doing, not just to spend time with us." Another person told they did have any choice over when they went to bed; they said "They tell us when it's time for bed, but I don't mind."

We observed staff were very focused on the task in hand and did not see them spending time speaking with people. For example, we saw staff speaking to people in a polite way, and offering people choices in a patient and friendly manner, yet they did not take the opportunity to engage any further in conversation.

Some staff did not treat people with dignity. For example we observed a member of staff assisting someone, as they did this they turned to us and remarked in front of the person, "They get like this, they want their own way all the time." The person the member of staff was commenting about had been in distress and could fully understand what was being said about them.
Important relationships were not always promoted. For example, we found most people were very able, and keen to discuss and converse with one another, but they needed a little prompting to facilitate this, which had not been forthcoming from staff.

We were speaking with two people, when a member of staff suddenly interrupted, and passed them photographs, saying, "These are of Christmas, you look at them, and pass them on." One of the people we were speaking with said, "I don't know what this photograph is doing here. It's the photo they took of me when I came to live here." This had been the only time during the day that we saw a member of staff engage in any conversation with residents which had not been task orientated.

These failings are a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Dignity and respect.

We mixed feedback from relatives when we asked them if they had been involved in a review of their family members care. Some relatives told us staff kept them informed on a regular basis, which helped them to feel involved, however when we inspected information we found that if family members had been involved in reviewing their relative care, this had not been recorded. One family said, "I was very involved with [names] care plan, I cannot say I have had any meetings but they do keep in contact with me."

Information on advocacy was not readily available to people who used the service, however no one required this at the time of the inspection.

People were not asked if they had any preference between a male or female assisting them with personal care, but were quite surprised when we asked if they had a preference. People assured us they did not mind. One person said, "I don't mind if it's a man, a woman, or someone with three heads. If they treat me nicely, that's all that really matters, isn't it."

Inadequate

Is the service responsive?

Our findings

People were not supported to participate in activities that were important to them and they told us staff did not take the time to get to know them. One person said, "There are no outings organised that I know of. Nobody ever offers to take me to the shops, I'd love to go if they did."

We observed and people repeatedly told us staff did not understand their individual needs and preferences, and did not provide care in a responsive and personal way. For example, some people told us they wanted to do activities outside of the service, but this had not been available to them. One person said, "We occasionally play snakes and ladders, but I'd like more activities. I've got a pack of cards, but nobody plays with me."

People told us that staff did not consider their emotional wellbeing when providing care to them. One person explained that, "They don't know much about me and they haven't got the time to sit and talk to us like you're doing." Another person said, "[The staff] might stop to chat about the weather, but they haven't got time for a proper chat like we're doing now. It's a treat to have you sit with me." We asked another person, if staff ever came and sat with them to have a chat and they replied, "Only if they've got something to tell us."

Staff did not know people's personal details. For example, we observed staff calling someone using a shortened version of their name, but this person told us, "I much prefer to be called by my full name, as it's the name I've always been called, but nobody here does."

People were not supported to maintain relationships or be involved in activities as much or as little as they wish. For example, there was a lack of staff in the main lounge where eight people sat for the majority of the day. We observed the television had been on all day. Several people mentioned this to us. One person said, "The TV is always on, but I don't really watch it." Another person told us, "The television is on all day every day. We never get asked what we want to watch. I don't like any of it."

Two relatives said that there was not enough stimulation for people. For example, one relative said, "I never see anything going on, like exercises for example. As a result, [Name] has seized up." Another family member told us, "I have been in here most days and there is never anything going on, they are just sat lined up against the wall."

These failings are a breach of Regulation 9 (3) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

Assessments were completed for people who were considering moving into Ashley House, but a further assessment of people's needs had not been undertaken when they returned following a stay in hospital.

Information contained a social profile, and included details such as food preferences, and people who were significant to them. People's day to day support needs were recorded and contained details of people's

individual daily needs such as mobility, personal hygiene, nutrition and health needs. The care plans did not give staff specific information about how the person's care needs were to be met and did not always give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person may have needed.

We checked care records and found these were regularly reviewed but did not reflect people's changing needs. For example, one person had slipped out of the wheelchair whilst being moved but their care records had not been updated and risk assessments had not been reviewed. Another person had experienced a choking incident which resulted in a hospital admission; no consideration had been given about how staff could help to reduce the risk of this happening again. Another person had been at the end of their life and staff appeared to be unaware of this. We ensured the person had been seen by a GP as part of our inspection.

People did not seem to know who to speak to about particular issues or requests, and did not know how to make a complaint. Some of the people did not want to share their views when asked about complaints. One person said, "I'm not the right person to ask, because I expect too much." Someone visiting the home, expressed gratitude that CQC were visiting, and asking people for their opinions. They said, "People will enjoy being able to talk to you. I'm sure there's more that could be done here."

The registered manager did not have a policy in place to ensure complaints and concerns were recorded and thoroughly investigated. We asked to inspect any complaints that had been made, and were told that no complaints had been made. The registered manager provided a number of thank you cards they had received.

These failings are a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

Mixed feedback was received when we asked staff if the service was well run. One staff member who had worked at the service for a number of years spoke highly of the registered manager, and said, "I feel supported by the manager; I can raise any issues or concerns with them." Another member of staff described the leadership as okay, and another member of staff raised significant concerns about the way the service had been managed and the way people were treated.

Improvement was not integral to the running of the service and there was a lack of shared understanding between the management and the people who used the service about what needed to be improved. For example, we looked at information related to the running of the service and found that the provider did not continually review the quality of the service being offered and look at ways it could improve. Robust audits that looked at all the aspects of the quality of the service provided to people had not been undertaken and risk assessments of the premises had not been routinely completed. This meant that we could not be assured that people's health and safety to could be maintained. For example, on the day of the inspection, the heating system had not been working and the registered manager did not know it was broken. There were some windows that did not have window restrictors in place and infection control audits hadn't been carried out. Some areas of the floor were very uneven and may have been a trip hazard.

An annual questionnaire to obtain people's views had been carried out a number of months prior to the inspection, but the responses had not been analysed. The questionnaires did not include the views of staff and visitors. Some of the questionnaires had made suggestions about the way the service could be improved, but the registered manager had not made any changes. For example some people had recommended improvements to the environment and this had not been carried out.

We found there had been a lack of a proactive approach from all levels of management in relation to root cause analysis. The registered manager did not focus on continuous improvement, and did not review themes and trends. They did not look at ways they could make changes. For example, accidents and incidents were recorded but the registered did not maintain an oversight to look at ways these could be reduced.

These failings are a breach of Regulation 17 (2) (b) (i) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

The registered manager did not understand their registration requirements around notifying us of any significant events to help us monitor how the provider keeps people safe. For example, we found information relating to safeguarding incidents that the local authority had investigated but the provider had not notified us.

These failings are a breach of Regulation 18 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Notification of other incidents.

People told us they did not understand the management structure and thought the registered manager was male rather than female. One person said, "We don't see much of the manager. His name is Mr [Name] he is good though." Another person said, "I am not sure who the manager is." And another person said, "I don't know who does what."

Regular meetings were not held with people or staff, and handover meetings had not been taking place. One member of staff said, "We don't get asked our views, and we don't have team meetings." We spoke with the registered manager and recommended they introduce regular meetings which encouraged and empowered people to express their views and look at ways they could improve the service.

The registered manager did not ensure people's private information was only accessible to the necessary people, because people's confidential information had not been kept securely. For example, people's care records were kept in an unlocked cupboard in the quiet lounge.

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 9 HSCA RA Regulations 2014 Person-centred care Person centred care, person centred care 9 (1) (3)

The enforcement action we took:

Requirement notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Dignity and Respect 10 (1)

The enforcement action we took:

Requirement notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent (11)

The enforcement action we took:

Requirement Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment (12) (2) (a) (b)

The enforcement action we took:

Requirement Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Meeting nutritional needs (14) (1) (4) (a) (c) (d)

The enforcement action we took:

Requirement Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premise and Equipment 15 (a) (c) (d) (e) (f)

The enforcement action we took:

Requirement Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance 17

The enforcement action we took:

Notice of Decsion

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing 18 (1)

The enforcement action we took:

Requirement Notice