Aaroncare Limited

Aaron Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection of Aaron Lodge Care Home took place on 14 and 20 February 2017.

The home was last inspected in May 2016 and judged as 'inadequate' overall and placed into 'Special Measures.' We identified ten breaches of the regulations.

These were in relation to safe care and treatment [two breaches of this regulation], dignity and respect, staffing levels, staff training, consent, person centred care, governance, nutrition and hydration and safeguarding.

This unannounced inspection took place to check if the provider had made enough improvements to meet their legal requirements.

Aaron Lodge is a dementia care home registered to provide care for up to 48 people living with dementia across two floors. There was a passenger lift within the care home.

At the time of the inspection 21 people were living at the home and the care provider had announced closure of the care home. The Local Authority was working with the care provider to ensure all people living at Aaron Lodge Care Home were being transferred to another suitable care home. We undertook this unannounced inspection to check that the people who lived there were safe.

A manager was present at the time of inspection that was brought into the care home to manage the transition of care for people to another care home. There was no registered manager in post within the care home at the time of 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.

People were not always being kept safe from harm and the provider remained in breach of the regulation related to safe care and treatment. Medicine records seen were not always accurate and there had been two incidents reported of the person being subjected to harm.

The care provider remained in breach of the regulation related to safe care and treatment.

Care plans we viewed had been updated with person centred information and some contained a photograph. The information within the care plans provided staff with enough information they needed to know to be able to care for the person however it was difficult to find information within them.

The provider was no longer in breach of regulation related to person centred care.

At the last inspection we raised concerns regarding the staffing levels in the home. The provider was in breach of regulations relating to this. We found there were not enough staff to provide the care people needed at the time they needed their care. We checked if there was enough staff to meet the needs of the people living at the care home on this inspection. The methods used were the SOFI [Short Observational Framework for Inspection] and other observations. We found there were enough staff to meet the needs of the people living in the care home at the time of this inspection. People were observed to be responded to by staff when they needed assistance and staff were observed engaging with people more frequently than on our last inspection. Staff were attempting to undertake activities with people but due to time constraints the care being delivered was mostly still task led.

The care provider was no longer in breach of the regulation related to staffing levels.

Previously we raised concerns about the service not always following the principles of the Mental Capacity Act (MCA) 2005. We found that consent was not being sought in line with the Mental Capacity Act 2005 and decisions were being made on behalf of people without following a best interest's process. At this inspection we found the principles of the Mental Capacity Act 2005 had been adhered to. The care provider demonstrated they had followed the best interests' process in line with the principles of the MCA 2005 legislation.

The provider was no longer in breach of this regulation related to Consent.

During our last inspection we raised concerns around people's dignity and safety. On this inspection we observed staff upheld people's dignity at all times and were respectful of people's wishes.

The provider was no longer in breach of the regulation related to dignity and respect.

At our last inspection we found that people were not always protected from abuse and the provider was in breach of regulations relating to this. We found that the procedure for reporting and acting on safeguarding's had improved since our last inspection in May 2016.

The provider was no longer in breach of this regulation related to safeguarding.

During our last inspection, we identified that not all staff had received up to date training as required by the provider. At this inspection we saw that staff had not received emergency first aid training and one staff member out of the four files we checked had not received up to date manual handling training. We were informed by the care provider the emergency first aid training had been placed on hold due to the announcement of the closure of the care home. The care provider also told us their in-house manual handling trainer's training needed updating prior to them completing any additional training with staff.

The care provider remained in breach of the regulation related to staff training.

During our last inspection we identified that people were not receiving enough to eat and drink. We checked if improvements had been made on this inspection. We found that people were provided with jugs of liquids in their bedrooms and there were jugs of liquids in the lounges on both floors for people to have a drink if they wished. For people who were unable to monitor their own fluid intake staff were observed asking people during the day if they would like a drink. Fluid balance charts were no longer being completed retrospectively and the system of recording had also improved. People's weights and food intake were being

monitored in line with the recommendations being made by the medical staff and health care professionals.

The care provider was no longer in breach of the regulation related to nutrition and hydration.

During our last inspection we found systems were not robust such as the system for recording fluids/drinks, communication systems and systems of recording and reporting abuse. We checked these systems at this inspection and found the systems had improved. There was a new doctor's visit sheet in care plans, a new more detailed handover sheet and a more robust recording and reporting of safeguarding concerns and incidents.

We no longer found the provider in breach of the regulation related to governance. However, further work was still required and we made a recommendation with regards to this as they did not always action concerns appropriately or pick up on some of the concerns we found.

You can see what action we told the provider to take at the back of this inspection report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always being recorded effectively therefore, we were unsure if people were always receiving their prescribed medication when they needed it.

Accidents and incidents were being recorded with a trends analysis.

Safeguarding systems were in place of recording and reported safeguarding concerns. Staff understood their responsibilities to report any concerns if they suspected someone was being abused and staff had heard of whistleblowing.

There were enough staff to meet the care needs of the people receiving care.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a training matrix in place and staff were receiving some training but had not completed all mandatory training such as emergency first aid.

People were receiving enough to eat and drink during the day and records such as a fluid balance chart were being completed by staff when appropriate.

Staff were receiving an induction, supervisions and appraisals.

The interior design of the care home had improved to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was caring.

Staff were observed asking people what they would like to provide them with choices during their care delivery.

People's dignity was maintained at all times during our inspection.

Staff were mostly providing task led care.

Advocacy services were being sought for people when needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints process in place with responses seen however the same complaints were seen. We could not be sure the actions being taken were effective. We made a recommendation with regards to this.

There was no activities coordinator within the care home. Activities were limited for people to when staff were able to provide them.

Care needs were being assessed and reviewed when appropriate.

People were receiving care when they needed it.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post managing the care home at the time of our inspection.

Audits were seen which had identified some of the concerns highlighted as part of this inspection. However, they did not always pick up on the concerns we found or action them appropriately. We made a recommendation with regards to this.

Improvements had been made to improve the communication systems within the care home such as a General Practitioner visit record in each person's care plan.

Aaron Lodge 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.

This inspection took place on 14 and 20 February 2017and was unannounced. The inspection team consisted of two adult social care inspectors.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury of scolding. The information in relation to this incident is being reviewed by the Commission.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of scalding. This inspection examined those risks.

We reviewed the information we held about the service before the inspection including the Provider Information Return (PIR) which was received from the service on 11 December 2016. This document provides information about the service. The commissioners of the service were contacted prior to the inspection.

During the inspection we spoke with eight staff members including the acting manager, six relatives/visitors and one visiting nurse. We viewed six care plans and case tracked two people who lived there which meant we looked at a range of their care records.

In view of the people living at Aaron Lodge Care Home having communication and cognitive difficulties we used observation as our main method of assessment with people who lived there. We undertook two SOFI [Short Observational Framework for Inspection] assessments where we observed the interactions between staff and people who lived there. SOFI is a way of observing care to help us understand the experience of people who had difficulty conversing with us.

Requires Improvement

Is the service safe?

Our findings

The care home was last inspected on 31 May, 1, 2 and 10 June 2016. The service was not safe and was in breach of three of the Health and Social Care Act Regulations 2014 for this domain in respect of safe care and treatment, safeguarding. This was due to not reporting all incidents and not all staff being up to date with safeguarding training. They were also in breach due to not having sufficient staffing levels to meet the care needs of people living with dementia.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found some improvements had been made to meet necessary requirements. However, the provider was found to be in breach of medicines on this inspection.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were mostly managed safely but we found some anomalies evidencing a lack of consistency for recording of medicines.

Each MAR (medicine administration record) contained a photograph for identification purposes and any known allergy. We looked at the way external medicines [creams] were administered. The medication administration records [MAR's] were two days into a new cycle of medicines. We saw creams prescribed for two people but there was no record on the MAR's to say these had been administered. The staff were not sure whether these medicines had been supplied as they could not be found on the medicines trolley. Staff informed us that creams are sometimes administered by care staff when attending to personal care in the morning [for example]. There were not records available to say which staff administered these. We were told cream chart were not being used. There was, therefore, no clear record for staff regarding the cream and its use [where to apply and when] or any examples of staff applying creams recording this. We were not therefore able to ascertain whether these medicines were in use for people.

We checked the storage of medicines in the fridge in the clinic room. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. Staff could not produce any records to evidence the temperature of the drug fridge was being recorded/monitored. We also found the drugs fridge to be unlocked although a recent audit by the provider had recommended this was to be locked to ensure the security of medicines. We found an antibiotic suspension was being stored in the fridge, this medicine was not on the persons MAR charts; staff were not aware whether this medicine was being administered.

Following our feedback to the manager of the home we were advised the course of the antibiotic suspension in question had been completed but staff should have discarded this the night before. This was why it was not on the MAR. We were also advised the creams were on the MAR sheets as they were 'historic creams' and they had not been removed from the MAR by the pharmacist.

In the above examples the records were not fully completed or up to date and staff were not aware of the

current status of the medicines in question. These records were confusing.

Following the inspection a senior manager for the provider reported that the supplying pharmacist was working closely with the home to strengthen ordering systems with the GP team and the home so these anomalies would be highlighted. The senior manager also noted that the senior carers needed to have stronger documentation and records and competencies of individual staff would be further assessed and support provided if needed.

People at the home had their medicines administered by the staff. Not all people had a plan of care which set out their care and support needs for their medicines but we were told this was 'risk assessed' and if a plan of care was needed, for specific medical conditions for example, or for the use of certain medicines then a plan would be agreed. Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews.

We checked a selection of MARs and found staff had signed to say they had administered the medicines. We observed staff administering medicines and they took their time to assess individuals for any pain relief [for example] and made a record following each administration of medication.

A protocol was in place for staff to follow when administering medicines to be given 'when required' (PRN). These were clear and gave staff the required information regarding their use. These 'PRN care plans' were not kept with the MAR's however and had to be located in peoples care files. We discussed how they would be easier to access and more relevant if kept with the medication records.

There were no controlled drugs in use. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We found understood the protocols if needed and there was appropriate storage available.

There were no people having medicines given 'covertly' [without their knowledge in their best interest]. We reviewed staff knowledge and found the senior carer was aware of best practice and understood the provider's protocol and policy around this.

Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews. We saw that medicines administration was audited by senior staff and managers. A monthly audit was seen dated 9 December 2016 which was generally quite compressive and had identified some issues to be actioned. Some issues identified such as 'fridge not locked' were still in evidence on our inspection. External medications such as creams were not included in the audit tool and the issue we found with recording had not been identified.

These findings were a breach of Regulation 12(1) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One SOFI was completed for a period of 40 minutes on the first floor of the care home. Five people were observed. There were a total of seven interactions observed. All were with staff. Four were categorised as good and three as neutral. There were no poor interactions. Positive examples included; asking if a person wanted a drink and supporting them with this and a change in a person's mood as a staff interacted with them. All of the people we observed had some staff interaction over the 40 minutes even if this was only with support whist drinking. Mood was recorded as positive for three of the 15 time frames and neutral for 12 of the 15 time frames. The second SOFI was completed on the ground floor of the care home were there were five people being observed in the ground floor lounge for a period of 30 minutes. There were a total of five

interactions observed by staff who were entering and leaving the lounge. Three were categorised as good and two as neutral. The interactions included staff asking a person what they would like for their lunch, a staff member supporting another person to place their slipper securely on their foot and another staff member providing another person with a cushion so they were comfortable. There were no time frames recording a negative impact for people.

We checked the rotas and spoke with the acting manager about the staffing situation within the care home. There were enough staff on duty to meet the care needs of the people for most of the time during this inspection. We established this through our observations using the SOFI, from other observations during the two day inspection and also from talking with relatives and staff. We observed in the ground floor dining room there were three out of five people who needed one to one from staff to ensure they were eating their food placed in front of them. There were three staff members on shift on the ground floor which meant there were then no staff available to support people who were not eating.

We viewed the incidents and accidents file and the handover sheets to check if all incidents and accidents were being recorded appropriately. Incident and accident forms had been completed and they were being reported to the local authority which was an improvement since the previous inspection. However, actions were not always seen following the incident for us to be sure the service was always learning from them. For example, one accident form we read stated that the person who had an unwitnessed fall had picked up the sensor mat and placed it onto their lap whilst sitting in their chair. We asked the managers what had been done following this as there were no actions seen such as requesting a reassessment of sensor equipment for the person.

Of the six care plans we checked we found they all had been reviewed with risks being identified and plans in place for staff to know how to reduce the risks for people they were caring for. For example, there were risk assessments seen including; dependency levels, falls, MUST tools (Malnutrition Universal Screening Tool), continence, moving and handling, pressure relief, use of bed rails and PEEPs (Personal Emergency Evacuation Plan) in place for people.

We were informed by the care provider about a serious injury to one person who was living with dementia who was provided with soup by a member of staff. The person attempted to drink the soup and spilt it over their legs. The soup was found to have been hot enough to scald the person who needed dressings for their burns. We asked staff how they tested the temperature of the soup before it was served and we were informed that it was tested by a thermometer probe prior to it leaving the kitchen. However, we were told by a staff member that the heated food trolley used to transport food had a thermostat and could be easily knocked which could raise the temperature of the food higher than recommended. There had also been another incident of scalding seen in the incident book. The Commission are continuing to monitor this and are working with partner agencies in respect of this incident.

Even though some improvements had been made the service remained in breach of this regulation.

This is a further breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked into the recruitment practices within the service and viewed four staff recruitment files. All the staff files contained a DBS (Disclosure and Barring Service) check before the staff member began working with people within the care home. There was also a UK Visa and Immigration Employer checking service seen in the records which meant the appropriate checks had been undertaken to ensure staff were lawfully working within the UK. Two out of the four staff files had adequate references. One staff member's file

contained a reference from the service's previous manager who was no longer working in Aaron Lodge Care Home which we did not regard as a valid reference and another reference from a previous employer who was not from the care sector. However, we read in the staff member's application form they had worked for another care provider but the service had not pursued obtaining a reference from them. Another staff file we viewed contained one reference as detailed on their application form which was a character reference and another reference from an employee not specified as a referee on their application form. We questioned this with the managers who confirmed the robustness of their recruitment practices would be improved in the future to include pursing a reference from a previous employer who was a care provider and in ensuring there is a clear audit trail of which referenced were being requested and why they did not match the referees on the application form.

This is a breach of regulation 19 Fit and Proper Persons of the Health and Social Care Act Regulations 2014.

Staff were aware of safeguarding and understood their responsibilities regarding reporting concerns. There were contemporaneous records where safeguarding concerns had been recorded and reported appropriately to the Safeguarding Authority. The service had developed an Unexplained Bruising Policy. This was important for staff to be aware how to deal with a circumstance whereby they observe a person living at the care home had unexplained bruising.
We received concerns prior to our inspection regarding the conduct of some staff members. The care provider had taken the appropriate measures and followed disciplinary procedures.

We were informed by the care provider about a serious injury to one person who was living with dementia who was provided with soup by a member of staff. The person attempted to drink the soup and spilt it over their legs. The soup was found to have been hot enough to scald the person who needed dressings for their burns. We asked staff how they tested the temperature of the soup before it was served and we were informed that it was tested by a thermometer probe prior to it leaving the kitchen. However, we were told by a staff member that the heated food trolley used to transport food had a thermostat and could be easily knocked which could raise the temperature of the food higher than recommended. There had also been another incident of scalding seen in the incident book. The Commission are continuing to monitor this and are working with partner agencies in respect of this incident.

For a person who was on thickened fluids (as they had poor swallowing), we found staff were knowledgeable regarding the consistency required. We found the person had a fluid chart recording their intake and this was being adequately monitored. However, the chart did not always record the stage of thickener being used in each recorded drink and we discussed the need to ensure consistent recording. A record of the number of scoops of thickening agent and the volume of liquid recorded on the person's intake and output chart would allow monitoring of the consistency in accordance with the person's swallowing assessment.

As part of our inspection we checked that electrical, gas and legionella checks had been undertaken and we saw valid certificates in the maintenance files we viewed. We also checked that regular fire safety checks were being undertaken and checks on the building to ensure it was safe. Weekly door guard checks were seen, fire alarm tests weekly, bedrail audits monthly. Fire drills, fire extinguishers, emergency lighting, extractor fans, fire doors and window restrictor checks were all seen as being undertaken and checked by the service.

A maintenance plan we viewed dated 6 October 2016 stated "small loft above main stair case next to lift shaft does not have any smoke detection" – recommendations were for a smoke alarm to be fitted. We asked to view any audits undertaken regarding the premises and found one audit dated 29 December 2016

recommended that a smoke alarm should be installed above the lift shaft in the building however, the smoke alarm had not been ordered by the care provider. We recommended the care provider took action to ensure all fire safety recommendations were being implemented. We were informed the smoke alarm was ordered on the day of inspection and would be installed.

The service was reasonably clean and free from strong odours. One concern was reported to the manager which was a fridge in the dining room on the first floor which was dirty and not on the cleaning rota, otherwise cleaning staff were very visible. We were informed by the managers that the fridge would be added to the cleaning rota.

Requires Improvement

Is the service effective?

Our findings

During our last inspection on 31 May, 1, 2 and 10 June 2016 the service we rated this domain as inadequate. We identified three breaches of the Health and Social Care Act Regulations 2014 related to consent, nutrition and hydration and staffing due to inadequate training for staff.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found some improvements had been made to meet necessary requirements. Two breaches of regulation had been met but one breach remained related to staff training.

There was a training matrix which confirmed the percentage of staff that were up to date with their training. It confirmed for example that 89.8 percent of staff had received safeguarding adults training. Staff who had been administering medicines in the home had completed practical competencies in administration of medications and were being assessed regularly. We saw details of the training completed. We did not see training had been recently provided in emergency first aid. We discussed this with the managers and the response we were given was that this training had been placed on hold due to the care provider announcing closure of the care home. We requested staff receive this training and they assured us they had reinstated training dates for staff to be provided with basic emergency first aid training. We queried the manual handling training for staff as we could not see a training certificate for one staff member out of the four files we checked. We were informed that the manual handling training was being completed in-house and the staff member who was the designated trainer needed to be updated in manual handling prior to them completing any additional training with staff.

Even though some improvements had been made the care provider remained in breach of this regulation.

This was a breach of Regulation 18 Staffing due to all staff not being provided with training required by the provider such as emergency first aid.
We viewed the supervision tracker and saw examples of supervision records being undertaken with staff in a one to one and group supervision.

We checked if the service were working within the Mental Capacity Act 2005 framework. 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 supported 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Our findings were that the registered manager had applied for a Deprivation

of Liberty Authorisation for all the people at the care home.

On our last inspection we found people's bedroom doors were being locked when they were not occupied without lawful consent which affected people gaining access to their rooms when they wished. We did not find this practice on this inspection and observed people were accessing their bedrooms which promoted a calmer more open environment for people. The impact of this was positive as we observed people who we had met on our last inspection who had been previously agitated walking up and down the corridors of the care home were now more settled in their rooms. We found records were DOLS authorisations had been reapplied for when appropriate and consent being sought by way of a best interests process.

We checked the systems in place for people to access drinks and fluids when they needed a drink during the day. There were jugs of fluids seen in the lounges and drinks seen in people's bedrooms. Hot and cold drinks trolleys were served during the morning and afternoon. We observed the lunch time experience for people in the ground floor dining room and found the tables had been dressed with a clean table cloth, place mats, napkins and glasses for people to drink from. Staff were heard offering people a choice of drinks including tea/coffee and types of juices. We also found people's nutrition and fluid intake was being recorded accurately on their fluid balance charts and food charts. People were being weighed appropriately in accordance with the recommendations of the Dietician.

We viewed an induction in all the four staff files we looked at and a training matrix for us to check how many staff had received training. One staff member we spoke with told us that they had mostly learnt things "on the job" and had two shadow shifts when they started but did not consider this was enough of an induction. The staff member said they had brought this to the attention of the acting manager who was being supportive.

We spoke with a visiting nurse form another care home who was assessing a person for possible admission. They said they found staff very helpful and knowledgeable regarding the person they had come to assess. They said the person was being nursed in bed and was being, "well cared for." The charts and care records the visiting nurse saw were up to date and contained sufficient information although difficult to navigate to find information.

The interior of the care home had been improved since our last inspection with murals, pictures, objects and memorabilia throughout the care home for people to see and touch. For example, there was a mannequin in one corridor decorated with a silk and lace dress from a previous era for people to feel and touch. There was dementia friendly signage in place to aid orientation. Clearly numbered doors had a picture frame with a photograph of the person. A dementia specialist had assessed the care home and made recommendations which the care provider was following.

One relative we spoke with told us "the one positive change within the care home since the last inspection was the interior decoration of the care home."

Requires Improvement

Is the service caring?

Our findings

During our last inspection in May 2016 we rated this domain as requires improvements and they were in breach of one regulation related to respect and dignity of the Health and Social Care Act Regulations 2014.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found improvements had been made to meet necessary requirements. At this inspection we found the service was no longer in breach of this regulation and had met their legal requirements.

We asked relatives/visitors if they considered staff were caring. One relative told us, "Being looked after well here. Staff have helped with the move and liaised well with social worker. They [staff] have been good with [person]." Another relative told us "[person] started to eat more, it couldn't be any better [meaning the care], staff are very nice, they offer drinks."

Throughout the two day inspection we observed people were generally calm and were being responded to when they needed assistance. People's bedrooms were also clean and appeared tidy as though time was being spent creating a pleasant environment for people. One person who was distressed shouting out consistently during our last inspection was observed sitting in their chair in their bedroom holding onto a soft teddy which they had been provided with since the last inspection.

We witnessed positive interactions generally from staff. Staff showed a good knowledge and understanding of the people they cared for. Although there were periods where care was task-led the majority of staff took time in the delivery of care and interacted well with residents.

One staff member was observed interacting in a sensitive and respectful way when offering one person a choice of foods for their lunch by speaking slowly and clearly, providing time for the person to think about the choice they wished to make before responding.

People were being encouraged by staff to be as independent as possible in making their own decisions such as what they wished to eat and drink. Staff were seen respecting people's dignity and were speaking with people in a respectful manner at all times during the inspection.

We were informed by the manager that one person whose first language was not English was referred for an advocate and the service were aware of the need to source advocacy services for people.

The rating in this domain remains as requires improvement. To improve the rating from requires improvement to Good would require a more consistent track record of good practice.

Requires Improvement

Is the service responsive?

Our findings

On our last inspection we rated this domain as inadequate and the service was in breach of two of the regulations of the Health and Social Care Act Regulations 2014 related to person centred care and safe care and treatment.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet the breaches. On this inspection we checked to make sure requirements had been met and we found they had met their legal requirement and were no longer in breach of the regulations.

One of the care records that I accessed showed that the person had limited capacity to be meaningfully involved in the assessment process or planning of care. However, there was evidence that family members had been involved in the assessment process. There was also evidence that family members had been invited to reviews of care.

We found people's care needs were being assessed and reviewed when there were changes to the plan of care. People were seen receiving care when they needed it. The care plans we viewed contained some person centred information including about the person's background and some care plans contained a picture of the person. Risks were being reviewed with clear guidelines for staff to know when to trigger a reassessment of the person's health. For example, we viewed one care plan which contained a MUST (Malnutrition Universal Screening Tool) detailing for staff that in the event the person's weight dropped to 48.8kg the person needed to be re referred back to the Dietician. We viewed a falls risk assessment which had been reviewed following a fall on 12 February 2017.

We viewed another person's care plan which contained the appropriate information for staff to know what to do and how to support the person. For example, we read that the person was at times behaving aggressively towards staff. We found it difficult to find the information as we would usually find this information in a behaviour care plan however, we found the information within the mental health section of the care plan with details of how the staff were advised to deal with this behaviour.

There was no activities coordinator in the care home providing activities at the time of our inspection. Although we observed two staff members attempting to provide some stimulation for people the time for staff to do this was limited. One relative we spoke with told us, "There's no activities going on for people." We were informed by the care provider that the focus was for staff to engage people with activities. We were also informed an activities coordinator was to be recruited. Another relative we spoke with said there were no activities for people who lived there and staff were "coming and going".

Two staff members were observed attempting to engage people in activities such as colouring and throwing/passing a ball from one person to the next which demonstrated they had an understanding of the need for people to have stimulation and were attempting to do this. The time available to staff to do this was very limited and therefore care seen being provided by staff was mostly task led.

We viewed the complaints file and found there had been 15 complaints since our last inspection. All of the complaints had been looked into by the manager and a response was provided to the complainant. We provided feedback that actions were not always effective to prevent the same concern reoccurring. For example, we saw that the same complaint was raised three times. The care provider had taken action and stated they had spoken to staff and updated the care plan but the relative complained on three separate occasions before the problem was rectified.

Staff meetings and relative/residents meetings were taking place which demonstrated the care provider was seeking the views of people. We viewed the minutes of the December 2016 which stated the service were looking to recruit an activities coordinator, family members were requesting more activities for people, some concerns about the soup were expressed and concerns from family members regarding some of the clothes they were bringing in for the person receiving care were being used for someone else who had no clothes of their own. The care provider told us they had plans to recruit a housekeeper to improve the laundry system and plans to recruit an activities coordinator.

We recommend the care provider ensures they are taking action to ensure lessons are being learnt from complaints and the appropriate steps are taken to ensure the same issues do not reoccur.

Requires Improvement

Is the service well-led?

Our findings

On our last inspection we found the service was rated inadequate for the well-led domain and was in breach of one regulation of the Health and Social Care Act Regulations 2014 related to governance.

At this inspection we did not find them in breach of this regulation and found the care provider now met legal requirements in this regard. However, work was still required to ensure improvements continued to be made.

There was an acting manager at the service during our inspection that had been brought into the care home to manage the transition of care for people to another care home. The manager had a good level of knowledge of the care home. The Area Manager who was also present for the inspection told us they were in the care home approximately one day each week to support the acting manager.

A relative told us there had been a "massive improvement". Another relative we spoke with told us they had no concerns about the care home.

We viewed the internal audit and action plan which had been last reviewed on 13 February 2017. It stated there were plans to provide training for two staff to become Dementia Champions and for an activities coordinator and a housekeeper to be recruited. It also stated "First Aid Training required. Courses to be booked as dates have been published". Therefore, the care provider was identifying areas which needed to be improved further. However, we were informed by the care provider the first aid courses were placed on hold in view of the announcement of the home closure. We advised the care provider to continue with the plans to ensure all staff had received mandatory first aid training which they assured us they would action. The care provider confirmed they had undertaken a recruitment audit but they had not identified the issues we found. The provider confirmed they would review their recruitment system to include requesting a reference from a previous employer in care if specified within the application form, thereby ensuring it was robust.

We viewed the external audit file and the medication audit which had been completed. There had been a falls analysis undertaken and an analysis of the safeguarding referrals undertaken by the area manager. Reflective practice using care plans was being undertaken which was a new system implemented by the area manager since our last inspection. This involved staff reading the updated care plan and signing to confirm they have read it and identifying any improvements that could be made to the plans or the provision of care.

During our last inspection we identified concerns in the communication systems within the care home. We found the information on the handover sheets was not always being acted upon appropriately such as all safeguarding concerns. Therefore, we checked the systems of communication on this inspection and requested a sample of handover sheets. Some of the handover sheets were missing which was due to the handover filing system not being robust. Some handover sheets were found by the end of our inspection but not all of them that we requested were found. We spoke with the managers who agreed this system needed

to be more robust. We did find that a new General Practitioner call out sheet had been introduced since our last inspection and these were seen placed in each person's care plan so medical recommendations and important information was being recorded clearly for staff to read and follow. This had improved the communication systems and the way information was being passed on and recorded since our last inspection.

We received several statutory notifications from the care provider since our previous inspection and found the quality of the information documented in the notifications to us was not always clear or detailed enough. We highlighted this to the care provider who recognised this and the need for clear, detailed information to be provided to us.

We recommend that the provider continues to review their approach to quality assurance and takes action accordingly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being managed safely. Records were not always up to date to be sure which medication was to be administered by staff. The care provider had not demonstrated they had done all they could to prevent further incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment practices in place were not robust as the appropriate references had not always been obtained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always undertaken the necessary training. Emergency first aid training had not been completed with all staff. The manual handling in-house trainer had not completed their refresher training and was unable to provide training at the time of our inspection.