Aston Grange Care Limited

Aston Grange Care Home

Inspection report

484-512 Forest Road
Walthamstow
London
E17 4PZ

Tel: 02085091509
Website: www.astongrangecarehome.co.uk

Date of inspection visit:
16 March 2016
18 March 2016

Date of publication:
25 January 2017

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 on 16 and 18 March 2016 and was unannounced. The service was last inspected in August 2015. At the last inspection the provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found. CQC will publish an update to this report when the regulatory response is confirmed.

Aston Grange Care Home provides accommodation for people who require nursing or personal care to a maximum of 45 people. At the time of our inspection 35 people were living at the service. The home is purpose built and arranged across three floors.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was unclean and there were significant risks that people were not protected against the risk of the spread of infection. Measures in place to prevent people accessing areas of the home that presented health and safety risks were not implemented. Risk assessments were not robust and did not contain sufficient measures to mitigate against the risk of harm.

There were insufficient staff to ensure that people's needs were met. This meant that the care provided was task focussed and was not personalised. People were not always supported in a way that respected and promoted their dignity. The training provided to staff was not sufficient to ensure they had the skills required to perform their roles.

The provider had not implemented sufficient measures to ensure that people's nutritional, hydration and healthcare needs were consistently met. People told us they did not like the food and observations showed that people were not finishing their meals. There were insufficient staff to facilitate a positive dining experience. Records of care and updates on people's health were captured through shared systems meaning that people's care plans did not always reflect their current needs.

Care plans did not contain details of people's preferences and lacked detail. People told us there were no activities that appealed to them. The only activities were group activities and there were no activities designed to be suitable for people living with dementia.

The leadership and governance of the service was ineffective. Audits were not robust and failed to identify multiple issues of safety and quality.

The management of medicines had improved since our last inspection.

The service's external recruitment processes were robust and ensured that new staff were recruited safely. It was unclear if internal recruitment ensured that people had the skills and knowledge required to perform their roles.

The provider had followed the principles of the Mental Capacity Act 2005 in relation to seeking authorisations to deprive people of their liberty. However, practice in terms of best interests decision making for specific decisions was poor.

People and relatives told us the staff were kind.

Staff were knowledgeable about safeguarding adults and whistleblowing and records showed the service had improved practice in this area.

The service had a robust complaints procedure and records showed this had been followed. People and relatives told us they knew how to make complaints, and where they had done so, the response had been satisfactory.

Staff told us they felt supported by the registered manager. Staff received regular supervisions and appraisals.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service remains 'Inadequate' and the service therefore remains 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not robust and did not contain measures to mitigate the risk of harm.

The home was dirty and infection control practice was poor.

There were not enough staff to meet people's needs.

There had been improvements in the recording of medicines administration.

The provider's recruitment practices ensured that newly recruited staff were suitable to work in the home.

Is the service effective?

Inadequate

The service was not effective.

The systems for ensuring people were supported to eat and drink enough to maintain a balanced diet were not effective.

The systems for ensuring that health information required to support people to maintain their health were not effective.

The training for new staff was not sufficient to ensure they had the skills required to perform their roles.

The provider had not always followed best practice in the application of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported in a way that respected and promoted their dignity.

Care plans did not contain information about people's preferences.

People said the staff were kind.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not personalised and care was not provided in a personalised way.

The activities provided were limited to group activities. There were no activities for people who did not want to join in groups.

There was a complaints policy and complaints were responded to in line with it. There was no thematic analysis of complaints made.

Is the service well-led?

Inadequate

The service was not well led.

Audits were completed but they were not robust or effective. They failed to identify multiple issues of safety and quality.

The management team had failed to improve the quality of the service since our last inspection.

The culture of the home was task focussed.

Aston Grange 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 16 and 18 March 2016 and was unannounced. The inspection was planned to follow up on the inspection completed in August 2015 when the service was rated as inadequate and placed in special measures.

Before the inspection we reviewed the information we already held about the service including statutory notifications. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the action plan they had submitted in response to our last inspection. We also sought feedback from the local authority commissioning and safeguarding teams and the local healthwatch.

The inspection was completed by three inspectors, a specialist advisor with expertise in dementia care and an expert by experience with experience of caring for someone living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people who lived in the home and four relatives. We spoke with 12 staff including the operations manager, the registered manager, the administrator, the chef, three senior carers, two carers, two domestic staff and the activities coordinator. We viewed nine care files including support plans, risk assessments, reviews, health and medications records. We looked at seven staff files including recruitment records, training, supervisions and appraisals. We also viewed the staff duty rotas, a range of audits and feedback, various meeting minutes, maintenance records, incident and accident logs, safeguarding records and policies and procedures for the home and other documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments were not robust and did not contain measures to reduce risk, infection control practice was poor, the premises were unsafe, and medicines were not managed in a safe way.

On at least five occasions during the course of the inspection members of the team found that sluice rooms had been left unlocked. Sluice rooms are clinical waste areas which contain both clinical waste and equipment for managing waste. This was unsafe as people using the service were walking around and were at risk of harm had they gone into the sluice rooms. One of the sluice rooms had a broken door handle, this meant that if someone had gone into the room and the door shut behind them they would have been trapped. The sluice rooms on each floor were cramped with equipment. There was no clear path to the sinks in any of the rooms and there was ingrained dirt in the floors. At our last inspection we found that the tiles around the sink area in one of the sluice rooms were damaged. There were damaged tiles in one of the sluice rooms at this inspection. This meant there was a high risk of cross contamination and spread of infection.

Both the shared and en-suite bathrooms and toilets in the home were in poor condition and unclean. There was ingrained dirt in the floors, mobility aids and toilets. On the first day of our inspection one toilet did not have a seat and another was missing a cistern lid. This had been addressed by the second day of our inspection after we brought it to the attention of the management team. A handyman had completed repairs. However, a framed seat used to support people in one toilet was badly corroded and unstable. The bathrooms, toilets and en-suite facilities had been fitted with rubber skirting around the edges of the room as an infection control measure. However, this was in a poor state of repair and was coming away from the walls. People were at risk from cross contamination from the framed seat and bathrooms because the provider could not be sure they were clean.

We observed poor hand hygiene practice by staff. For example, a member of domestic staff did not change their gloves between cleaning the bathroom door and operating the lift. A member of care staff changed their gloves but did not wash their hands after supporting one person with personal care and before supporting a different person to eat. There were no hand washing facilities in the laundry room or in the top floor kitchenette. This meant that staff were unable to easily wash their hands to reduce the risk of infection.

Each floor had a dedicated cupboard for the storage of cleaning materials and equipment. On the first day of our inspection the cupboards were found to be cramped and disorganised. The colour-coded mops that were used to clean different areas of the home were mixed together on the floor. This meant that the mops used to clean waste were touching the mops used to clean non-clinical areas increasing the risk of cross contamination. This was brought to the attention of the management team. On the second day of our inspection the cupboards had been re-arranged so that each floor stored only a designated type of cleaning equipment. For example, the ground floor was used to store the equipment needed for waste areas. However, the storage cupboards remained dirty with ingrained dirt in the flooring and the mop heads

remained on the floor with buckets piled in the sinks. This meant the infection control risks had not been appropriately addressed. Records showed that none of the four domestic staff had received training in infection control since our last inspection and three had never received it.

At our last inspection we identified that people's risk assessments were not robust or personalised. At this inspection this remained the case. In all nine care files viewed the medicines risk assessment was identical. The risk assessments described the medication administration process rather than addressing the individual risks people faced regarding their medicines. This was raised as being insufficient in our last inspection report but no action had been taken to ensure the individual risks of people's specific medicines was contained in people's files.

Moving and handling risk assessments were not robust and did not provide specific instructions for staff to follow. Three of the moving and handling risk assessments contained identical control measures. These were that staff should follow policies and procedures and receive training on moving and handling. Where people used specialist equipment there were no directions for staff to follow. For example, one person's moving and handling risk assessment stated that staff should "Use a body sling hoist with correct sling size." There was no information about what the correct sling size was. Another person used a board to help them to transfer from their wheelchair to other surfaces. The risk assessment stated, "Staff need to use wooden curved transfer board and slide sheet." There was no further guidance for staff on how to support this person to transfer.

Where people had additional risks identified the measures in place were insufficient to reduce the risk of harm. For example, one person was smoking in their bedroom. The home had contacted the fire service about this and liaised with the local authority. They had been advised to put in place a robust risk assessment. The risk assessment in place stated, "Staff to remind [person] to stop smoking in the room for health and safety." And "Staff to remind [person] to go out and smoke in the garden and when [person] becomes aggressive to leave him and not go near him for safety reasons." This person's room was viewed with their consent. There was no additional fire prevention equipment in the room or any kind of ashtray. The person was using a cereal bowl which was half full with cigarette ends. This was positioned on a small table alongside a pile of flammable newspapers. It had been noted in the senior's log book that this person had burned a hole in their jumper while smoking in bed but there were no measures in place to reduce the risk of this activity. In addition, a visual inspection of this person's bedroom door revealed it did not close properly and the handle was broken. This meant the risk of fire was not managed. This person left the service three days after our inspection visit.

The above issues are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection the home had failed to ensure that people had the medicines they required and recording of administration was poor. Records showed that the home had taken action to address these issues. The home now had appropriate ordering systems in place. Record keeping around medicines administration had much improved and the number of errors had significantly reduced. Records viewed were complete and audits showed where errors had been identified in the previous month appropriate action had been taken. The home was completing regular audits of medicines administration to ensure this progress was maintained. Although practice had much improved five prescribed creams were found in shared areas of the home on the first day of our inspection. This was addressed immediately. The practice observed on the ground and first floors was good. However, on the second floor, observations showed the medication trolley being left unlocked and unattended while staff went to administer medicines. This is poor practice and meant there was a risk of people accessing medicines that could be harmful to them.

At our last inspection we found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there were not enough staff to meet people's needs. At this inspection the home had increased staffing levels but they remained insufficient to meet people's needs. The issue identified above regarding the medicines trolley was due to there being insufficient staff to support people with meals and administer medicines at the same time.

People, their relatives and staff said that staffing levels had improved but were still not sufficient. One person said, "I don't think there are enough staff." Another person said, "Sometimes there are not enough staff, mainly weekends and at times during the day. They come as soon as they can." A third person said, "Sometimes they take a while to respond." A relative said, "Often there are no staff on the landings – just in one room together." A staff member said, "I don't think it's improved. You look at the needs of the people and the needs have changed. The care plans need two staff but the staffing levels don't change." Another staff member said, "I don't think there are enough staff on the top floor as you need people to assist with hoisting and that leaves no one on the floor with the other residents."

On day one of our inspection observations showed that nine people on the first floor were without any staff support for 20 minutes while other people were being supported with personal care. On the second floor six people, including people living with dementia who were known to behave aggressively to others and people who could not mobilise without support, were without any staff present for 15 minutes. We observed that people on the second floor had fluctuating moods and could be unpredictable in their behaviour. On the second day of our inspection a member of staff from the second floor had to stay beyond their shift finish time to allow a colleague to have a break.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection of the home we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received training in safeguarding adults, the safeguarding adults' policy did not contain local details and an incident of abuse had not been raised as a safeguarding alert. Records showed that half the staff team of 51 had received training in safeguarding adults since our last inspection. However, the manager and seven staff described in the training matrix as "new" had not received training in safeguarding adults. Staff were knowledgeable about the different types of abuse people living in the home might be vulnerable to, and knew how to report any concerns. Records showed that safeguarding issues were being responded to appropriately. This meant the service is no longer in breach of Regulation 13.

The service had a robust external staff recruitment system. We saw that appropriate checks were carried out before staff began work. References were obtained and criminal records checks were carried out to check that staff did not have any criminal convictions. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people living at the service.

It was not clear that the internal recruitment system was robust. One carer worker was promoted to senior care worker role however, the registered manager could not produce any documentation about this process. The registered manager told us the position was advertised internally in the home and the staff member was interviewed. However the registered manager told us they did not record the interview. The staff member told us they were offered the job and did not have an interview. At the feedback on the first day of the inspection the registered manager told us there were two senior carer positions advertised and only two internal staff applied and that is why they got the job. There was no skills profile for the role and therefore it was not clear if the applicants had been able to demonstrate they had appropriate skills and

knowledge for the more senior role.

Inadequate

Is the service effective?

Our findings

At our last inspection the home was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the arrangements for monitoring and meeting the hydration and nutritional needs of people were not robust.

The nine care plans reviewed at this inspection each contained a nutritional and hydration needs and risk assessment. These stated that if a person lost two kilogrammes in one month they should be referred to a dietician. When an elevated risk was identified care plans stated that people should be weighed fortnightly. However, in two care plans where this was stated only monthly recordings were in files. This meant that people were not being monitored according to their risk assessments. There were inconsistencies between people's nutritional needs and risk assessments and records of care. For example, one person's needs and risk assessment stated they had a good appetite and ate well. Records of care delivered showed that this person regularly refused meals. As there were no food and fluid monitoring sheets in place for this person there was no record of precisely how much or how often this person ate. This meant there were no measures in place to mitigate the risks associated with irregular eating patterns and malnutrition.

Where people were identified as being at an elevated risk of poor nutrition, food and fluid monitoring charts were implemented. However these were poorly completed. Fluid intake was recorded inconsistently, on some occasions a volume was stated, on others notes stated "half a cup of tea." None of the records viewed had totals calculated. This meant there was no record of the actual volumes consumed that could be used to identify additional risk. One file showed that their risk had been assessed in February 2016 and this had indicated the person should be referred to a dietician. There was no further record in the person's file and in discussion with the senior staff member on duty it was confirmed the referral had not been made. This meant the risk of poor nutritional intake had not been addressed.

People told us the food was bland and unappetising. One person said, "Soup is not good, it's like water." Another person said, "There is no taste." Observations during lunchtime showed that people were not eating well. In one room six people were observed to not finish their meals. In another room, the only people who completed their meals were those who were supported by staff to eat. The home produced a four-week menu whereby the same menu was used for four consecutive weeks then changed. Care plans contained limited details about people's preferences. For example, one stated "[Person's relative] says they are not a fussy eater." In the kitchen the only preferences recorded were for four people, one vegetarian, two who did not eat pork and one person liked cheese sandwiches.

The chef had a list of people who required specialist diets due to diabetes, but the list for people who required their meals to have a modified texture was completed daily by staff. When people have conditions which affect their ability to eat and drink safely they need the consistency of their food modified. The consistency of food is recommended by a speech and language therapist. The chef was asked about whether they understood the difference between a soft diet and a pureed diet. They stated, "No, we do pureed meals, all meat and vegetables are liquidised and then they have mashed potato." People with diabetes were offered either fruit or yoghurt for dessert. The chef told us they do not offer sugar free

desserts. This meant that people were not being supported to have specialist dietary needs met.

Observations of lunch on the first floor showed people were not offered support in response to needs. Five out of six people ate their meals with their fingers, only one resident was supported to use cutlery when this was noticed. Another resident waited ten minutes for their food to be cut into manageable pieces, this only happened when staff noticed they were attempting to eat a potato using a knife. Observations on the second floor showed those who could eat independently were served first. Those who required support to eat their meals had to wait for their food. There was no way to keep the food warm until it was served, staff advised us the hot trolley had broken. This meant those supported to eat had cold food. The home has replaced the hot food trolley on this unit since the inspection took place.

The above is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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). Records showed that appropriate applications had been made to the local authority where people lacked capacity and were deprived of their liberty.

When people lacked capacity and it was in their best interests to receive care that was a restriction on their liberty, for example, the use of bed rails or the administration of covert medication, the home had liaised with families and relevant professionals. However, this took the form of a letter to relatives asking for their consent on the person's behalf for the restriction. This meant the service was not acting in accordance with the MCA as the relatives had no legal authority to make these decisions on the person's behalf. This was discussed with the registered manager and operations manager who provided an updated Best Interest checklist. The checklist clarified the process and would ensure appropriate consultation. In addition, one person's file contained a form stating that they did not wish to be resuscitated in the event of a medical emergency. The form stated the form stated the person had capacity yet was signed by a relative who had no legal authority to consent on the person's behalf. Another person's file contained a document instructing healthcare professionals to allow a natural death. This form had been signed by the person's relative, the registered manager and the GP. However, the dates of signatures were different and the relative had no legal authority to consent on the person's behalf. This meant the service was not following best practice guidance about how to act in accordance with the MCA.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff received regular formal supervision and we saw records to confirm this. Recorded supervision topics included discussions on safeguarding, accidents and incidents, key working, care files, medicines, life histories for people, and team work. Records showed that appraisals were completed annually and were up to date.

New staff were provided with induction training however, a member of staff said, "The training is not enough for a person who has just started." The induction record of a new member of staff showed they had covered

14 topics including incidents and accidents, referrals, medicines and care plan reviews in one day. This meant that none of these topics were covered in any detail.

Training records showed that the training completed by staff identified as "new" was minimal. One member of staff who had been employed by the service for three months had only completed training in dementia and falls prevention. Another who started in November 2015 had only completed training in medicines administration and food hygiene and a third who started in February 2016 had no completed training recorded. The home recruited staff who did not have a background in care. The lack of training meant that staff were not equipped with the knowledge and skills they required to perform their roles. The service was not supporting staff to complete the Care Certificate. The Care Certificate is a recognised training scheme which provides staff with the fundamental knowledge required to work in the care sector.

The home was visited once a week by the GP and people and their relatives told us they received healthcare support as needed. One relative told us when their relative was unwell they, "Saw the doctor straight away." Records showed that when people were unwell they were supported to access appropriate healthcare support, via the GP or rapid response team. However, these records were difficult to locate and follow as some information was kept in people's care files while other information was recorded in the senior's log book. For example, one person had been diagnosed with constipation by the rapid response team. This was recorded in the senior's log book but the person's care file had not been updated. In addition, bowel movements were recorded in the senior's log book. This meant that it was difficult to monitor people's health and requirements for medical input as information was contained in a shared log.

Staff told us changes in people's health needs were recorded in the senior's log book and shared through handover. However, discussions with staff demonstrated that this was not an effective way for information to be shared. For example, one person had been referred to the district nurse for an assessment for incontinence pads. Neither of the carers on duty was sure why this referral had been made. In addition, in a discussion around catheter care neither of these carers could explain how often the bags should be changed. This meant that people were at risk of receiving support that was not in line with the latest healthcare advice.

Requires Improvement

Is the service caring?

Our findings

At the last inspection the service was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. People were not treated with dignity as there was not enough equipment to support people quickly and people were supported in bathrooms with the door open. At this inspection we found the service had sufficient equipment to ensure that people did not have to wait for equipment in order to be supported.

However, people were not treated with dignity at all times. We saw one person in a bathroom with the door open, a staff member intervened to tell us, "It's alright, I've just done her." This was not a respectful way of talking about supporting someone with personal care. When one person was being supported to transfer staff were heard talking at a normal volume with other people present about whether or not this person required personal care. This was not an appropriate way to support people with dignity.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and relatives described the staff as caring. One person said, "They are very kind to me." Another person said, "They do care." A relative said, "They are very caring. I am very happy with how they look after her." Despite the task focussed nature of much of the support observed, some positive interactions did take place. For example, a staff member greeted then supported one person to eat using the person's mother tongue. The person went from passively watching the room to being actively engaged when they were spoken to in their first language. During the inspection the Short Observational Framework for Inspections (SOFI) was used. This showed there were no positive interactions during the half an hour observations were conducted. All interactions were functional.

At our last inspection we found that care plans contained limited information about people's life histories and preferences. This continued to be the case at this inspection. In the "Brief personal history" section of one person's file it stated that they had previously liked cooking and cleaning. Other than their relationship status and that they had children this was the only information available to staff about this person. Staff told us they learnt information about people's pasts from colleagues or relatives. The management action plan showed work around completing people's life histories should have been completed by January 2016. The registered manager told us this was scheduled for April 2016.

There were records that people's relatives had been involved in making decisions about care. One person told us, "They [staff] usually decide on my care along with the Doctor." Records did not show that people had been involved in making decisions about their care. In two files viewed it was recorded people had capacity with regards to decisions about their care, however in the section of the reviews where they could record their signature "Unable to sign" was recorded. There were no additional notes capturing people's views on their care.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because care plans did not reflect people's preferences and care was not designed with a view to achieving their preferences.

Care plans were not detailed enough to provide staff with the information they needed to provide personalised care. For example, one plan stated, "[Person] needs assistance of two staff [for care task]" Another plan stated, "Support with all personal care needs." A third said, "[Person] needs full support from staff with all her personal care needs." There were no further details about people's preferences of what the precise nature of support looked like. One person told us, "I would prefer a bath but I think a shower is quicker for staff."

The home was not set up in a personalised way. For example, incontinence pads were stored in communal cupboards in hallways and it was not possible to identify whose pads were whose. After we had observed lunch on the top floor a member of the inspection team enquired if people would be offered a hot drink. A member of staff responded "They have tea at 3pm." This meant support was not responsive to individual needs or preferences.

People told us that activities were limited at the home. One person said, "We don't do any activities." Another person said, "We sit around and talk, watch television. There's not a lot going on." A third person told us, "There are no real activities of any interest." The home employed an activities coordinator. During our inspection the coordinator supported people to access the visiting hairdresser and facilitated a bingo session that eight people attended. Records showed that many people did not engage in the group activities offered by the home.

Observations showed people were not supported with one-to-one activities. When people chose not to join in group activities they were not offered an alternative. Three support plans viewed stated that people should be "Encouraged to join in activities." However, other than one person liking music no preferences were recorded. In one person's care file it was clearly recorded they did not like group activities. Their care plan stated, "Now [person] is mostly sleeping or wandering. Try to engage with different activities but [person] is not interested." There was a handwritten addition stating, "Pencils not to be given to [person] as she breaks them and that's a risk." There was no information about what had been tried to attempt to engage this person with activities and no exploration of what their preferences might be. Many of the people in the home were living with dementia. There were no dementia friendly activities, such as rummage boxes, available to support people to engage. Rummage boxes are personalised boxes containing items relating to a person's life that can help trigger memories or provide activities the person can engage with. The activities coordinator had not received training on activities for people living with dementia.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Observations showed that people were not asked if they needed to go to the toilet. On the second floor two

people who relied on staff anticipating their needs were not supported to use the toilet between 9am and 3pm. This was confirmed by a senior member of staff. A member of the inspection team explored this with the staff. A staff member told us they were usually supported at 2:30. Another member of staff said that one person, "Wears a large pad and will be changed after lunch as she doesn't wee much." One person told us, "I would like them to change my pad more often. Sometimes it gets very wet and messy."

The service had a robust complaints policy which included details of the expected timescale for response and how to escalate concerns. People and relatives told us they knew how to complain and several people had made complaints. Relatives told us their complaints were resolved and they felt they were listened to. Records showed that complaints were responded to in line with the policy. The issue of people not being supported to receive personal care in a timely manner was reflected in complaints raised by relatives. Three relatives had complained in the last six months that people had not been supported to have personal care in a timely manner. The registered manager conducted monthly audits of complaints to ensure that they had been dealt with in line with the policy. However, this audit did not include any analysis of the content of complaints. This meant themes and issues were not highlighted and the service was not routinely learning from complaints made.

The home had held one relatives' and one residents meeting since our last inspection. At the residents' meeting people had raised issues about the food and the menu but there was no action plan to show that people had been listened to. The relatives' meeting had been used to discuss the outcome of our previous inspection. Relatives told us they felt that staff listened to them and responded to their feedback. One relative told us, "I believe they [staff] do listen to us as visitors.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the systems to monitor, evaluate and improve the quality of care were not sufficient.

Since our last inspection the manager has become registered and the operations manager has visited regularly. People and staff were positive about the registered manager. One person said, "[Registered manager] is approachable." A member of staff said, "She [registered manager] is really good. I feel supported." However, none of the people we spoke with could identify the operations manager by name. Regarding the operations manager staff told us, "We see [operations manager] with [registered manager] but she doesn't come around to see the residents." Staff reported that they were unhappy and felt unsupported by the provider.

Staff told us they raised concerns about the service but there was no action. This was confirmed by the staff meeting record from February 2016 where as a result of receiving food hygiene training, staff had raised concerns about food being served cold. During our inspection food was being served cold. This showed that the concerns raised by staff had not been acted upon.

Records of visits by the operations manager showed they visited the home regularly to complete audits and meet with the registered manager. However, the audits completed were ineffective as they had not improved the quality of care since our last inspection. The monitoring report visits for December 2015, January and February 2016 recorded that "All areas of the home clean and tidy." The December and January reports recorded there were no issues with infection control or cleanliness and no evidence of odour. The February report identified that sluice sinks needed to be cleaned. This evaluation did not correspond with the observations of the inspection team where the level of ingrained dirt in bathrooms, kitchens and shared areas was high. The registered manager and operations manager had not been aware that toilets did not have seats, or of other issues that presented an infection control risk.

The registered manager completed monthly audits of care plans and records showed the operations manager sampled three care files per month. The registered manager's audit noted whether or not files required reviewing or updating and allocated actions to staff. The operations manager's audit stated in all three months that care plans contained "Adequate detail about how service user wishes the day to day care to be delivered." This evaluation did not reflect the findings of our inspection which established care files lacked detail about people's support needs and wishes. During the inspection it was established that neither the registered manager nor the operations manager had received any training on personalised care planning. This meant they did not know what a good care plan looked like and were not able to properly evaluate the quality of the service provided.

The registered manager completed monthly audits of accidents and incidents. This audit checked paperwork had been properly completed and recorded follow up actions. Multiple incidents of aggression from and between people living in the home were recorded. The analysis of these incidents showed that

safeguarding alerts had been made, and there was on-going monitoring and contact with health professionals when injuries were sustained. However, there was no analysis of the potential causes or triggers for the aggressive behaviour. Recorded actions for two people who were behaving aggressively to others related to them moving out of the home rather than any attempt to identify the cause of their behaviour.

The operations manager's audit included a recording of an observation of care delivered. Records did not show where in the home this observation took place. Our observations showed the levels of support and pressures on staffing were more acute on the first and second floor. The section of the audit relating to staffing levels stated, "In line with dependences." The reports showed that staffing had been increased by one care assistant at night during December. The service provided a copy of the dependency tool used to calculate staffing levels and copies of the completed tool. There were no observations of care included to support the evaluation of staffing needs and the tool suggested a maximum daily need of four hours per day of support for people with the most complex needs. The observations of care during the inspection demonstrate this tool and its implementation has not been effective at this home.

Records showed that while staff were receiving supervision and appraisals, the registered manager had not received any formal supervision. The operations manager stated they met regularly with the registered manager and considered this to be supportive. Records of these meetings showed they were focussed on the tasks of managing the home and did not consider the development and support needs of the registered manager. The registered manager had only completed training in first aid, food hygiene and falls prevention since our last inspection. They had not received training in safeguarding, the Mental Capacity Act (2005), Dementia, infection control, moving and handling or health and safety since being employed by the service. The registered manager told us they had not had time to complete any training. This meant they were not able to demonstrate leadership and best practice in areas where the home was performing poorly.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity as they were not supported with personal care in timely manner and their needs were discussed in front of other people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Service users were at risk of not having their nutritional needs met because monitoring of food and drink intake was inadequate.

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 People were not receiving person centred care because care plans did not reflect their preferences and care was not designed with a view to achieving preferences.

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the Mental Capacity Act 2005 as relatives without legal authority were asked to consent on behalf of service users.

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not robust and lacked measures to reduce and manage risks. Infection control practice was poor and people were exposed to the risk of the spread of infections.

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and audit systems were ineffective and did not identify or address areas of concern.

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs in a safe way.

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider's registration.