Richard Whitehouse

Wheathills House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 3 January 2019 and was unannounced. We last inspected this home in March and April 2018 and completed a published report; the overall rating was Inadequate which meant that the service was placed into special measures. We put conditions on the provider's registration with us. This meant admissions into the home were restricted; we required the provider to develop people's care records, provide training and to send us a report detailing how improvements were being made. The provider had not complied with the conditions of registration and had not completed all of the required actions. This impacted on the safety and wellbeing of people who used the service.

Wheathills House is a residential care home for 31 older people, some of whom were living with dementia. At the time of our inspection there were 20 people using the service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The overall rating for this service remains 'Inadequate' and the service 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 provider is also the registered manager for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Within the report we refer to them as 'the provider'.

The provider had failed to ensure improvements had been made, to ensure people received safe care.

Where people may have been harmed, they had not identified incidents as potential safeguarding concerns, and not reported these to the local authority or sent this information to us.

People's health care needs had not always been fully assessed when they moved into the home to ensure their needs could be met; the staff did not know how new people needed to be supported to receive their care to keep well. Necessary checks had not been made with health professionals prior to admission to ensure their care could be provided safely and to obtain details of any prescribed medicines.

Improvements were needed with how medicines were managed to ensure there were safe systems for people to receive medicines as prescribed. Improvements were needed with how medicines were audited and stored.

The provider had failed to ensure that they had received effective training along with the staff team, to understand how to provide necessary care for people. The staff had received training, but the provider had not recognised this was not effective.

People were not always supported to have maximum choice and control of their lives and staff did not always supported them in the least restrictive way possible; the policies and systems in the service did not support this practice. Where people lacked capacity, the provider and staff had not understood how to assess this and to ensure decisions were made in their best interests. Where restrictions were in place, such as monitors and CCTV, the provider had not sought people's consent to ensure the rights and freedom was not restricted. There were no clear systems in place to identify how information was used, retained or stored. Where restrictions were in place, the provider had not identified these and applications had not been sought to ensure these were lawful.

Quality monitoring systems were not effective and had not assessed all areas of care to ensure improvements could be identified; these systems were not used to drive improvements. The provider did not have a clear overview of the service provided or actions that were necessary to improve the quality of the service. The provider had not worked in partnership with other agencies to understand best practice care or how to make the necessary improvements.

Staff recruitment procedures were not thorough and the provider had not ensured all necessary recruitment checks had been completed prior to staff working in the service. People felt there was enough staff to keep them safe, although the provider did not review this against people's dependency levels to ensure this continued to meet people's needs.

People's care plans had been developed to guide staff to provide their individual care needs. Further improvements were still needed to ensure these reflected people's views about care towards the end of their life.

Where people became ill, the staff were responsive and ensured additional health care was sought to help people keep well. Risks to people were now assessed to ensure where people had identified risks such as a risk of choking or risks with movement. Information was available to guide staff about how to mitigate these risks. Accidents or incidents were now recorded and used to identify any trends to improve the safety of people. The environment was suitable to promote people's safety and the necessary fire precautions had been actioned.

People felt the staff were kind and considerate and they were happy with the level of activities provided and felt these interested them. The provider had a complaints policy and procedure, however, no complaints

had been received. Relatives and people who used the service knew the provider by name and felt that they were approachable if they had any problems or concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was inadequate.

People were not always safe and protected from harm and abuse. Initial assessments did not reflect people's health needs fully to ensure safe care could be provided. Improvements were still needed to ensure safe systems were in place for people to receive their medicines as prescribed. Staff did not always recognise safeguarding incidents and had not reported these. There were enough staff to meet people's needs although there was no system in place to ensure this reflected people's changing dependency needs. Safe recruitment procedures remained unsuitable to ensure new staff were suitable to working the home. Risks to individuals were assessed and these were reviewed regularly to keep people safe. Infection control procedures were maintained and the home was clean.

Is the service effective?

Requires Improvement

The service requires improvement.

Where people did not have capacity and were no longer able to make decisions, this had not been assessed to ensure decisions made were in their best interests. Where monitoring was in place through movement sensors and CCTV, people had not consented to this and applications to ensure restrictions were lawful had not been considered. Staff had a received training but this was not always effective to ensure they understood how to provide best practice care. People enjoyed the food and their nutritional needs were met. People were supported to maintain good health.

Is the service caring?

Requires Improvement

The service requires improvement.

The provider had not ensured that improvements were made within the service to ensure people were safe and well cared for. People were treated with kindness and compassion by staff and their dignity and privacy were promoted and respected. People were encouraged to be independent and visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service requires improvement.

People's care records had been reviewed to reflect how they wanted to be supported. Further improvements were needed to ensure people's wishes at the end of their life were considered. People were supported to follow their interests and take part in activities. People knew how to raise any concerns and felt confident they would be responded to.

Is the service well-led?

Inadequate

The service was inadequate.

Effective systems were not in place to check the quality of the service and drive continuous improvement. The provider had not made suitable improvements within the service and had not complied with their conditions of registration.

Wheathills House

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 visit took place on the 3 January 2019 and was unannounced. The inspection visit was carried out by an inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider had sent us a provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used a range of different methods to help us understand people's experiences. We spoke with eight people who used the service and also observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We spoke with one person's relative to gain their feedback. We asked for feedback from the local authority and safeguarding team. We reviewed information the provider sent to us to show how they could meet their conditions of registration. We asked the provider to send us information about the recruitment of new staff, health assessments, their statement of purpose and admissions. However, we did not receive all the information as required, or within our timescales.

We spoke with the registered manager, the care manager, the activity staff member and three care staff and the cook. We reviewed care plans for five people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. We reviewed audits and quality checks for medicines management, accidents and incidents, meeting minutes and health and safety checks.

Inadequate

Is the service safe?

Our findings

Within our last published report, we recorded the service was rated inadequate in this area as the provider had not taken suitable action to keep people safe. On this inspection, although we found some improvements had been made, we still identified multiple breaches which meant the provider had not made suitable improvements and this area remains inadequate.

In our last published report, we identified that people were not protected from abuse and the management and staff team did not have sufficient practical knowledge of safeguarding to ensure people were protected from abuse or harm. This meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found improvements had not been made.

During this inspection, we saw two incidents forms had been completed which recorded people had been harmed by other people living in the home. These had not been identified as potential safeguarding concerns and these incidents had not been referred to the local authority safeguarding adults team. The staff told us that where there were safeguarding concerns, these would be raised with the management team who would make the alert. A member of staff confirmed these incidents had not been reported. The provider recorded within the service development plan that staff had received training to understand safeguarding and reporting methods. However, this was not effective as the incidents had not been reported and no action had been taken to investigate them.

This meant there is an on-going breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within our last published report, we recorded improvements were needed with how medicines were managed; risk and health care needs were met and how safety measures had been addressed and to ensure suitable fire systems were in place. This meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found that the provider had met some parts of this regulation. However, we found further improvements were still needed.

When new people moved into the service, suitable checks had not been taken to ensure they received their medicines as prescribed. One person moved into the home on the day of our inspection. The provider had recorded the medicines they needed as part of their assessment, although no checks had been made with their GP or pharmacist to establish whether these were their current medicines and when these should be administered. No medicines records had been prepared to ensure staff understood when this person should have their medicines. After lunch, this person told us they should have had my medicine at lunch time but they hadn't received them. We brought this to the attention of the staff who told us they would contact their GP to check which medicines they needed. The provider had not recognised that medicines checks were needed and had not completed these to ensure medicine management was safe. During the inspection, the staff made the necessary arrangements to ensure they had accurate information about these medicines, and the person received their medicines later in the day.

Improvements were still needed to ensure that records were kept of medicines received into the home. Where people had medicines, 'as required' and could have one or two tablets, staff had not always recorded how many tablets had been given. There was no accurate record of medicines stored in the home, to ensure checks could be made that people received their medicines as prescribed. Where medicines were stored in a fridge to ensure their integrity, a record of the daily temperature was recorded. However, a minimum and maximum temperature was not taken to demonstrate all medicines had been stored within a suitable temperature range throughout the day.

This meant breach there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within our last published report, we recorded that adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. Pre-employment checks designed to help providers ensure staff were suitable to work at the service were not always completed. This meant there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found improvements were still needed. We looked at two records for staff who had been recently recruited to the service and found evidence to show that criminal record checks and references had not always been sought before they started working in the service. The provider told us they were not aware that a risk assessment should be completed to demonstrate how their decision to start the staff working without suitable records had been made. Following our inspection, the provider provided us with information about the induction and that staff should work in a supervised capacity until necessary records had been received. We asked on three occasions for evidence of references for one member of staff, this was not provided. This meant the provider had not considered all necessary recruitment checks to ensure new staff were suitable to work with people who used the service.

Within our last published report, we identified that there were not always sufficient numbers of staff to ensure the safety of people who lived at Wheathills House which meant there was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that some improvements had been made in this area.

On this inspection, people who used the service were independent in many areas of their care and did not always require support from staff to move around the home and help with personal care. People felt there was enough staff to support them and we saw where people needed assistance this was provided.

The staff advised us that where possible, they accompanied people on hospital visits, especially where no family members were available to do so. However, we had received information through safeguarding alerts from health professionals that two people had attended hospital without staff support, which had a negative impact on their care as necessary information about their care and medicines were not available. As people were unaccompanied, health staff could not speak with staff to ask about their care and support needs.

The provider told us a dependency tool was not used to calculate or guide them on how many staff were needed on duty; there was the same number of staff on duty each day. The staff explained that the staffing provided was calculated on the number of people resident in the home rather than considering their dependency needs. Although we found there were suitable numbers of staff for the people currently resident in the home, it is a concern that this was not kept under review to reflect people's changing needs.

Lessons were not always learnt where improvements were needed. Our last published report recorded multiple breaches of regulations. The provider had made improvements in some of the areas, but we identified where improvements were still needed. The provider had not considered how improvements could always be made to ensure people received safe and effective care.

Risks to people's health and safety had now been assessed. The staff understood people's needs, including any risks and knew how to provide care and support to reduce potential harm. Where risks had been identified, assessments had been completed which recorded the steps that were needed to minimise these; for example, with how people were supported to move around the home. We saw when equipment was used to help people to stand, the staff followed the agreed plan of care and used the equipment safely. The staff explained they had completed training to help people to move safely and were confident they understood how to support them. The staff understood and recognised people could continue to make decisions about the risks they took and could take responsible risks when they were assessed as not needing support. For example, we saw people moved around the home independently; they had mobility equipment including walking sticks and walking frames to help them to move safely.

Our last published report identified that people were not protected from the risk of choking. On this inspection we found improvements had been made. Where people were at risk nutritionally they were supported to have additional food or supplements and people had the option of having a softer diet due to risk of choking. Guidance had been sought from health care professionals to ensure the food was presented in a manner that reduced the risk of choking; the staff explained that this meant there was a mashed or softer diet prepared. We saw at the lunch time meal, staff sat with people encouraging them to eat and supporting them to stay safe. Staff understood why they were providing support and what action to take if they started to choke or had difficulties when eating. The care records included information about their diet and how food needed to be prepared.

Within our last published report, we recorded that there were no effective systems in place to analyse patterns of falls to try and reduce recurrence. On this inspection we found improvements had been made. When accidents or incidents occurred in the home, such as people experiencing trips and falls, any injury was recorded and staff completed accident and incident forms. We saw these recorded how the incident had occurred, if known, and any action they had taken. A falls analysis was carried out to identify any patterns or trends to give an overview of the risk to people to review their care to reduce the recurrence of these incidents.

Within our last published report, we recorded that following a visit from a fire officer, fire risks had not been responded to and left people at risk of avoidable harm. On this inspection we found the provider had taken action to address the environmental concerns. They were confident that the environment was safe and suitable protection standards were in place to protect people in the event of a fire.

Within our last published report, we identified that improvements were needed to ensure there were processes in place for staff to follow and maintain infection control standards. On this inspection we found improvements had been made. People were satisfied with the standard of cleanliness in the home. The staff had access to and wore gloves and aprons where this was needed and hand washing facilities were available. An infection control audit was completed to monitor that standards were being maintained and staff understood why they measures were implemented.

Requires Improvement

Is the service effective?

Our findings

Within our last two published inspection reports, we identified people's rights under the Mental Capacity Act 2005 were not promoted and there was an on-going breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found no improvements had been made.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Where people had capacity to consent to their care, they had signed their care records to evidence their agreement. Where staff felt people may not have capacity, a document recorded where staff considered they did not have capacity, but an assessment to demonstrate that capacity had been assessed had not been completed.

Some people had movement sensors in their bedrooms and staff reported this was to alert them to any movement when they were not present. There was no evidence that people had consented to the use of this sensor which could potentially restrict their movement. In addition, the home had CCTV installed in all communal areas of the home, including the lounge, dining room and corridors. There was no evidence that the provider had considered people's consent to being filmed and there was no information recorded within the Statement of Purpose about how the CCTV would be used and information retained. Where potential restrictions were in place the provider had not identified these and where people lacked capacity, applications to lawfully restrict people of their liberty had not been made.

The provider recorded within their service improvement plan that staff had received training for MCA, although we saw they did not understand how to implement this knowledge to ensure capacity was assessed. This meant people's rights were not protected and decisions may not be in their best interests.

This meant there was an on-going breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within our last published report, we recorded that people received care and support from staff who did not have the necessary skills and competence to support them effectively. This meant there was a breach of

Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we found improvements were still needed.

People were not supported effectively and in line with best practice guidance. The provider recorded within their service improvement plan that staff were now fully compliant with safeguarding, medication and mental capacity. However, we found that this training was not effective as staff had not recognised or understood when to make safeguarding referrals, ensure safe medicines systems and how to assess capacity. The staff received regular supervision and appraisals to review their performance, although this had not been effective to ensure staff understood the training that had been delivered. This meant this lack of knowledge and awareness and effective support from the management team could place people at risk of harm.

We asked the provider for information about how staff received an induction in to the service as during our inspection, this was not available. The provider sent us this information which recorded that staff had completed an induction and recorded when staff had been observed to check their competence and understanding. There was limited evidence about how these observations were carried out and how effective the induction was. The statement of purpose recorded that all staff would complete the care certificate as part of their induction within twelve weeks of their employment. The provider told us that staff had not completed the care certificate and they did not have the facilities to offer this to new staff. This meant staff did not have the opportunity to gain this certificate to develop the right skills and knowledge to deliver effective care and support.

People's health was managed well when they were already resident in the home and had been assessed as having a health need, Information was available within the care plan to guide staff about how they needed to be supported. People had regular access to healthcare services and staff were aware of any changes in people's health. Where staff were concerned about people's health, they contacted the GP or made arrangements for them to go to hospital. There was a record when people had visited the doctors, health professionals or the opticians and what health intervention they had needed.

People were supported to maintain a healthy balanced diet and asked what they would like to eat for each meal. We saw people could have a drink throughout the day, and they were offered a choice of hot and cold drinks. People's specific dietary needs were documented and respected. For example, people living with diabetes or people who preferred to eat a vegetarian diet.

Within our last published report, we identified that the needs of people living with dementia were not considered in the design and decoration of the home. On this inspection we found that the provider has reviewed how they could support people to recognise different areas of the home and had ordered new dementia friendly signage. They told us this would be used to support people to find their way around the home. People could move about their home safely as there was sufficient communal space to enable people to pass or have room to use their wheelchair or walking aids.

Requires Improvement

Is the service caring?

Our findings

In our last published report, we recorded that people's dignity was not always promoted and there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found improvements had been made. However, people's care was compromised as the provider had not ensured that sufficient improvements had been made within the service to ensure people received the care they needed. For example, when attending hospital appointments, health professionals did not always have the information they needed, safeguarding incidents had not always been recognised or reported and the provider had not ensured that staff received effective training to ensure decisions were made in their best interests where they lacked capacity.

The staff recognised the importance of not intruding into people's private space. People had their own bedroom that they had been encouraged to display personal possessions, pictures and photographs. Personal care was carried out discreetly in bedrooms and bathrooms and when people were supported to move using any mechanical aid, the staff ensured they were covered to protect their dignity. We heard staff talking sensitively and discreetly to people about whether they needed assistance to get to the bathroom. The staff were patient with people when they provided support and we saw them speaking and engaging with them in a positive way. Staff understood the importance of treating people with respect and did not discriminate based on people's choices and how they chose to express themselves.

People who used the service told us the staff were caring and we saw staff responded kindly to people. For example, we saw one member of staff had noticed a person wasn't responding when speaking with them and asked if their hearing aid batteries needed changing. When this had been completed, they replied "Ah that's better, I can hear you again," accompanied by a smile. One person had received a pair of shoes for Christmas and complained that they were too tight. A member of staff asked them if they could have a look at the shoes and offered to use a shoe stretcher to see if they could be stretched to fit. The person said," Yes please love, I'd like to be able to wear them, it's just the elastic that needs to give a little."

People were supported to retain their independence and make choices about how they spent their day. We saw that people were asked what they wanted and where they preferred to be; for example, after a meal, some people requested to go to their bedrooms for a rest and staff supported them to do so. People told us that they were encouraged to be as independent as possible. One person said, "I like to look after myself and do what I can, the staff will only help me where I need them to."

At lunchtime we observed the meal served in the main dining room and saw that people were provided with suitable levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. We saw one person started to choke and staff immediately went to their assistance when they saw what was happening; they stayed with them until they felt safe again.

People could choose to spend their time where they felt comfortable and one person told us, "I like it here

and being with my friends. We get on very well." People were relaxed in the company of staff and we observed friendly conversations and laughter. Staff were not intrusive and when they walked around communal areas, they spoke with people who they knew well.

Staff recognised the importance people placed on their personal belongings. People could have their bags and personal possessions near to them. We saw when people went for lunch, the staff remembered to take their personal belongings with them and placed them within easy reach.

People's mobility aids were kept close to them so they could move around the home independently if they chose to do so. At lunch time these were moved to the side of the dining room to provide people with sufficient space to eat in comfort. One person noticed their frame had been moved and the member of staff said, 'I've moved it, it's here look, it's quite safe till you want it." This comforted the person.

The staff supported people already resident in the home to have their medicines when they were prescribed. One person told us, "I have a lot of medication to take, I know they've got it sorted for me. If I ask for anything they will help me if they can." The staff explained what their medicines were for and people were given time to take them.

People maintained relationships with family and friends and staff recognised people's rights to have personal relationships and have opportunities to be intimate and share time together. We saw family and friends visited throughout the day and there was a relaxed atmosphere and people were comfortable with staff.

Requires Improvement

Is the service responsive?

Our findings

Within our last published report, we recorded that the provider was not always responsive to people's needs and wishes and people's care records did not include information needed to ensure they received the right care. This meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we saw improvements had been made although further improvements were needed.

The provider had reviewed the care records and these now included guidance about how people wanted to be supported to reflect how they wanted their care provided. Where people had a period of respite care in the home, there was now a care plan in place giving a summary of the person's support needs.

Within our last published report, we recorded that people people's end of life wishes may not be respected as these were not recorded. The care plans still needed information about how people wanted to be supported when nearing their end of life. The management team and staff had not explored people's individual wishes in relation to their end of life care and recorded whether they had any specific wishes whilst people were able to contribute. A member of staff told us they felt that the staff team provided people with good support at this time. Where people had chosen to stay in the home they had provided individual care to enable them to stay in their home. They felt confident they had been able to support them to stay as comfortable as possible.

Within the PIR, the provider had recorded they did not understand how the service could meet the Accessible information Standard. The Accessible Information Standard requires providers to consider how information or communication needs relating to a disability, impairment or sensory loss can be shared. Since completion of the PIR, the provider had accessed the necessary information and was looking at how to introduce this into the home. They were able to show us information they had sourced and were now aware of what was required.

People could now make choices about their time and how to spend their day. People were supported by staff who knew them well, understood their preferences and were responsive to their changing needs. When people's care needs changed, the care plans were now reviewed with them to reflect how people wanted to be supported. One member of staff told us, "The plans are much better now. They are reviewed more often and include a lot more information." Information from each shift was handed over to staff to ensure that all staff were aware of any changes.

People were involved in activities that interested them. On the day of the inspection, people were participating in a cryptic quiz about nursery rhymes, their meaning and origin. The quiz provoked discussion about people's childhood and they shared stories about their parents fear of the work house, sharing beds with siblings; enjoying their time exploring the local countryside and cooking with grandparents. There was a lot of discussion and laughter and people told us they enjoyed participating.

People enjoyed visiting local areas of interest and used community transport. One person particularly

enjoyed visiting the Arboretum and seeing the monument to commemorate the women's land army. They told us, "Many of us here were part of the land army and have now received our medals. It was special to be able to visit there." People who used the service generally moved from the local area and they enjoyed continuing to celebrate and remember local festivals and events. One person told us, "We have a man that visits us each season. He films the local area and what it looks like through that season and any shows and events. He then comes here and he brings his projector and we watch his films. We really enjoy this as although we may not want to go there, its lovely to see the changing landscape and what is happening at the shows." Another person told us, "We did flower arranging here and entered our displays in the local agricultural show. We had a clean sweep and won first, second and third prizes. We were really happy about that."

Events were organised in the home that encouraged family participation. One person told us, "We've had a coffee morning for charity and welcomed everyone here. It's always lovely to share this with family. We had a brass band visit us over Christmas too, which our family could come and listen to. They were so good, we've booked them again to come in the summer." People spoke highly of the activities provided in the home and the staff. One person told us, "I feel lucky to live here and there's always something for me to do. If the activity staff aren't coming in, then they will leave puzzles or quizzes to do. We like to think of it as our 'homework'. There's nothing that they can't put their hand to."

People's religious and spiritual needs were considered and people were supported to practice their faith. A service with music was held each week and a representative from a local church visited to offered communion for people. People told us the current arrangements met their needs and they no longer wanted to attend a church or place of worship.

People knew how to make complaints and were confident that they would be listened to. One person told us, "I feel able to talk to the staff if I was worried." The provider told us that where any complaint was received, they would investigate this.

Inadequate

Is the service well-led?

Our findings

Within our last published report, we recorded that the service was inadequate in this area and that systems were not in place to ensure people received safe and effective care. As a result of our concerns, we placed conditions on the provider's registration. These were to restrict admissions to the home, to send us a monthly report about how improvements were being made and to demonstrate how care records were reviewed to reflect people's needs. These conditions had not been met. We have rated the service as Inadequate and the service continues to be in Special Measures.

The provider had admitted people into the service without contacting us for our written agreement. This meant that we had been unable to make a judgement that the provider was able to meet their needs before they moved into the home, to keep them safe and to ensure there was suitable staffing arrangements in place.

The provider had not complied with conditions of their registration to send us reports every month detailing the improvements that were being made within the service. The service improvement plans that have been sent stated that the necessary improvements had been made. However, on this inspection, we found that the provider had failed to identify where improvements were still needed.

At this inspection we saw that some improvements had been made but that the provider had not completed all the actions to ensure that the home was well managed. We found the provider was still in breach of Regulation 11,12,13 and 17 of the Health and Social Care Act 2008 (Regulates Activities).

Improvements were needed to ensure people's health needs were met when they moved into the home. We saw an assessment which did not fully record information about a person's health care needs, and how these needs were to be met to enable them to keep well. When we spoke with the person, they disclosed additional information to us about how they needed to sit, their night time routines and equipment they needed to comfortable. The provider had not considered all areas of their health and how they could meet these; we asked for further information about how they could demonstrate they could meet their needs. This information was not provided to us as we requested. Following our inspection, it was identified that the person had significant health needs which the provider was not aware of. This lack of oversight of their current health needs meant there were at risk of harm and necessary information had not been obtained to ensure they received the most suitable health support.

Quality audits had been developed within the home to monitor care delivery and a service improvement plan was completed to record how progress was being made. We found these were not always effective. The quality monitoring systems had not identified people's capacity had not been suitably assessed and they were not making decisions that were in people's best interests. Consent had not been sought for potential restrictions or for monitoring people in the home. Safeguarding alerts had not always been identified and improvements were still needed to ensure people were safe. We asked the provider to complete these safeguarding alerts and following our inspection received a copy of the alert. A lack of effective monitoring systems meant these had not been used to drive improvements in all areas of the service.

The provider had not sought support and guidance from partner organisations including the local authority to help them to make improvements. The provider was reluctant to work with other agencies and some partner agencies told us they felt unwelcome in the home; they also confirmed they had not been approached to support the provider to make improvements. The provider had not ensured their own training was up to date to ensure staff were working with best practice guidance.

The provider had not developed a system to ensure the service was suitably staffed including during the night. The provider informed us that the staffing was calculated against the number of people using the service and there was no system in place to review staffing against people's dependency support needs.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their report and rating in their office, but this was not easily visible for people using or visiting the service. People and relatives we spoke with were not aware of the ratings of the service or the improvements that were needed. The report on their website was displayed through the 'Contact us' heading and not displayed on the landing page. It was not clear where to access our report to ensure people could clearly be informed about our current judgement of Inadequate at this service. The provider told us they would move this to comply with our guidance. At the time of this draft report being completed, this had not been actioned.

During our inspection, some evidence relating to recruitment procedure, assessment of people's health care needs, details of people's admission and a copy of the Statement of Purpose was requested. We did not receive this information as requested and following our inspection, we wrote to the provider on two further occasions to request this information to support us to make a judgement about the service. Although we received the Statement of Purpose and information relating to admissions. We did not receive all necessary recruitment evidence or a full health assessment of a person's needs. This meant the provider had not provided us with the necessary required evidence to make a judgement about how the service was managed.

Within our last published report, we recorded the provider had not informed us about serious incidents that happened in the home. On this inspection we found improvements had not been made. The provider was aware of a safeguarding incident and had not informed us as required. They had failed to recognise potential safeguarding concerns and had not referred these to the local authority or notified us. This meant we were unable to check the provider had acted in the most suitable way and monitor the service.

This evidence demonstrates an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sought people's views on their care through a survey although this information was not analysed to review how improvements could be made. There was no system in place to address any comments where people had chosen to respond anonymously. A member of staff informed us that people would be approached directly for any comments. A new poster was displayed in the home for the provider to report any findings of a survey; this was 'You said, We did.' This was not being used and there was no information displayed. The provider told us, people could discuss their views each month at a 'resident meeting'. The minutes were not available although the provider told us they 'were productive to make the feedback better.'

There was a registered manager in post who was the provider of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Providers 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 and their relatives knew the registered manager was and told us they would speak with them when they worked in the home.

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 Care and treatment was not always provided in a safe way for service users and the registered person did not have systems to ensure proper and safe management of medicines.