Sun Care Homes Limited

Victoria Cottage Residential Home

Inspection report

13-15 Station Road
Lowdham
Nottingham
Nottinghamshire
NG14 7DU

Tel: 01159663375

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in January 2016 and we found breaches of regulation. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements. We returned to the service to carry out a focused inspection on 19 April 2016 and we found the provider had not made the improvements to meet the legal requirements. The provider sent us an action plan telling us how and by when they would make the improvements to meet the regulation they continued to be in breach of.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Cottage Residential Home on our website at www.cqc.org.uk.

We inspected the service on 11 October 2016. The inspection was unannounced. Victoria Cottage Residential Home is owned and managed by Sun Care Homes Limited. It is registered to provide accommodation for up to 18 older people. On the day of our inspection nine people were using the service. The service did not have a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that although the registered provider was continuing to work with a consultant to drive improvements in the service and continued to upgrade the environment, this had not resulted in people being given safe, effective and responsive care and support.

People were still not protected from the risk of harm, due to ineffective systems in place to protect them. Risks in relation to people's daily life were not always being assessed or planned for. Medicines systems were now managed safely and people were receiving their medicines as prescribed.

Although more training had been given to staff, people were supported by staff who still did not have all of the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions if they had the capacity to do so. However people who did not have the capacity to make certain decisions were not protected by the Mental Capacity Act 2005. People had restrictions placed upon them without the required authorisation to do so and care was not planned to ensure it was delivered in the least restrictive way.

There was a lack of planning and delivery of safe and responsive care and this resulted in the risk of people not being cared for appropriately. People felt they could raise concerns if they wished to.

There was still a lack of appropriate governance and risk management framework and again this resulted in us finding ongoing breaches in regulation and negative outcomes for some people who used the service. People were not being involved in giving their views on how the service was run and the systems in place to monitor and improve the quality of the service provided were ineffective.

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 vary 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 always safe.

People may not be protected from abuse because the systems in place to protect people from the risk were not robust.

People continued to be exposed to risks to their health and wellbeing because ways on minimising these were not identified and planned for.

People lived in an environment which was not always clean and hygienic.

People were receiving their medicines as prescribed. There were enough staff to provide care and support to people.

Is the service effective?

Inadequate

The service was not effective.

We found that action which had been taken to improve the effectiveness of the service had not resulted in people receiving effective care and support.

People were still supported by staff who were not provided with enough training to enable them to support people safely.

Where people needed support to make decisions they were not protected under the Mental Capacity Act 2005. People received support which was not assessed and planned for to ensure it was delivered in the least restrictive way.

People were not always supported to maintain their nutrition.

Is the service responsive?

Inadequate

The service was not responsive.

We found that action had been taken to implement new care planning but this was not robust and had not resulted in improving the care people were receiving.

People felt there concerns would be listened to and there were systems in place to deal with concerns raised.

Is the service well-led?

Inadequate

The service was not well led.

We found that action had been taken to improve the way the service was monitored but these had not been effective in improving the quality of care some people were receiving.

People were still not involved in giving their views on how the service was run.

Victoria Cottage Residential 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.

We undertook an unannounced focused inspection of Victoria Cottage Residential Home on 11 October 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 19 April 2016 inspection had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and assessing whether statutory notifications had been received. A notification is information about important events which the provider is required to send us by law. We spoke with commissioners who fund the care for some people and looked at feedback received from Nottinghamshire County Council following their recent visit. Before the inspection, 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.

During the visit we spoke with five people who used the service and the relatives of three people. We carried out observations throughout the day in the service and 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 five members of support staff, the cook, maintenance staff, the housekeeper, the acting

manager, the deputy manager and the registered provider. We looked at the care records of five people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

The last time we inspected the service we found there were improvements needed in relation to safeguarding people from the risk of abuse, assessing and minimising the risks to people's wellbeing and the safety of medicines. During this visit we had ongoing concerns about all of these aspects of care and support, with the exception of medicines management. Additionally we found further concerns in relation to the safe recruitment of staff.

We looked at the recruitment records and found that people were not being protected against the risk of receiving support from staff who may be unsuitable to provide them with support. In the recruitment files we looked at we found that the application process had not been followed correctly. One staff member did not have an application form or references in their file and the acting manager was unaware if these had been provided. Other staff had not provided detail of their previous employment history or provided evidence that they were physically fit to undertake the work they would be required to. One staff member had provided the contact details of two friends as referees and these people had provided the references rather than a previous employer. Other forms were not completed such as the personal file checklist and the interview form. Only one file contained any proof of the applicant's identity. Each staff member did have a suitability check undertaken by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's fitness to work with people to assist employers in making safer recruitment decisions.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people we spoke with told us they felt safe, people could not rely that systems in place would protect them from harm. One person told us, "I feel safe, I don't know what it is (that makes me feel safe) but what it is, is a nice place." The two relatives we spoke with told us they felt their relations were safe in the service and staff we spoke with were aware of different types of abuse and how these should be reported. However, we saw from records there had been four incidents and an unexplained injury in the service and this information should have been shared with the local authority for consideration under their safeguarding adult's procedures. Information about three of these incidents had not been shared with the local authority or been investigated. Furthermore no action had been taken within the service in order to prevent any reoccurrence, which meant there was a risk of incidents of this nature occurring again.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks in relation to people were not assessed or planned for. For example, two people were at high risk of developing an infection and both had suffered ill health when they had this infection in the past. Neither had a care plan in place informing staff of this risk, how to reduce this risk or what symptoms they may display if a further infection was developing, to prompt staff to seek advice from the GP. There was an 'acute care plan' put in place after one of these people had suffered ill health from an infection with advice from the GP, This would enable staff to monitor and record the person's fluid intake and output and we saw staff had

done this for a period of time. However the monitoring and recording had stopped after a period of weeks without any advice from the GP that it was safe to do so.
Additionally one of these people was at high risk of falling from their bed and records showed they had fallen from bed twice in the seven months prior to our visit. On one occasion the person, who lived with a dementia related illness, had been found by staff, shuffling on their bottom into the corridor. We asked the manager what action they had taken to ensure staff would be alerted if the person fell from bed and we were told a sensor mat had been purchased and would be fitted imminently, which would alert staff to any fall. However it is of concern that the person had fallen from bed in February 2016 and August 2016 and as of 11 October 2016 the sensor mat was not in place. On the day we visited the person was in bed until lunchtime and we saw they had their legs dangling out of bed for the majority of the morning, which showed the risk of them falling out. Their call bell was tucked behind their headboard and so they would not have been able to summon help from staff if they wanted support to get out of bed.
Another person's care plan contained conflicting information in relation to a risk around choking. The person's care plan stated they should be given a pureed diet but we observed the person was not given a pureed diet on the day we visited. When we spoke with the cook they were not aware of the need for a pureed diet. The deputy manager told us the person should be on a 'fork mashable' diet rather than pureed and said this was due to a risk of choking. However records showed the person was being given food such as biscuits and the care plan was not clear on what food the person should avoid. Advice had not been sought from the Speech and Language Therapy Team (SALT) who are the specialists in determining diets for people at risk of choking.
Prior to our visit the Nottinghamshire County Council told us they had visited the service in September 2016 and had observed some unsafe moving and handling practices. These concerns had been fed back to the provider who had given assurances that this would be addressed. However when we visited we saw this area of concern had not been rectified. We carried out observations of staff supporting people to move around and also found concerns in relation to how this was carried out. We observed one person being supported out of their wheelchair into an armchair and we saw staff placed their arms under the person's arms and physically support the person to stand up. This is called a 'drag lift' and is unsafe practice and placed the person at risk of injury. We observed another person being supported by staff to stand up and we saw staff pushed the person from behind to get them into a standing position, which is not safe practice. On another occasion a staff member was pushing a person in a wheelchair. The staff member was using one hand to control the wheelchair whilst carrying a mug of coffee in the other.
Despite ongoing concerns in relation to infection control in the service we found people were still not being protected from acquiring a social care related infection. We saw the waterproof mattresses on two people's beds were in poor condition and smelled strongly of urine. The waterproof cover on one of these mattresses was in such a poor condition that the cover had perished and urine was able to seep through to the foam. We also found that a third bedroom smelled very strongly of urine and the acting deputy manager told us they were aware of why this was. However action had not been taken to address this.
This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by adequate numbers of staff. One person told us, "They (staff) come pretty quick if I use the buzzer." We observed there were staff available throughout the day and when a person needed assistance or support this was responded to in the timely way. The relatives we spoke with told us they felt there were enough staff employed by the service.

The manager told us there were three care staff planned to be on duty during each day and two care staff at night. In addition there was domestic and kitchen support each day and a maintenance person employed on week days. The manager told us they ensured the required number care staff were provided each shift and if any absence from work could not be covered from within the staff team they would arrange for an

agency member of staff to work that shift.
People told us they received their medicines when they should. One person told us, "They say when they have got to get me some more (medicines) and go off to the chemist shop." Another person told us, "They have a sort of drugs round and bring it to you. They make sure you take it."

We found medicines systems were being managed safely with staff following safe protocols when they administered medicines. Medicines were signed for appropriately and the records tallied with the stocks of medicines in the service which showed people had been given their medicines as prescribed. Staff who were administering medicines had their competency assessed, to ensure they knew how to safely administer and manage medicines, and had received training in how to do this safely.

Inadequate

Is the service effective?

Our findings

The last time we inspected the service we found there were improvements needed in relation to people being supported by inadequately trained staff, people being supported with nutrition and healthcare and the protection of people under the Mental Capacity Act (MCA) 2005. During this inspection we found further concerns in relation to these aspects of care and support which people were receiving.

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.

We found that despite this being an issue at our previous two inspections people were still not protected under the MCA as the provider was not applying the principals of this legislation appropriately. We spoke with three staff about their knowledge of the MCA and two were unclear about the principals of the Act or how it related to the people they were supporting. Records showed that only nine of the 21 staff employed by the provider had received training in relation to the MCA 2005.
We saw that the consultant had implemented capacity assessment forms for aspects of people's support such as medicines and pressure ulcer management, however these were not completed in line with the principals of the MCA. There was no recording of what questions people had been asked in order to assess if they could weigh up and retain the information about these decisions and there was a lack of including the views of relatives or health professionals involved in the decision.
One person who had been assessed as lacking the capacity to make decisions about emergency health care had information in their care plan stating that their relative did not wish the person to have any interventions if their health deteriorated, and did not wish them to be admitted to hospital. However this had not been assessed under the MCA to ensure this decision was in the person's best interests. Additionally this person was regularly refusing medicines, which were important to their physical and mental health. There was an entry in the person's care plan stating that any pattern of refusal should result in an assessment for covert medicines, however this had not been carried out. Covert medicines are medicines given without the person's knowledge in food or fluid when assessed as being in their best interests and agreed with a GP. The acting manager told us and records showed that this was due to a relative stating they did not wish this intervention to be carried out. However this had not been assessed under the MCA to see if this was in the person's best interest not to have covert medicines. This resulted in the person regularly not having medicines which had a detrimental impact on the person's physical and mental health.

This was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). We checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that despite this being an issue at our previous two inspections people were still not protected from the risk of being supported in the least restrictive way. One person had a specialised 'tilt chair' due to a high risk in relation to falls and developing a pressure ulcer. The deputy manager told us at our last inspection that the chair was in place to keep the person safe and stop them from getting up out of the chair. This person lacked capacity to understand this decision and a MCA assessment had been completed to show this decision was in their best interests. However the acting manager had not applied for a DoLS for this person to ensure the restriction placed upon them, preventing them from getting out of the chair was authorised as the least restrictive method of minimising these risks.

The acting manager had sent applications for some people who used the service where it was felt they may have restrictions placed upon them which would be a deprivation of their liberty. However the forms did not always give information which would be required by the local authority assessment team. For example the deputy manager had made a DoLS application for one person, who lived with a dementia related illness. This person was resistive to personal care but needed care to be delivered in their best interests to ensure their wellbeing. The acting manager had not mentioned the person's resistance to personal care on the application. Additionally the person's resistance to personal care was not detailed in their care plan and so there was no guidance for staff on how to respond to this in the least restrictive way. Staff told us the person was resistive to personal care and we heard the person screaming and resisting care when staff were supporting them.
Another person sometimes communicated through their behaviour and a member of staff told us how they had identified certain practices had worked effectively in supporting this person. The staff member said other staff may also be aware of this but they had not made a point of passing these practices on to other staff. The staff member said they did not know if these had been included in the person's care plan, which we found had not been when we looked.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive support to make sure they had enough to eat and drink. We observed some of the morning breakfast meal and saw people were provided with hot drinks, cereals and toast, however there was a lack of organisation and positive mealtime experience to encourage people to eat well. For example there were six people using four tables, with two people being sat on a table to themselves and facing away from other people. People were sat for long periods of time waiting to be given a drink or something to eat and we saw one person was brought some toast with a fresh cup of coffee as there previous one had gone cold. At times the cook was involved in supporting people which prevented them from applying their attention to the serving of the meal. For example at one point they were asked to remain in the dining area to watch people whilst care staff went about other tasks. Later in the day we observed a person, who needed a lot of support from staff, trying to pick their cup up in to get a drink. They tried and failed to pick the cup up for a period of 15 minutes before a member of staff noticed and supported them with their drink, despite there being two staff in the area during this time.

The care plan of one person showed they had been losing weight and gave guidance for staff on how to minimise the risk of them losing further weight. The care plan asked that staff ensured they had regular snacks and was prompted with meals. On the day we visited we observed this person was in bed until 11.45am and was not given any food or fluid during this time. Staff assisted the person to get up and took them into the dining room at 12.30pm, at which point the person had a drink and a meal. According to

records the last time the person had food or fluids was 5.30pm the previous night. Another person had a care plan in place which stated they were at risk of weight gain, which was unhealthy for them, and the care plan stated a gain of 3KG within a three month period should be acted on and reported to the GP. We saw the person had a recent 5KG gain in the space of a month and this had not been acted on or reported to the GP.

This was an ongoing breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were still being supported by staff who did not have the skills and knowledge they needed to support people safely. Prior to our inspection we received information of concern in relation to how one person had been supported with an ongoing health condition and the health professionals involved described staff as not having the skills and knowledge to support this person with their health condition. This had resulted in the person being admitted to hospital. During our visit we spoke with a visiting health professional and asked them what improvements the service needed to make and they told us the training needed to improve. We also observed staff practice and saw that safe moving and handling practices were not always adhered to.

Records showed that staff training had increased but some staff were still working without the required training and the provider did not have systems in place to assess if the training was effective. Training was provided through a mixture of on line training and face to face training. Staff were able to complete the on line training at the service or from their own home. The manager told us they received an email confirming when staff had completed any of the online courses. However they did not have any procedure to check the staff member had been the person who completed this training and there was no follow up discussion with staff to see if they would, or had, implemented this training into their practice. The manager said staff were paid for those courses they completed at home which a staff member confirmed they had been.

Staff spoke of some of the training they had completed recently. One staff member said they had finished nearly all of their eLearning. Staff training records for this staff member confirmed this was the case, however there were some other staff who had not completed any or very little of this training. Two staff told us they had been unable to complete any of the eLearning training because they had not yet been able to access the training website as they did not have working access details. Both staff members said they had requested a log in and they did not know why they had not been given one.

The training matrix showed there were a number of staff still had training in a number of areas to complete. Following the visit the consult sent us an email with an updated training matrix saying, "More certificates for training that took place in September have been found so I have updated the training matrix to include them." However there were still gaps in the training that staff had completed, for example out of 21 staff eight staff had not completed training in relation to safeguarding people from abuse, five had not completed training in infection control and no staff had received training in supporting people with nutrition. The acting manager had not received any training in relation to fire safety and had not received training in safeguarding people from abuse since 2014, despite the providers training matrix stating this should be done annually.

There were eight staff listed on the training matrix as having completed the Care Certificate. There were no certificates available to evidence this or any of the work books that need to be completed as part of this training. We spoke with one staff member on duty who was recorded on the training matrix as having completed this training. They were initially unable to recall this training, and when they were given some details about this they were only able to speak vaguely about it, which could indicate a lack of

understanding about the training.

This was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People who used the service and relatives we spoke with commented positively on the staff with one person saying, "Everyone is so very nice." One relative told us, "I have no concerns about the staff, I think they are great." Another relative told us, "The staff team are friendly, the cook is really nice." We spoke with a visiting health professional and they told us, "Staff are really trying to make improvements." We saw some staff had attended training sessions held at the service, these included moving and positioning, caring for people with dementia and managing challenging behaviour. The manager told us a further course on caring for people with dementia was planned for later in the week where some more staff would attend this training.

People told us that staff supported them when they were ill. One person told us, "They (staff) are sensitive if you are not well, in some cases they sense you are not well, they notice something is up, that's sensitive of them." Staff we spoke with were able to provide an overview of some people's health conditions and the support they needed. They were aware of potential risks and what monitoring was carried out as well as what action they would need to take in the event of an emergency. Staff were also able to describe the support they gave to a person to manage a physical need they required staff to undertake. One staff member told us they had been provided with training for this by a district nurse.

People we spoke with who had the capacity to make decisions told us they felt staff supported them with this. One person told us, "They don't decide things without asking you."

Inadequate

Is the service responsive?

Our findings

The last time we inspected the service we found there were improvements needed in relation to people having their support needs assessed and planned for to ensure they were cared for safely. During this inspection we remained concerned about this.

People we spoke with told us they were happy in the service and relatives also said they did not have any concerns about the quality of care their relation was receiving. One relative told us, "They (staff) have done a great job of looking after [relation]." However our findings did not reflect what people had told us and we continued to be concerned at the risk people were placed at due to a lack of effective assessment and planning of care. Although the provider told us in the PIR that they reviewed care plans and risk assessments regularly to ensure that they remained appropriate and effective, during this visit we again found issues with the same care plans that we had concerns about when we inspected in January 2016 and again in April 2016. The care plans had been updated but still did not to include all aspects of people's current needs in order to provide staff with the information they needed to support people safely.

People could not be assured they would receive the care they required. There were new 'care plan overviews' designed to give staff a snapshot of people's primary needs. However these were not comprehensive and did not include all primary needs such as one person was high risk of falls and developing an infection but these were not included. Another person was at high risk of developing a urine infection and had recently been in hospital with acute kidney injury but this was not included on the overview and there was no care plan in place for this risk. Staff we spoke with told us they had not read all of people's care plans, or even the overview of the care plan that had been prepared for each person. One staff member told us they had read some care plans and the overview care plan. They told us this was helpful as they then had an overview of people's needs and the overview care plan gave them a quick reference point if they were unsure of anything.

We saw there were three people who had been assessed as being at high risk of developing pressure ulcers and were not supported with the risks in relation to this. External healthcare professionals had recommended these three people should be given support to reposition one to two hourly during the day and two to four hourly during the night and this was reflected in each person's care plan. However records showed this was not happening and so these three people were placed at risk of developing a pressure ulcer. Additionally one of these people was now being cared for in bed, which would increase the risk of them developing a pressure ulcer, and yet the assessment of risk around them developing a pressure ulcer had not been reviewed for almost two months and prior to when they were being cared for in bed.
We saw that risks in relation to people's care and support were still not being assessed and planned for safely. A care plan had been implemented for one person in relation to a health condition, which was a contributory factor to the person having outbursts of challenging behaviour. However the plan was not detailed enough, stating the health condition was a contributing factor to their behaviour and should be 'managed effectively'. Records showed this health condition was not being managed effectively and staff were not taking the appropriate action to respond to this. The care plan did not specify at what point staff should seek advice. This person had been assessed by external professionals in relation to their mobility and

they had recommended regular chair exercises be done with the person to try and increase their mobility. This had been added to their care plan but we found the person was not being regularly supported to do the exercises. We checked the person's care records and staff were not recording any exercises and when we asked a member of staff about this they were not aware of the need for any exercises.

This was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care that was poorly planned and disorganised. We carried out observations in the service and during the morning of our visit we saw two staff who were entering and leaving a bathroom, in which they were supporting a person to have a bath. We looked at the person's care plan, which stated the person needed to be supported by two staff to assist with their mobility, and ensure their safety. It was written in the person's care plan that staff should, 'Ensure they have all the resources (i.e. soap, flannel, towel etc.) to hand before supporting [name] with personal hygiene.' We saw that both staff left the bathroom on separate occasions to collect resources they had not taken to the bathroom in advance. We also saw one of the staff assisted another staff member support a different person with a mobility transfer, and then was asked to remain in the lounge whist the other staff member went to carry out a different task. This meant the person who needed two staff to ensure their safety in the bathroom was left for some time with only one member of staff present. That staff member later told us the person had been sat on the toilet and was still attached to the straps leading to the stand aid, a piece of mobility equipment they needed throughout this time.

We later saw another person was taken to the toilet by two staff. A third member of staff then swapped with one of these staff to apply some cream and then swapped back again. This meant the person had different members of staff entering and leaving the bathroom whilst being supported with care of a personal nature. Opportunities for people to follow their hobbies and interest were being developed and some had been implemented. One relative told us, "Activities have improved tremendously." We spoke with people about the activities offered and one person told us, "There is always something going on, it is just a question if it suits." Another said, "I will fit in with most things, like playing games." We observed people taking part in activities during the visit which included drawing, playing games, looking at books, listening to music and a film was put on in the afternoon.

Staff told us some people preferred individual activities which were provided. They also spoke of 'pampering' and we saw one person had recently had their nails painted. Several staff referred to a recent activity that had been well received and involved a number of fairground type activities. There had also been a recent sports day held. There were pictures made in and photographs of recent activities displayed in communal areas. The acting manager told us the deputy manager was trying a lot of different activities and games to see which people enjoyed and would like to take place on a regular basis.

People we spoke with told us they felt able to raise concerns if they needed to. One person told us, "They (staff) are open to discussion." Another person told us, "I would just complain, but there is not a need for it in my case." Relatives also told us they would feel comfortable raising a concern. We saw that a copy of the complaints procedure had been displayed in the reception area of the service.

The acting deputy manager told us there had not been any complaints since we inspected the service in April 2016 and so we were unable to assess if the service responded to concerns appropriately. However there was a complaints procedure in the office with forms to records any complaints received and staff were aware of the need to record and act on concerns raised.

Inadequate

Is the service well-led?

Our findings

The last time we inspected the service we found there were improvements needed in relation to the provider's lack of effective systems in place to monitor the quality and safety of the service. The lack of effective systems had led to negative outcomes for some people who used the service. During this inspection we continued to be concerned about the care people were receiving and the systems in place to identify to develop and improve the service, based on the needs of the people who used it.

There has not been a registered manager in post since September 2015. There was an acting manager in post and the provider told us in their action plan that the acting manager would commence the process of registering with us by 16 February 2016. At the time of our visit we had not received this application. A condition of the registration is that there should be a registered manager in post. We will continue to monitor this.

The provider still had a consultant working with them to implement an effective monitoring system to identify and bring about the improvements required. However we found that many aspects of improvements we had asked for had not been addressed. The consultant, acting on behalf of the provider, told us they would send us an update of the action plan each month. However they had not sent an update of the action plan since June 2016.

During this inspection we found that the provider and consultant had not made all of the improvements they told us they would in the most recent update of the action plan. For example the provider told us that by on 18 March 2016 they had completed actions in relation to ensuring that mental capacity assessments had been completed along with best interest's decision making. Evidence we found during this visit showed that this had not been completed in line with the MCA 2005. They told us that by 31 March 2016 a comprehensive care plan would be in place for all of the people using the service and that a review of care plans would be undertaken to ensure that they reflected individual needs. Evidence we found during this visit showed this had not been completed effectively.

The action plan stated that a robust quality assurance toolkit would be introduced by 16 June 2016 to be introduced to ensure the safeness and effectiveness of the service and to provide ongoing monthly auditing of the entire home. The provider also told us in the PIR that they had recently introduced new audits which were conducted by the auditor to map the 'lived experience' for individuals who live at the home. However we saw that the audits implemented had not been carried out as planned. For example a monthly home audit was carried out by the consultant and the deputy manager in July 2016 and had not been carried out since. This audit covered all aspects of the service but did not identify the issues we found during our visit. There was also a catering audit and an infection control audit carried in July 2016 which should have been carried out monthly but have not been. Both of these audits carried out in July had an action plan in place but not all of the actions had been completed, despite the timescales expiring. For example the kitchen was supposed to be re-painted, a spillage kit was to be ordered and kitchen staff were to be trained in fire procedures. None of these had been completed at the time we visited. The infection control audit had not identified the many gaps we saw on the cleaning schedules and had not identified two pressure relieving

mattresses which were in a poor state. This showed that the registered provider was not making the improvements they told us they would and did not provide us with assurances that improvements would be made.

Despite the provider telling us in their action plan that they implemented systems in February 2016, to support and coach staff and management on when to make appropriate referrals to other professionals and also telling us they would audit this, the provider was still not notifying us of events in the service. There had been two incidents where people who used the service had sustained an injury whilst being supported by staff, one of which the acting manager had referred to the local authority safeguarding adult's team for consideration under safeguarding procedures. There had also been two incidents where one person who used the service had hit another person. We were not notified of any of these incidents.

Cleaning schedules were being used in the service, however we saw there were frequent gaps in the cleaning schedules used by staff to show they had cleaned areas of the service and the schedules did not specify toilets in people's bedrooms, pressure mattresses or cushions needed to be cleaned. Medicines audits had been implemented and these were identifying issues in relation to medicines and bringing about improvements, however the audits had not identified that the records kept to monitor the medicines fridge temperatures were flagging that the temperature was consistently higher than the safe recommended levels.

There had been meetings held for people who used the service, however at the most recent meeting people had said they did not wish these to continue as if they had any issues they could raise them there and then with staff. The acting manager told us there had not been any surveys sent to people or their relatives to seek their views of the service and no alternative means of gathering the views of people on the quality of the service were in place.

This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and relatives we spoke with described the acting manager as approachable and helpful. One person told us, "Very good, [acting manager] is very nice. She is aware of what is going on." One relative described receiving regular updates from the acting manager and told us they felt more included and that communication was better. Another relative told us they felt the manager was, "Very good."

Staff described the acting manager and deputy manager as approachable and said they would sort out any problems. A recently employed member of staff told us they had been told about our concerns when they had attended their interview and felt the manager had been open and honest about the situation. Staff told us they now had the opportunity to attend regular meetings where they could give their opinions of how the service could improve.

Relatives and staff we spoke with spoke about improvements to the environment and how hard staff were working to try and make improvements. Staff spoke of things being better with the environment, staffing levels and provision of activities. One staff member said, "Everyone is really trying to make everything right." A relative told us, "It has improved no end, there are new beds and carpets and improvements to the environment." We found there had been continued improvements in relation to the environment with additional assisted bathrooms made available for people to use. The redecoration of some bedrooms had been carried out and new flooring had been laid in some areas of the service. We saw there were regular checks made in relation to the safety of the environment and the service was being regularly maintained.

Additional cleaning staff had been employed to ensure there were cleaning staff working in the service seven days a week.

There was a diary in the entrance area for anyone to record any compliments in. We saw there had been 10 compliments made since our last visit in April 2016. These were made by relatives and complemented the service on people's care and appearance as well as enjoying activities and the cleanliness and decor of the home. There was a monthly newsletter displayed and given to relatives. This informed people about events that had taken place and of those planned in the future.