Mr Paul Nicholas Mould

Quarry Bank Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 3 and 10 September 2018. Both days were unannounced.

At the last inspection on 13 July 2017, we rated the service as 'Requires Improvement' and we asked the provider to take action to make improvements in relation to safe care and good governance. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe and well-led to at least good. During this inspection we found improvements had not been made and there were shortfalls in other areas which resulted in breaches to five regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Quarry Bank Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide personal care and accommodation for up to 23 older people, including those living with dementia. At the time of our inspection there were 19 people living at the home.

The service is required to have a registered manager in post. A registered manager is a person who has registered with CQC 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. At the time of the inspection there was no registered manager in place. The provider had contacted CQC to inform us that the registered manager had taken some time off work and there was an acting manager in post.

Serious infection control concerns were identified and measures were not sufficient to prevent the risk to people of infections spreading. The service was poorly maintained and action was required to ensure people lived in an environment that safely met their needs. Measures required to reduce the risk of harm to people were not always in place. We were concerned about the provision of fire safety within the building as staff had not completed a fire drill, some staff did not know where the evacuation point was and the personal emergency evacuation plan (PEEP) did not reflect all people currently within the service.

The provider and management team had completed minimal checks on the quality of care provided. When governance systems were in place, they failed to record actions or drive forward improvements. The checks had not picked up on the shortfalls identified during the inspection.

Medicine procedures and systems were not robust, staff were not trained or had their competency check to ensure safe practices were in place. Improvements were required in relation to protocols and risk assessments relating to medicines to ensure that medicine practices were safe.

Staff were not sufficiently trained or supported to enable them to fully understand their role. Staff had a basic understanding of how to safeguard people from abuse. We have made a recommendation about

improving the meal time experience for people.

Care records failed to demonstrate that the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied. A lack of monitoring of DoLS applications resulted in no valid DoLS being in place for people who required them. The service had not completed any best interest's meetings when making decisions for those people who lacked capacity.

People's nutrition and hydration needs were catered for however, people's provision of choice needed to be improved at meal times.

Some staff demonstrated knowledge of people and this helped them to provide some person-centred care. However, staff were heavily reliant on the support of the acting manager at times when people could be distressed.

Care plan's failed to reflect people's current needs and risks. Poor behaviour management plans placed staff and people at risk within the service. Accidents and incidents were not reviewed or monitored for trends and reoccurrences. Lessons learnt were not considered.

The meeting of people's wider needs could be improved through the provision of more meaningful activities that are monitored and reviewed. There was limited access to activities within the home for people who would also benefit from access to a safe and secure garden.

Recruitment processes were in place but these needed to be more robust. We made a recommendation about ensuring safe recruitment practices were followed.

Relatives we spoke with provided mixed feedback about the service. Professionals gave positive feedback about the care that staff provided to people.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

We found multiple concerns and are considering our regulatory response. 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 not safe.

People were exposed to a serious risk of infection and environmental risks within the service.

Medication processes were not robust. Protocols and guidance was not in place to assist staff in ensuring the safe administration of medicines.

Staff were insufficiently trained or supported to enable them to fully understand their role. Recruitment processes in place needed to be more robust.

Risk had not been managed effectively, which had placed people who used the service at risk of harm and injury.

Is the service effective?

Inadequate

The service was not effective.

Improvements were needed to the premises to ensure people lived within a well-maintained environment that met their needs.

Staff training was not up to date and some staff lacked essential knowledge to enable them to support people effectively. Staff were not appropriately supported in their role through regular supervision and appraisals.

People's mealtime experience required improvement to ensure that people were supported to have choice. follow best practice.

People who lacked capacity had not had their rights upheld under the Mental Capacity Act. There were no best interest decisions and no valid DoLS in place for people who required them.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with respect, but we observed that staff did not always treat people in a way that preserved their privacy and dignity.

Communication with people needed to be improved through the provision of better care planning and training for staff.

People, their relatives and professionals spoke positively about the caring nature of the staff team.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not updated to reflect people's change in needs and they lacked detail which promoted person-centred care.

The service failed to provide meaningful activities to meet the wider needs of people.

There was a complaints policy and procedure in place, but the service failed keep a log of complaints and their actions taken.

Is the service well-led?

Inadequate

The service was not well-led

An effective quality assurance system was not in place. This had led to breaches of multiple regulations. Audits conducted had not been robust and action plans were not in place to drive continuous improvements to the service.

People, their relatives and staff were not provided regular opportunities to be involved in decisions about the service or offer feedback. When feedback was obtained the provider failed to act to address concerns raised

An acting manager was in post due to the registered managers absence. The provider had informed CQC of the registered managers absence from the service.

Quarry Bank 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 checked 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 was a comprehensive inspection that took place on 3 and 10 September 2018. Both days were unannounced. The inspection team consisted of one inspector and one assistant inspector on the first day. The second day consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. We used information the provider sent us in the Provider Information Return. 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 reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales.

We sought feedback from the local authority commissioning and safeguarding teams.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. We spoke with three people who lived at the service, two visitors, four care staff, one cleaner, one chef, the acting manager and the provider. We spoke with four visiting professionals and an infection control nurse who we invited to the service for part of the second day of inspection. We were unable to use our Short Observational Framework for Inspection (SOFI) during the inspection due to the environment and people's distress around strangers within the service. SOFI is a way of observing care to

help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records in full, containing care planning documentation and daily records. We also looked at documents in 13 other people's care records. We viewed the records for four staff relating to their recruitment, supervision and appraisal. We viewed records relating to the management of the service, including any audit checks, surveys and the provider's policies and procedures. We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2017, we found people were not being protected against the risk of unsafe care, particularly in relation to infection prevention and control. We concluded this demonstrated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection, we found improvements had not been made and there had been deterioration in other areas.

During both days of inspection, serious infection control concerns were identified which placed people at risk, as detailed below. The law requires that the registered person must have regard to the Code of Practice on prevention and control of infections, and related guidance, issued by the Department of Health. The examples below evidenced a failure to comply with the code.

We found mattresses and mattress bases that were stained. One bed had been remade with sheets that were stained with faeces. We found chair cushions that were saturated in urine, covered in mould, stained and covered in dry faeces. Bedding in all rooms was old, faded and had holes/rips in them. There were faeces on the floor in a bedroom and all commodes were rusty and dirty. All chairs within communal spaces had rips/cuts and chips on, not allowing for effective cleaning. Carpets throughout the whole building were stained and smelt. Flooring within all bathrooms and toilets were inadequate to allow for effective cleaning as they contained holes and rips and were not sealed at the edges. General dirt and dust was identified throughout the building. There were no cleaning schedules in place.

Systems and processes were inadequate to ensure people's laundry was clean and free from the risks associated with cross infection. The laundry room was unorganised and unclean and failed to separate 'clean' and 'dirty' areas. The macerator (a device where incontinence products are shredded into fine particles and then discharged into the sewerage system) was stored in the laundry close to areas where clean clothing and bedding was. It had the lid open containing used incontinence aids and faeces was on the outside of the machine. Used incontinence aids were found in bins that were not sealed or had lids on, in places that people could access them. Not all staff were bare below the elbows, this included kitchen staff who were wearing rings and nail varnish. This posed a risk of cross contamination. Soap, sanitizer and paper towels were not available in some bathrooms, toilets and bedrooms for the duration of the inspection to support effective standards of hand hygiene.

CQC's concerns regarding infection control were shared after the first day of the inspection with the acting manager, however, no action had been taken to address these concerns by the second day of inspection, which was one week later.

We found serious concerns about the management of fire safety within the service. We have made the local fire service aware of our concerns. The service did not complete regular fire drills to ensure that all staff and people knew what to do in the event of a fire. Some staff were unsure of where the evacuation point was. All people should have a PEEP in place. PEEP's are tailor-made to secure the safety of a specific person in the

event of an emergency evacuation and must be drawn up for that individual so that the method of evacuation can be agreed. We were shown the service's current PEEP that was in place for the whole service. This document was not up to date. Seven people were not included on the list, six people were included but were recorded as being in an incorrect bedroom. This exposed those people to the risk of not receiving the care and support they would require in an emergency. Although our concerns were shared, when we returned on the second day of inspection, this document had still not been updated.

People and staff were at risk of harm due to poor behaviour management plans. Care plans failed to identify any potential triggers, strategies, when to administer medicines or when to access additional support from other agencies at times of people's distress. This meant appropriate guidance was not in place to manage people's behaviours or prevent their reoccurrence.

Only one person in the service had bedrails in place. They did not have a risk assessment for this and no checks had been completed on this bedrail which placed the person at risk of harm. The acting manager advised these would be implemented immediately.

The service made decisions based on risk, that were not risk assessed. For example, we identified three bedrooms that had the water turned off to the wash hand basins. This affected people and staff's ability to wash their hands. We were told that this was due to the person within that bedroom having a history of flooding the room. However, when we checked the care plan records there was no risk assessment or care plan record in relation to the risk of this person causing a flood.

The systems for administering medicines were not robust. Staff had not received training or had their competency checked before administering medicines. A lack of competency could lead to errors in the administration of medicines, including people not receiving their medicines as prescribed.

We found a number of people had been prescribed 'as required' medicines, however, there were no protocol's in place to advise staff when to administer the medicine. People who received their medicines covertly had no covert plans in place directing staff on when and how to administer this medicine. Failing to ensure appropriate guidance is in place could lead to people being over medicated, overdosed, being administered when not required and in an inconsistent way.

Care plans failed to identify risks of taking medication, such as blood thinning medicines, for some people. People with diabetes had no plan in place regarding this condition. Not all staff were aware of all people who had diabetes.

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

We identified areas of the premises and some equipment that were not safely maintained. We found broken and missing radiator covers in communal spaces and bedrooms. A window that did not close as the window latch was missing and the window in the dining room had a hole through the glass. The acting manager stated that maintenance for this window was being arranged. However, it had not been addressed by our return visit one week later. There were holes in flooring of the staff toilet. Some carpets were not fitted. This created a trip hazard for people within the service. Two light fittings in the downstairs toilet required refitting to the ceiling to make safe.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for four care staff. These evidenced that a Disclosure and Barring Service (DBS) check was in place prior them starting work. The DBS carry out a criminal record and barring check to help employers make safer recruiting decisions. Recruitment paperwork was not robust. Some people had not had their employment history explored, some files did not contain copies of identification and not everyone had two references from a previous employer.

We recommend that the provider seeks guidance from a reliable source regarding safe recruitment practices.

The registered provider had a system in place to record accidents and incidents. However, we found there was a lack of recording to demonstrate any actions taken or any lessons learnt following incidents and accidents. This exposed people within the service to continued or increased risks.

Maintenance records showed safety checks and servicing had been completed on the gas supply system, hoists and slings, the passenger lift and the electrical installation. We found there were plans in place to respond to any emergencies that might arise.

Safeguarding and whistleblowing (telling someone) policies were in place at the service and staff we spoke with demonstrated basic knowledge of what to do if they had concerns.

Inadequate

Is the service effective?

Our findings

We found the service's premises and equipment were poorly maintained. We identified cracks in ceilings and a number of wooden window frames that were flaking and required maintenance. Decoration throughout the building required attention. All door frames, doors and walls had paintwork that was badly chipped. Wallpaper was visibly peeling away from walls in bedrooms. Furniture in people's bedrooms was chipped, broken and had handles missing. Walls were stained in bedrooms and one bedroom wall had writing on it which we were advised by the acting manager 'had been there weeks.'

As we looked around the service it was clear to see that the outside environment did not support the needs of people living with dementia. The property was next to a main road and the garden was not secure. It was open plan with no security for those people living with dementia who would be unable to manage their personal safety if they went out alone. All pathways were gravel which would make it difficult for people with reduced mobility to walk over.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not sufficiently trained or supported to carry out their role effectively. On speaking with staff some had not attended any training and others hadn't attended training in a long time (years) since working at the service. Some staff confirmed they had not attended mental health, dementia, challenging behaviour or Mental Capacity Act training. These were training needs requirements due to the care needs of people who were using the service. We requested a copy of the services training matrix but were advised that the acting manager did not have access to this. The provider advised us that the training matrix was not up to date and they would send one to us after the inspection.

Records showed that staff supervision meetings had not been held in line with the provider's policy of every two months. There were no records of any annual appraisals and this was confirmed by the acting manager and staff that we spoke with. Staff told us they felt supported by management but hadn't had supervisions. "No I don't have supervisions. If I wanted to I could come and have a word. I don't attend staff meetings, unless I need to. Actually, I'm not sure if they take place."

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans we reviewed failed to clearly identify people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack 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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Monitoring of the DoLS expiry dates was not completed and this had resulted in all authorisations being out of date with no applications to renew completed. People who had recently moved into the service, who potentially met the criteria for a DoLS had not had one applied for. One person had moved into the service in April 2018 yet the application had still not been made at the time of the inspection. This meant that people were being unlawfully deprived of their liberty.

We found that care plans failed to reflect the principles of the MCA and some capacity assessments were not fully completed and left incomplete for over two years. The service had failed to carry out best interest's decisions when required. Three people could receive their medicines covertly. Although there was a letter from a GP confirming this in their care files, there was no records of any best interest's meetings in place. One person had a bed rail in place, they didn't have capacity to consent to this, but no best interest decision had been recorded. On speaking with the acting manager, we were advised that the service had not conducted any best interest meetings or decisions for any people within their service.

This failure to act within the legal principles of the Mental Capacity Act means that people's rights were not being protected under this Act.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the dining room experience during the first day of inspection. We observed people eating in the main dining room. Where people required assistance from staff to eat and drink, this was provided. People who used the service gave positive feedback about the food they received. Their comments included, "Yes, all the food is nice here. At the same time of day, they ask me what I want for tea. They would change it for me if I didn't want that."

We observed people were not asked or encouraged to choose what they wanted to eat, there was no menu displayed and people with dementia were not shown food options. People were not given the opportunity to make an informed choice. Staff told us, "If people can't choose, we pick the healthiest or most filling option for them."

We recommend that the service seeks advice and guidance from a reputable source, about best practice in relation to meal time experiences.

Records showed a range of healthcare professionals were involved in the care and treatment of people who used the service. We saw contact in care plans relating to the community mental health team and speech and language therapists. Health care professionals confirmed they were contacted by the service. Comments from them included, "We are contacted when needed. We don't hear much from them, which tends to mean they are managing people's needs."

Requires Improvement

Is the service caring?

Our findings

We found that people's dignity was not promoted or respected at all times. When speaking with staff they were only able to provide us with limited examples of how they respected people's dignity. Their responses included "We speak quietly about the bathroom and make sure that we shut the door." We observed staff that did not always respect people's privacy by knocking on resident's doors before entering rooms. Staff told us that they had not attended any dignity training.

We identified during the inspection that the all communal toilet doors and bedrooms didn't have locks on them. The acting manager advised it was because people locked themselves in. We witnessed during the inspection one person accessing the toilet independently and the door becoming open whilst they were using the toilet. This compromised the person's dignity. The service had failed to consider alternatives whilst the locks were absent such an, 'in use' sign that could be displayed on the toilet door. People's right to privacy was encroached through being unable to lock their own bedroom door.

We observed that staff were mostly effective in communicating with people, however, they needed a lot of support from the acting manager with encouragement and guidance. Throughout the inspection, staff sought frequent support from the acting manager to assist them in communicating with people during times when they could become distressed. A lack of clear instruction within care plans regarding communication with people meant staff needed to access this guidance from the acting manager on a regular basis.

There was no information regarding advocacy services in the building. We asked one member of staff if anyone had an advocate in place and they didn't know what an advocate was. Advocates provide independent support to help ensure that people's views and preferences are heard. After we explained, the staff member told us that they didn't think anyone in the service had an advocate in place.

People who used the service spoke positively about the staff. Comments included, "They are lovely staff here, all very kind." Relatives told us, "Yes, staff are kind and caring" and "Staff can interact fairly well with [name of person]. They manage to calm them down." Professional visitors to the service did not have any negative comments about staff approach.

We asked staff about how they promoted people's independence. Staff told us, "We encourage them to do things for themselves that we know they can do." Care plans reflected people's independence and recorded what actions some people needed support with and where people could undertake tasks for themselves.

People's friends and relatives were welcome to visit, there were no restrictions to the amount of time they could spend at the service. A relative we spoke with said, "I am made to feel welcome." Staff told us, "Visitors always get a greeting from us when they arrive. We offer them drinks. We ask if they want to go to private area. There are no restrictions on visitors, but normally they don't come at meal times."

People's cultural and religious needs were considered when care plans were being developed. Information

about people's religious beliefs was included within the care plan.

People's records were stored securely and access was limited to staff who required the information to carry out their roles. Staff understood the need to maintain people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

The provider had a complaints policy and procedure in place. We asked to see the complaints log but we were told by the provider that there wasn't one. The service had failed to keep a log of complaints received and how the service had responded to these. People told us they felt they knew who to speak to if they had a complaint. One person told us, "I would speak to [name of provider], I see them sat in their office." One relative told us, "If I have any concerns I speak to the previous manager or the acting manager, but they just say, 'we do our best'."

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

A pre-admission assessment was completed by the manager before people moved into the service. This was not sufficiently detailed to advise staff of people's needs when they first arrived at the service.

Care plans contained basic information and although monthly reviews were recorded there was minimal evidence of care plans being updated or developed when people's needs changed. The plans included information about people's individual needs, such as; communication, incontinence, skin integrity, moving and handling, personal care and nutrition. We found that care plans were not always person centred as they had failed to reflect people's individual preferences around their care support. We found staff recording in daily notes to be repetitive and failed to accurately reflect how care was provided in line with the person's care plan.

The provider's expectation was that reviews of care plans would take place monthly. We found some gaps in this over the last year. For one person, their mobility care plan had not been reviewed since May 2018. During this time their mobility had changed significantly and this had failed to be captured within the care plan. Another person had a bed rail in place yet this was not reflected anywhere within the care plan. We identified another person whose care plan in relation to aggression and behaviour did not reflect what was being described in the person's daily notes. The care plan had not been reviewed and updated to capture the current needs of that person.

When reviews had taken place, this involved a signature to confirm the person's needs remained the same. Although the person's needs may have remained the same, we found that clear opportunities had been missed to update the care plan with more knowledge and understanding of that person, which would have provided a more update to date, effective and person-centred care plan.

Relatives we spoke with during the inspection told us they had not been involved in the creation of the care plan or any reviews in their family member's care. This was confirmed by the acting manager who advised that they do not invite relatives or other significant parties to reviews. Families and friends are often the people who know the person best and failing to involve them in care plans or reviews can result in key person-centred information being missed and not reflected in the person's plan of care.

The service was failing to meet people's wider needs through the provision of regular activities. Activities were recorded as being sporadic. The only records shown were contained in the diary which documented activities on various days that included TV, newspapers, music and film. The service had also recently engaged an external group to deliver a movement session and the acting manager told us this was booked for every five weeks. There was no formal recording of activities and their outcomes. The service failed to monitor or reflect on what activities people enjoyed and what outcomes they were achieving. Although we identified people within the service who walked with purpose, there was no safe outside space for people to access. There were no rummage boxes in communal areas and people did not have access to items which would distract them. A rummage box is a container filled with familiar items as a means of reminiscence.

A relative told us of other activities that took place in the service, they said, "Last week there was a karaoke session, that comes once a month and one Friday there was bingo, but I don't know how often that is."

Staff told us they felt that enough activities took place, Comments included, "Yes, there is enough activities. We do bingo, painting and crafts, chair football jigsaws and dominoes. The care staff do this. We try do them every day but sometimes people don't want to do them."

The Accessible Information Standard is a framework put in place by the National Health Service (NHS) from August 2016, making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We asked the acting manager what they understood about the Accessible Information Standard. The acting manager confirmed they didn't know what this was.

There was the option within people's care plan to record their end of life preferences. We saw some people had completed this. On discussion with staff, some had good knowledge of how to support people receiving end of life. However, staff had not received training in end of life care and therefore were insufficiently trained to facilitate discussions with people in this area.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2017, we found the provider was not effectively monitoring the standard of the service provided and made a recommendation to make improvements. At this inspection the provider had not completed the improvements needed. We also found continued concerns in relation to safe care and new concerns with person centred care, consent to care, premises and equipment and staffing.

We found there was a lack of systems and processes in place to ensure people received a good standard of care and compliance with the requirements. Despite the concerns identified in our last inspection two inspections, in July 2017 and June 2016, in relation to infection control and lack of managerial oversight and good governance, there continued to be no improvement in these areas.

Issues we had identified at the inspection had not been identified through a quality assurance system. We found quality audits were minimal and failed to record actions or drive forward any improvements. This demonstrated a lack of management oversight and a failure to assess, monitor and improve the quality and safety of the service provided.

For example, we reviewed the only two audits completed on infection control/prevention since our last inspection in July 2017. The first audit completed October 2017 showed that questions in relation to the standards in people's bedrooms were not answered. No actions were identified or recorded as part of this audit. The second audit completed in July 2018, identified shortfalls in relation to expected standards. Although shortfalls had been identified, no dates to be completed by were recorded in the July audit and no review of this audit and its progress had occurred. It had not been signed by the manager where it stated it should be. No action had been taken following these audits. Therefore, although concerns in standards of infection control had been identified, the provider, had failed to take action to address these placing people within the service at risk of infection.

We reviewed the only two medication audits that had been completed since our last inspection. We found that both audits highlighted the exact same areas that were not compliant, evidencing that they were not driving forward or sustaining improvements. Both audits failed to identify the concerns that we found during inspection in relation to medicine administration. The service did not have effective or robust audit procedures in place to ensure that medicine was administered safely.

There were no health and safety, care plan, kitchen, or environment audits completed by the previous manager, the acting manager or the provider. Kitchen records to support safe management of food had not been completed since July 2018 and the records to be reviewed and signed by a manager had not been completed. This demonstrated a clear lack of oversight.

There were no records of staff meetings, resident's meetings or relative's meetings. We spoke with two relatives during the inspection who confirmed that they had not been invited to attend any meetings. The acting manager confirmed that no staff or residents had taken place 'that they were aware of' and staff we spoke with confirmed that they had not attended a team meeting.

We were provided with copies of surveys returned from families and professionals that had been sent out earlier this year. Feedback had been received from three professionals. All responses in relation to the decoration of the service were negative, for example, 'carpets need cleaning/changing', 'dated and weary' and 'strong smell of urine throughout'. Despite this opinion being sought, no action had been identified or taken as a result of the feedback. A failure to seek and act on feedback from relevant persons demonstrates a lack of commitment to continually evaluate and improve on the service.

Record keeping within the service was not robust. The provider and manager were failing to ensure that accurate and complete records of care were being maintained for each person who used the service. Safety checks of bed rails and mattresses were not in place.

We found that although staff felt supported by the acting manager there had been a lack of consistent supervision and development of the staff team which not been identified by the provider. There were no systems in place for provider oversight of the supervision or appraisal systems. Gaps in knowledge and skills had impacted on the delivery of person-centred care that met the needs of the people who used the service. A lack of provider oversight in this area meant this had remained undetected.

There was in effective record keeping in place in relation to actions taken following accidents and incidents. This resulted in a lack of monitoring or oversight of accidents and incidents. There was no monitoring of trends or recording of any lessons learnt.

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

Something like Immediately following our inspection, we formally notified the provider of our escalating and significant concerns. We asked the provider to tell us what urgent actions they would take with immediate effect to mitigate the risks we identified at this inspection. For example, in relation to the fire safety concerns and the poor standards of hygiene we found. We received a response with their improvement action within the timescale requested.

The service had good relationships with visiting professionals. Visiting professionals, we spoke with confirmed this. Comments included, "[Name of acting manager] seems to know people well. It's only the third time I have been here, but it seems that people have improved since being here."

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. From the records we saw, the provider was informing us of relevant important events.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person-centred care.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not obtained in line with the Mental Capacity Act.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to provide oversight of the service.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not trained to meet the needs of people.

The enforcement action we took:

Notice of proposal to cancel registration.