Beaconsfield Care Limited

Mayfield House Residential Home

Inspection report

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Tel: 01932229390

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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 18 June 2018 and was unannounced. Our last inspection was in June 2017 where we identified one breach of the legal requirements relating to consent. We also identified shortfalls in record keeping and risk management. At this inspection, we identified a continued breach of the legal requirements in relation to consent, as well as four further breaches in relation to risk, infection control, medicines, person centred care, dignity, complaints and governance.

Mayfield House is a 'care home'. 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.

Mayfield House accommodates up to 34 people in one adapted building. The service supports older people who have physical conditions and require support with mobility. The majority of people at the home were living with dementia. At the time of our visit, there were 20 people living at the home.

There was not a registered manager in post, the manager of the home was in the process of registering with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had failed to sustain improvements at the service. After our last inspection, we noted improvements had been made and the service came out of special measures. However, these improvements had not been embedded and by the time of this inspection there had been two changes in management in the last 12 months. We also found that there was a lack of governance and record keeping at the service. We identified risks to people that had not been assessed and there was no guidance for staff on how to support them safely. Information about people's needs and what was important to them was inconsistent and inaccurate. There was no analysis of incidents or complaints which showed there was not a proactive approach to identifying and responding to concerns or risks.

Shortfalls in the maintenance of the home environment meant that people were not always protected from the risk of the spread of infection. We identified bathroom and toilet areas in which a lack of repairs meant rooms could not be properly cleaned and equipment was stored within these environments which heightened the risk of it becoming contaminated. The provider's audits and checks had failed to identify or address these issues. We identified odours in areas of the home that meant people did not always live in a home environment that provided dignity. We also found times where the home environment did not effectively support people living with dementia.

People were not always supported to access healthcare professionals. We identified instances where people had not attended planned appointments and there was no evidence of staff taking action in response to

this. We also identified clinical risks not being monitored and a lack of guidance for staff where people were living with diabetes. We identified inaccuracies in medicines recording and management that meant people did not always receive their medicines safely.

People's consent was not always sought in line with current legislation. Staff did not always correctly follow the Mental Capacity Act 2005 (MCA) when placing restrictions upon people. We observed staff not always being respectful of people's privacy and people were not always involved in their care. There was a lack of variety of activities and outings for people to take part in. Information on how people could raise a complaint was not accurate and the provider did not have a system to track and monitor verbal complaints. We made a recommendation about complaints.

There were enough staff at the home to respond to people's needs and appropriate checks had been undertaken on new staff to ensure that they were suited to their roles. Staff completed training before working with people and this was regularly refreshed. Staff were knowledgeable about safeguarding adults and knew how to raise any concerns that they had. Staff had regular meetings as well as handovers to enable them to communicate together effectively. People spoke positively about the food on offer to them but we did find instances that people's food preferences were not documented. We made a recommendation about menu planning.

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.

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.

Risks to people were not always appropriately assessed and managed and there was a lack of monitoring of accidents and incidents.

Shortfalls in the maintenance of the home environment meant that people were not always protected against the risk of the spread of infection.

People's medicines were not always managed safely.

There were sufficient numbers of staff working at the home and the provider had carried out appropriate checks to ensure that staff were suitable for their roles.

Staff understood their roles in safeguarding people from abuse.

Is the service effective?

Requires Improvement

The service was not effective.

Staff continued not to follow the correct legal processes for gaining consent from people.

People were not always supported to access healthcare professionals or meet their healthcare needs.

The home environment was not always suited to people living with dementia.

People liked the food that was prepared for them and the kitchen staff knew people's dietary needs. We made a recommendation about menu planning.

Is the service caring?

Requires Improvement

The service was not always caring.

Shortfalls in the home environment meant people did not always live in a home that encouraged dignity.

Staff were observed not always being respectful to people's privacy. People were not always involved in their care.

We observed some pleasant interactions between people and staff that showed staff were committed and caring.

Staff understood the importance of encouraging people to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a timetable of activities in place but people did not have access to outings.

Care plans were inconsistent and sometimes lacked important information about people's needs and backgrounds.

Reviews were not always carried out and information in care plans was not updated following changes.

There was a complaints policy in place but this was incorrect and the provider did not document complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The checks and audits carried out by management had not identified or addressed shortfalls in the home environment.

Important records were not always complete and up to date. There was a lack of analysis of incidents, daily notes and complaints.

Improvements identified at our last four inspections had not been sufficiently implemented and embedded.

Staff had regular team meetings to discuss their roles and encourage communication.

The provider had been notifying CQC of important incidents and events where they were required to do so.

Mayfield House 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.

The inspection took place on 18 June 2018 and was unannounced.

The inspection was carried out by three inspectors 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.

As part of our planning we contacted the local authority and placing authorities for feedback on the service. We reviewed feedback from people and relatives submitted to CQC and we also checked online feedback. We reviewed notifications that the provider had submitted to CQC to identify any areas that we would need to follow up on during our visit.

Due to technical problems, the provider was not asked to complete a 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 took this into account when we inspected the service and made the judgements in this report.

As part of the inspection, we spoke with seven people and observed their interactions and care from staff. We spoke with the manager, the deputy manager, the nominated individual, five care staff and a kitchen assistant. We looked at care plans for six people, records of incidents, complaints and records of checks and audits. We looked at three staff files and records of staff meetings and residents' meetings.

Inadequate

Is the service safe?

Our findings

At our inspection in June 2017, we identified that risk assessments were not always thorough and up to date. However, we did observe that risks to people were being managed and the previous manager was in the process of updating risk assessments. Therefore, we rated the service as Requires Improvement in Safe because the improvements to risk management plans had not been fully implemented. At this inspection, we found further information missing from people's risk management plans.

People told us that they felt safe living at the home. One person said, "Yes its safe here." Two other people told us they felt safe and looked comfortable whilst staff supported them.

Despite people feeling safe, we identified shortfalls in the way risks were assessed and managed. Records showed instances where risks had been identified and these had not been assessed or mitigated. In two people's records, we noted their social services assessments identified risks associated with them drinking alcohol. In both cases, the risk had not been assessed and there was no mention of it in their care plans. Whilst staff were aware of the risk and one of the people told us their alcohol intake was limited by staff, the lack of information in care records showed that the provider did not take a proactive approach identifying and responding to risks.

Another person was living with dementia and could become agitated. In their daily notes, we noted regular recent instances of them becoming agitated, causing them to become verbally and physically aggressive towards staff. This risk had not been assessed and there was no guidance for staff on how to support this person safely. Risks relating to people's mobility were assessed and we saw examples with clear plans in place for staff. However, during our inspection we observed two staff support a person to move using a 'drag lift'. A 'drag lift' is where a person is lifted under their arms and is not accepted best practice because it heightens the risk of injury to the person and staff. This showed that where risk management plans were in place, they were not always being followed.

In another instance, a person was living with diabetes and their care plan lacked information on their condition and how it affected them. There was no information for staff on how to identify the signs and symptoms of a hypoglycaemic or hyperglycaemic attack, caused by blood sugar levels becoming too low or too high. Daily notes documented regular sweets and treats, such as biscuits and cakes, that the person had eaten but there was no chart to monitor this. This meant there was a lack of information for healthcare professionals. We met with the kitchen staff and saw that they were aware of the person's diabetes and ensured diabetic desserts were freshly prepared using sweeteners. However, there was a lack of information in the person's records and a lack of monitoring of this person's food intake to ensure these risks could be managed.

There was a lack of monitoring of accidents and incidents. Records relating to accidents and incidents were inconsistent and difficult to track. Incident forms were not stored in chronological order and differed in format. Information on incident records was not always clear and did not show what action staff had taken or who accidents occurred to. For example, a recent incident did not record the name of the person involved

in it and lacked information on how the person had been supported after a fall. There was a lack of analysis of incidents by the provider which meant that they could not identify any patterns or trends. The manager told us that they planned to introduce an incident matrix, but they had not put this in place by the time of our visit. This meant there were not clear systems in place to learn lessons if anything went wrong.

There was a lack of measures in place to reduce the risk of the spread of infection. The provider had a policy in place for infection control but we found instances where this was not being followed. For example, in one bathroom we found toiletries and two people's prescribed creams left out. This heightened the risk of contamination and these items becoming a vehicle for the spread of infection when they were next used. The provider's policy specified that toiletries and creams should not be stored in this way, but our findings showed that this guidance was not being followed by staff. We also found an overflowing bin and a red bag for soiled laundry, containing linen, open on the floor.

In a shower room we found wheelchairs stored in the shower area as well as a hairdressers' bowl stored above the toilet which the manager told us had been used a few days ago. Use of these items by people could expose them to contamination and they were not stored in line with best practice. The manager told us that this shower room was not used frequently, but records of water temperature checks showed that this bathroom had been used by a person four days before our visit. We also noted that the seal in the floor in the shower room had been damaged and we also found a toilet which had no seal around the base of the bowl. This meant that floor boards were exposed and water or bodily fluids could permeate the wood which could then harbour bacteria and make it difficult to ensure that floors were hygienically clean. After the inspection, the provider submitted evidence that efforts had been made to repair the flooring in the toilet and move the wheelchairs. However, we will require further action from the provider to ensure infection control risks are addressed proactively.

Medicines were not always managed safely. Whilst we did note medicines were stored safely and we observed staff administering medicines appropriately, medicine administration records (MARs) contained inconsistencies. Two people's MARs showed regular medicines being given on a PRN basis. In both cases, staff regularly used 'N' to denote 'PRN not given' despite the MAR showing these medicines were to be administered daily. We also noted that one person's weekly tablet had been dispensed despite not being due to be for four more days. Staff said that this may have been administered instead of last week's dose, but this dose was also dispensed. MARs were not clear on when the medicine was administered, meaning the person may have received their weekly dose too early. After the inspection, the provider confirmed a tablet had gone missing from the person's blister pack which staff had highlighted so that a replacement could be ordered. The person had received the next week's dose whilst they awaited the new prescription. However, this information had not been clearly documented and handed over to the staff member who was administering this person's medicines on the day of our visit.

The failure to appropriately assess and document risks, the shortfalls in relation to infection control and the lack of robust medicine records was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff at the home to keep people safe. The provider calculated staffing numbers based on people's needs and we noted this level had been sustained. On the day of our visit, three staff had called in sick and the provider called in staff from their bank and we noted one staff member was from an agency. The provider had minimised use of agency staff but where they did they had ensured consistent staff attended. We spoke with an agency staff member who told us the provider gave them the training they needed and they regularly worked at the service.

The provider carried out appropriate checks on new staff to ensure that they were suitable for their roles. Staff files contained evidence of work histories, health declarations, references, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS).

Staff understood their roles in safeguarding people from abuse. When asked how to identify or raise concerns, they were knowledgeable about reporting procedures. One staff member said, "I would tell my line manager immediately and follow it up. I could also ring 999, go to social services or CQC." There had not been any recent safeguarding and before the inspection the local authority confirmed they did not have any concerns about the service. However, as already reported we identified concerns with how incidents were recorded and responded to.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our inspections in August 2015, August 2016 and June 2017 we found that the correct legal process was not followed where people were unable to consent to care or restrictions. There was a lack of mental capacity assessments carried out to assess people's ability to make decisions. Best interest decisions were not always documented and applications to authorise the use of restrictions were not always sent to the local authority. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider after our inspection in June 2017. They stated they had made improvements in this area by July 2017. Our findings showed that improvements had not been made in line with the provider's timescales.

At this inspection, we found that the correct legal process continued to not always be followed by staff. We did see mental capacity assessments in people's records but they were not decision specific. For example, where one person had risks related to drinking alcohol, restrictions were put in place to manage risk, without a capacity assessment taking place to clarify the person's ability to make this decision. The person did have an assessment of their ability to make a decision to live at the home and this found the person lacked the capacity to make this decision. This showed there was doubt over the person's capacity to consent to restricting their alcohol intake and yet no best interests' decision had been made. We also noted that this person was having blood tests from visiting professionals and there was no record of whether they had the mental capacity to consent to this.

We noted that four people had capacity assessments and best interest decisions stating they would be subject to restrictions as they lacked the mental capacity to make the decision to go out of the home independently. We did not see DoLS applications for these people on the day of inspection because the provider's records were incomplete. After the inspection we saw evidence of a DoLS application for one of these people. For two others, the manager told us that they had not applied for a DoLS because these people were originally staying at the home temporarily and had since become permanent. This showed a lack of understanding of the DoLS and MCA process which states this should be followed in all instances where restrictions are placed upon people, regardless of how long they will be staying at the home. In the other instance, the provider's DoLS tracker stated an application had been submitted but we did not receive a copy of this.

The failure to follow the correct legal process when placing restrictions upon people was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not always met. Whilst we did see evidence of staff liaising with visiting processionals such as the community psychiatric nurse (CPN) and district nurses, we found instances where people were not supported to access healthcare professionals. For example, we saw a letter in one person's file stating they had been discharged from an ophthalmology service because they had not attended three appointments. The healthcare professional had written on the letter 'none of the residents have attended their appointments', indicating other people from the home had a similar concern. We asked the manager to look into this issue and submit evidence of what action was taken. After the inspection, the manager submitted evidence to show one appointment for this person was missed due to them refusing to attend. However, there was no evidence to show what action had been taken to support the person to attend the subsequent missed appointments. The manager was also unable to ascertain what the note was referring to with regards to other residents. This showed that there was no system to track people's healthcare appointments and staff were not always supporting people to attend them.

The home environment had been adapted to people's needs, but it was not always suited to the people that lived there. Most people at the home were living with dementia and we noted signage and prompts around the home for this. These included pictures to help people to orientate themselves. However, on the day of our visit we noted that a board in the communal area to inform people of the day and date was showing a date five days before our inspection. Spaces for the weather and activities were also blank. This showed staff were not updating this and it was therefore not supporting people living with dementia to orientate themselves. We also noted one corridor where there were no handrails. We observed staff supporting a person here and the person looked unsteady and did not have a handrail to hold onto.

The failure to ensure people regularly accessed healthcare professionals, and shortfalls in the home environment were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were satisfied with the food that was prepared for them. One person said, "I am quite satisfied with the food." We observed people finishing their meals and they responded positively when we asked about the food they were prepared.

Aside from our concerns with monitoring of diabetes risks reported in Safe, we saw examples of people's dietary needs being met. For example, one person required pureed food and thickened drinks to reduce the risk of choking. There was a care plan for this and kitchen staff had records of this need. This person was given pureed food on the day and kitchen staff told us how they moulded pureed food to make it appetising on the plate. We noted that this person ate most of their meal at lunch time.

People had a choice each day and there was a menu on display in the home providing information on what was available. We observed staff asking people what food they would like in the morning and they were served their choice at lunchtime. Kitchen staff told us that they provided an alternative option where people did not want either option on the menu. We noted that food smelt appetising and well-presented and people finished their meals. Care plans documented people's food preferences, but these records were not always consistent. For example, two people's care plans simply stated 'likes most foods' whilst another recorded that they were allergic to some poultry and eggs. We did not see record of what people's favourite foods were or evidence that these had informed menu planning.

We recommend that the provider reviews their care planning to ensure people's food preferences are

documented and these are catered for in menu planning.

Staff had appropriate training to meet people's needs, however from our findings on the day staff were not always following best practice in relation to the training they had received. For example, we observed poor moving and handling practice and we noted staff hadn't followed best practice in relation to infection control. Despite having had MCA training, the correct process was not being followed and we spoke with one staff member who was unsure about the MCA. Aside from this, there was a programme of training in place and staff spoke positively about it. One staff member said, "[Manager] did my induction with me." New staff completed an induction which involved shadowing experienced staff and completing mandatory training courses. Staff files showed evidence of staff completing training in areas such as health and safety, MCA, food hygiene and infection control. Staff had completed the care certificate or additional qualifications to develop their knowledge. The care certificate is an agreed set of standards in adult social care.

The provider kept a record of staff training to keep track of when it was due. We looked at this record and saw that training was up to date in most cases. We did identify some gaps in staff attending training in supporting people who may display behaviours that challenge staff. However, during the day we observed some good practice in this area. For example, when one person became confused and anxious, staff spoke to them calmly and deescalated the situation. Staff also told us that they received regular supervision and we saw evidence of these in staff files. However, our findings showed supervision was not effective in ensuring staff had the right knowledge and support for their roles.

We recommend that the provider reviews supervision to ensure staff have regular opportunities to discuss and develop their practice

Requires Improvement

Is the service caring?

Our findings

People told us that the service was caring. One person said, "They [staff] are all wonderful." Another person hugged a staff member when we asked if they got on well with them.

Despite this positive feedback on staff, we found shortfalls in people's home environment that meant their dignity was not always considered. The shower room and a toilet had a strong damp smell and we noted a strong odour of urine in one bedroom and one communal area. This meant people had to endure this odour on a daily basis within their home environment. Whilst our previous inspection noted improvement works carried out at the home, we found areas of the home that lacked homely décor and were not bright or clean. There was a lack of checks of people's home environment and no ongoing improvement plan to ensure it was regularly refreshed.

People were not always involved in their care. We looked in three people's rooms and noted two rooms were sparse and not decorated in a way to make the person feel at home. These people were living with dementia this meant opportunities for them to make requests were limited. However, we could not see any effort made to make these rooms feel homely for these people, based on their backgrounds or personalities. Walls were blank and there was a lack of personal belongings or decoration in these rooms. People did have pictures on bedroom doors that reflected their personalities and backgrounds and areas of the home had been decorated since our last visit. We also found instances where people's religious needs were not accurately documented. For example, one person's care plan documented that they were a Christian on one page and on another page recorded that they did not have a faith.

People's privacy was not always respected by staff. During the inspection, we were speaking with a person in their room and staff opened the door to the person's room. Staff did this without knocking which did not show respect for the person's privacy. We asked the person if this always happened and they said, "It happens all the time. They should knock but they don't, I could be coming out the toilet or something."

The shortfalls in the home environment that impacted on people's dignity, lack of involvement of people in their care and staff not always being respectful of people's privacy was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Aside from the concern about privacy, we observed pleasant caring interactions between people and staff. One person became anxious and we observed that staff took the person's hand and took them for a walk in the garden as it was a warm day. We saw the person shortly after this and the interaction had improved their mood. Another person became confused and started to show signs of agitated. Staff responded quickly and talked to the person about the lunch that day and diverted the person's attention. This caused the person to become calmer in their demeanour.

People were encouraged to be independent. Staff were knowledgeable about how to promote people's independence. One staff member said, "I always see if people would like a bath or shower and I always prompt them to do things for themselves and I help them when they can't." During the inspection we

observed people being supported to eat independently. For example, one person was living with dementia and their care plan stated they required prompting and encouragement from staff to eat. We observed staff doing this at lunch time and the person was able to finish their meal without support. Care plans contained information on people's strengths, although we noted that these sometimes lacked detail. We have reported on this further in Responsive and Well-led.

We did see instances where staff involved people in their care. One staff member said, "If people want to stay in bed then we give them time. With dressing, most people can choose what outfit they want to wear." We observed people being offered day to day choices throughout the day. For example, people were offered a choice of activities and we observed one person chose to do some painting. During the day people were offered regular choices of drinks as well as snacks.

Requires Improvement

Is the service responsive?

Our findings

We received mixed reviews about the activities on offer. One person said, "We are having a music exercise today, it's a lot of fun." However another person told us, "My family take me out at the weekend. The staff only accompanied me to the shops a couple of times when I first moved here."

There was a lack of opportunities for people to go out. People told us that they were not able to go out unless relatives took them. Staff also told us that there were no outings at the home and we did not see evidence of staff supporting people to go out. Whilst we noted relatives did take people out, those who did not have support of relatives lacked opportunities to engage with the local community. Whilst we did note improvements to activities which we have detailed below, the lack of opportunity to access the community meant that some people did not have a wide variety of activities to choose from.

Care was not always planned in a person-centred way. There were inconsistent levels of information in people's care plans. For example, one person's care plan stated they liked to be clean shaven and have a shave each day, then when we met the person we noted that they had a beard. Another person was being treated for a medical condition with regular visits from professionals. The care the person received would have required additional guidance for staff but this was not mentioned in their care plan. Three care plans contained detailed information on people's backgrounds but two lacked detail on people's preferences, routine and their life before coming to live at the home. We noted staff did display a good knowledge of people's needs and preferences, but the inconsistent and incorrect information in people's plans meant new and temporary staff did not have the necessary information to provide people with person-centred care. Whilst we did see some evidence of reviews, it was evident from the examples seen that people's preferences were not being updated if they changed.

At the time of our visit, no one was receiving end of life care. However, we noted that there was no record of advanced wishes or people's preferences when this time of their lives came. This showed that there was not a proactive approach to end of life care and staff lacked information on people's preferences in this area, should they need it.

The lack of outings for people and the shortfalls in person centred care planning was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other instances, we did see person centred care planning. For example, one person had a long and interesting career in writing and had travelled a lot and this was in their care plan. A staff member was knowledgeable about this and said they enjoyed talking to the person about their working life. Another person had particular preferences about clothes that they liked to wear and this was documented and staff were knowledgeable about this.

Improvements to activities were underway. There was a timetable of activities on offer and these included exercise, films, music and visiting entertainers. We observed staff doing one to one art activities with people as well as a musical activity as well as a visit from therapy dogs during the inspection. People appeared

happy and engaged in the activities that took place on the day. At the time of our inspection a new activity co-ordinator had recently started work at the service and had they begun to develop a timetable of activities. We noted these had been discussed at staff meetings and residents' meetings to involve them in making ideas for new activities. We will follow up on the improvements made to activities at our next inspection

There was some information lacking informing people of how to complain and no record of verbal complaints. We checked the complaints log and noted there were no written complaints. The manager told us that they had received verbal complaints in relation to the laundry, but they did not keep a central record of these. There was a complaints policy in place which was displayed within the home. This informed people and relative of how to raise any issues with the provider but we noted it did not inform people of their right to contact the Local Government & Social Care Ombudsman (LGSCO) should they wish to take their complaint further. The policy contained information about CQC but we noted that the contact information was out of date and did not accurately reflect CQCs role as a regulator in how we monitor complaints.

The inaccurate complaints policy and lack of system to document and monitor verbal complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Feedback on the management of the service was mixed. One person said, "The manager is excellent, she does everything I ask her." However, two people said that they did not know who the manager was. Staff feedback was also mixed, one staff member told us, "[Manager]'s very good. She talks to you politely." However, another staff member said, "I can't really say much."

We found a lack of governance at the home that meant concerns we identified were not being addressed proactively. Whilst we saw the checks of the home environment were taking place, they had not identified the same concerns that we found during our inspection. For example, a recent infection control audit had not identified or addressed the concerns that we found with the home environment. We noted that the majority of audits seen did not identify any improvements to be made. Recent health and safety audits had not picked up an environmental risk that we identified. We observed that a multi plug in the staff area was raised causing it to hang next to a water cooler which presented a risk. None of the audits seen identified this potential risk. This showed that audits were not robust in identifying ways to improve people's home environment and ensure safety. We also noted there was a lack of audits relating to records. Our findings showed multiple gaps in records and no analysis in place. There was no analysis of incidents and records of people's visits to healthcare professionals were inconsistent. This meant risk and clinical needs could not be effectively monitored. We also noted that people's care plans were not being audited. This caused out of date information to remain in care plans as they had not been picked up by staff.

The provider failed to maintain accurate and up to date records. We found numerous occasions in which care plans did not reflect people's current needs. For example, one person's 'one page profile' documented that they liked to smoke a cigarette each day. When we asked about this, the manager informed us that the person stopped smoking some time ago. This profile page was designed to enable staff to get to know people quickly, but this was not effective with inconsistent information. As reported in Safe and Responsive, there were multiple instances of records not reflecting people's needs and risks. Important health and safety information was also missing. During our visit, we were unable to establish the last time the lift had been serviced and water tests for legionella. The provider submitted evidence of these to CQC after the visit, but there was not a clear system to document and track when these important safety checks were due.

There was a lack of improvements in response to our previous concerns. At our last inspection, we noted that staff had not followed the correct legal process for gaining consent. After our last inspection, we issued a warning notice and the provider created an action plan. They told CQC improvements had been implemented in July 2017. At this visit, we found continued shortfalls in this area which meant that this was the fourth consecutive inspection that the provider had failed to address this concern. Our last inspection also highlighted that risk management plans were lacking in detail and work was underway to improve them. Despite this, we found identified risks without plans for staff on how to manage them, which we have reported on in Safe.

There was a lack of stable management at the home. There had been two changes to the manager in the last 12 months. There was a lack of oversight from the provider during this time which had contributed to

inconsistencies in auditing and records and meant improvements were not being sustained. In response to previous concerns the provider had introduced an external company to invest in the home and complete external audits. However, the provider informed us after our inspection that there was a plan to cease this and no external audits had taken place since December 2017. The current manager had been in post for four months but told us that they had not had time to implement audits in areas such as care plans and incidents. The provider was not carrying out checks of this and there was no ongoing plan to improve the service. The deputy manager told us that they had plans to create links with a local school, but we did not see any current evidence of links being developed with the local community.

The provider did not always involve people and relatives in the running of the home. There was a lack of meetings of residents and relatives to provide opportunities to be involved in making decisions at the home. Surveys were taking place and we noted mostly positive responses in February 2018 and September 2017. However, one relative left a comment on their survey in February raising concerns of personal care needs not being met. There was no record of what action had been taken in response to this and we also noted there was no overall analysis of survey responses to monitor these and identify improvements.

The failure to carry out robust checks, the shortfalls in record keeping and the continued failure to improve in response to concerns was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had regular meetings to keep them informed of the running of the home. Staff told us meetings had increased since the new manager took over and records supported this. We saw evidence of monthly meetings that were used to discuss care and good practice. A recent meeting had been used to remind staff of the dress code and expectation of nightly checks for people. Meeting minutes documented staff views to provide opportunities for them to make suggestions.

The provider understood the requirements of their registration. Providers are required to notify CQC of important events such as injuries, deaths and allegations of abuse. We found that where required, the provider had submitted notifications to CQC and provided information on the actions being taken by them in response to incidents.