Mr Paul Bliss

Leonard Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an inspection on 13 and 19 July 2017. Before the inspection, we had received a number of concerns about the level of care provided by the service. This was a comprehensive inspection and followed up concerns from our last inspection in February 2017. At the February 2017 inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The breaches related to safe care and treatment; good governance; safeguarding service users from abuse and improper treatment; fit and proper persons employed; need for consent; staffing and failing to submit statutory notifications of incidents that affected the health, safety and welfare of people. The service has been in special measures since February 2016. In November 2016 the Commission imposed a condition on the provider's registration that the service must not admit any new service users for the purposes of the regulated activity.

Leonard Elms Care Home provides accommodation for people who require nursing and personal care, including those living with dementia. The service comprises of two units, the Cherries and the Elms. The Cherries unit specialises in dementia care and the Elms unit is for general nursing care. Prior to this inspection CQC had restricted admissions at the home. The home can accommodate up to 73 people and on the days of our inspection there were 36 people living at the service.

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

At our previous inspection, people were not always receiving safe care and treatment. At this inspection, we found insufficient improvements had been made. Medicines were not consistently managed safely. People were not consistently cared for in a safe and clean environment. The delivery of care did not ensure that people's risks were adequately managed.

At our previous inspections, people who lacked capacity did not always have decisions made following the principles of the Mental Capacity Act 2005. Although improvements had been made consent to care was not consistently sought in line with legislation and guidance.

At our previous inspection, we found that people were not always receiving individualised care. At this inspection, insufficient improvements had been made. Care plans were not consistently detailed to help staff provide personalised care based on current needs. They were not consistently written in conjunction with people or their representatives.

People's records were not always completed correctly or monitored to manage their health conditions.

People and their relatives felt that the staff were caring. Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people. The observed dining experience was mixed. It did not consistently enhance social interaction between people or fully enable choices.

At our previous inspection, we found the provider failed to notify CQC of all incidents that affected the health, safety and welfare of people who use the service. At this inspection, sufficient improvements had been made. The provider is now submitting statutory notifications, when required.

At our previous inspection, people were not always being protected by the recruitment process. At this inspection records showed that a range of checks had been carried out on staff to determine their suitability for work.

At the previous inspection, there were inadequate systems and processes in place to protect people from abuse. At this inspection, we found sufficient improvements had been made. Where any form of abuse was suspected or reported by a third party the provider took appropriate action such as undertaking an internal investigation and making a referral to the appropriate body, such as the local authority safeguarding team. This included notifying CQC.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned.

Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. New staff undertook an induction and mandatory training programme before starting to care for people on their own.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Staff felt well supported by the manager. The manager held a regular programme of staff meetings to advise them of operational issues and actions required.

People and their relatives also spoke highly of the manager and the provider. People were encouraged to provide feedback on their experience of the service.

Although some improvements had been made since the previous inspection this is the fifth inspection that the provider has failed to fully meet all the regulations. Since the previous inspection in February 2017, there have also been repeated breaches of the same regulations. These include: safe care and treatment; need for consent; person centred care; and good governance.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their audit systems had not identified that the continued breaches of the regulations had failed to be sufficiently rectified.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering the action we are taking.

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.

Medicines were not consistently managed safely.

The delivery of care did not ensure that people's risks were adequately managed.

People were not consistently cared for in a safe and clean environment.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents.

Is the service effective?

Requires Improvement

The service was not effective.

The provider had not protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

People's rights were not consistently being upheld in line with the Mental Capacity Act (MCA) 2005.

New staff undertook an induction and mandatory training programme before starting to care for people on their own.

Is the service caring?

Requires Improvement

The service was not always caring.

The dining experience did not consistently enhance social interaction between people or fully enable choices.

People and their relatives felt that the staff were caring.

Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not consistently detailed to help staff provide personalised care based on current needs.

Care plans were not consistently written in conjunction with people or their representatives.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Inadequate

The service was not well-led.

This is the fifth inspection that the provider has failed to fully meet all the regulations.

Systems were not operated effectively to assess and monitor the quality and safety of the service provided.

People were encouraged to provide feedback on their experience of the service.

Staff felt well supported by the manager.

Leonard Elms Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an inspection on 13 and 19 July 2017. Before the inspection, we had received a number of concerns about the level of care provided by the service. As a result, the inspection was brought forward. This was a comprehensive inspection and followed up on concerns from our last inspection in February 2017 when the home remained in special measures.

The inspection was unannounced. On 13 July, the inspection was undertaken by three inspectors. On 19 July, the inspection was conducted by two inspectors, a pharmacist inspector 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.

Before the inspection, we looked at paperwork from the local authority and other intelligence we held internally about the home. We also reviewed the provider's action plans, which were regularly submitted to CQC.

Over the two days, we spoke with 11 people, six visitors, nine members of staff, the manager, the operations manager, the clinical director and the provider. We observed care and support in the communal areas. We looked at the medicines policy and 33 medicine administration records (MAR's) in current use and eight people's care topical application records. We reviewed eight care plans and a sample of food and fluid charts and repositioning records. We also reviewed the provider's audits relating to the health, safety and welfare of people who use the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection, people were not always receiving safe care and treatment. At this inspection, we found insufficient improvements had been made.

Medicines were not consistently managed safely. We found that the MAR charts for medicines administered by the nurses had been completed correctly. However, when medicines were administered as part of a delegated task the records were incomplete and did not show that people were having their medicines as prescribed. We saw for one person that they were prescribed eye drops to be administered at night; the record indicated that from 26 June 2017 until the date of the inspection that this had not been administered on 13 occasions, as the person was asleep. No action had been taken to contact the person's GP to agree a more convenient administration time meaning that this person was at risk of having permanent damage to their sight.

For another person we observed a topical medicine prescribed to be administered twice a day to all areas of dry skin, the chart commenced on the 26 June and entries were only made on the 14, 15, 16, 17 and 18 of July. This meant that the person was not getting their medicine as prescribed and increased the risk of them suffering harm to the skin.

We found that a number of people were prescribed their medicines to be administered when required. For some people there was insufficient information for care workers to make a decision on how to administer these medicines, nor was there sufficient information to inform staff of the expected outcome. When these medicines were administered there was no accompanying record to show why the person had been assessed as needing the medicines. There was also no record made of the outcome of the administration. This means that it was not possible to feedback to the GP the effectiveness of these medicines.

We saw that a number of people were having their fluids thickened in accordance with the directions of a health care professional and had thickener prescribed for them. We asked two members of staff how they would carry this out. Whilst both told us that they had received training the method described by them was not in accordance with the manufacturer's directions. Also the list provided for the care workers to follow did not contain information to the current prescription for the individuals. This means that people may not get their fluids thickened to the correct consistency and placed them at risk of choking . We also found that two people were sharing a thickening fluid prescribed for one person. We observed that one tin was left in the kitchen and was being used for the two people.

When we read the provider's current policy and procedures we found that these were not always followed or that it did not reflect current practice. The policy made reference to external guidance documents that had been superseded and also to collecting medicines from pharmacies not in the same geographical area as the service.

Routine audits of medicines management were carried out and whilst some of the issues we saw had been identified they had not taken action to ensure when these would be corrected. This means that people

cannot be assured that prompt action would be taken when shortfalls were identified.

Care plans contained risk assessments for areas such as falls, skin integrity, mobility and nutrition. When risks had been identified the majority of care plans provided guidance for staff on how to reduce the risks of harm to people. For example, moving and handling plans contained details of any equipment that was required and mobility plans listed the mobility aids that people needed to use to reduce the risk of falling. However, in one person's plan it had been documented that they were a high risk of falling. It had been documented that the person had been referred to the falls clinic in February 2017, but there was nothing documented of the outcome of this or whether the person had actually been reviewed by the team. The person had since fallen five times during May 2017. We discussed this with the Clinical Lead who said they would follow this up. There was not an appropriate arrangement in place for reviewing and taking appropriate actions regarding these falls to minimise the risks to the person.

When people had been assessed as being a high risk of developing pressure ulcers , the plans detailed which pressure relieving aids should be used, such as air mattresses and pressure relieving cushions. We saw that these were used correctly. All of the air mattresses we looked at were set in accordance with people's weights and staff knew how to check the mattress was at the correct setting because the necessary information was attached to the mattress pumps. However, although the care plans informed staff how often people's positions should be changed in order to reduce the pressure, the associated position change charts did not always reflect care plan guidance. For example, we looked at the charts for two people. For one person, the guidance for staff was that the person should have their position changed every two hours. Over a three day period, the charts showed that staff had done this for two of the days, but on one day the chart was blank from 10.30 to 16.24, which indicated the person had not been moved for six hours. The charts for the other person also stated they should have their position changed every two hours. However, on three consecutive days, there were gaps in the charts, which indicated the person had not been moved for up to six hours. This meant there was a risk of people being uncomfortable and developing skin soreness or breakdown.

Daily records of care for another person assessed as being at high risk of developing pressure ulcers did not evidence they received the care described in their care plan. This person was not able to walk and required moving and handling to get out of bed and change their position. Their plan stated they should be repositioned every 3 hours. The daily recording sheets kept in their room and completed by care staff showed significant time gaps where no positional changes were recorded. For example, on 12 July 2017 there was no information on positioning from 08:05 to 18:40. Staff told us it was important for this person to only be cared for in bed when absolutely necessary. They had their own specialist chair to sit in when not in bed. However, the daily records did not provide detail on whether they were in bed or sat up elsewhere in the home on 11 or 12 July 2017.

The same person was prescribed creams to be put on their skin to keep it in good condition and prevent damage. Some were prescribed to be applied only when needed. However, two were prescribed to be applied every day. The daily records for this showed these were not always applied. For example, on 7 and 10 July 2017 there was no record of their application. There was no evidence of the person's care plan being implemented consistently. The delivery of care did not ensure that people's risks were adequately monitored and managed.

At our previous inspection, the provider told us they would make sure people's needs would be coordinated by the registered manager and nurses. It was evident that this had not been adequately addressed as shortfalls remained.

People were not consistently cared for in a safe and clean environment. People's rooms were clean and uncluttered with clear access to toilets. However, personal toiletries were kept in the Cherries Unit on a low open shelf and in one bathroom; there was a sharp edged razor. This placed people at risk of harm. Waste bins did not have lids and some were overflowing. This increased the risk of cross infection. Continence products were stored on the bathroom floor. The infection control audit conducted in October 2016 identified that the bathroom in the Cherries Unit had various items such as toiletries, creams that had been prescribed, and a used disposable razor on the shelf. The audit stated; 'Razor disposed of immediately and staff informed that none of the above should be left in the bathroom.' Despite this audit, we found similar concerns in July 2017. The infection control audit conducted in October 2016 and June 2017 also raised concerns about the cleanliness of the service in both units. It was evident from their audits that these issues had failed to be adequately addressed in a timely manner. The chef told us that they were going to implement housekeeping and equipment cleaning schedules.

This is the third inspection that the provider has been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, people were not always being protected by the recruitment process. We found some discrepancies in staff files; this meant the provider could not guarantee the suitability of staff. At this inspection, records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults. We did note that a risk assessment had been conducted following receipt of a positive DBS notification to assess whether the person was suitable to take up the position.

At the last inspection, there were inadequate systems and processes in place to protect people from abuse and these were not operating effectively. Sufficient improvements had been made. Staff said they had been trained to recognise signs of abuse and all said they knew how to report any concerns. All said they felt confident that any concerns they raised would be taken seriously. Where any form of abuse was suspected or reported by a third party the provider took appropriate action such as undertaking an internal investigation and making an referral to the appropriate body, such as the local authority safeguarding team. The previous inspection identified that staff used physical intervention when providing personal care for one person. They had now received training in physical breakaway and safer holding techniques.

Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. All of the staff we spoke with said there were enough staff and comments included "Yes, there's enough of us". Throughout the inspection we saw that staff were visible throughout the building and responded swiftly to people's needs.

People told us they felt safe. Comments included; "I am quite safe here"; "I am alright here, I can please myself, nobody bothers me"; "I am safe because there is always someone around if I need help"; "I am safe here because staff are plentiful", and "I am safe enough even though I have problems, which I find frustrating, I have confidence in the staff when hoisting."

Requires Improvement

Is the service effective?

Our findings

The provider had not protected people against the risk of poor or inappropriate care, as accurate records were not being maintained. Some people were having their fluid intake monitored. However, the fluid charts in place did not always demonstrate that people were receiving enough. For example, the charts for one person had a daily fluid intake target of 1400ms, but on 18 July 2017 their intake had been recorded as 650mls. The daily notes for this person for the same day were "good intake, drinking well." Another person had a daily target of 1600mls, but on 17 July 2017, the recorded intake was 750mls. The only reference to this in the person's daily notes was "enjoyed a jam sandwich and drink before bed." One person's daily target was 1600mls, but on 17 July 2017, the documented intake was just 480mls; there was nothing documented within the daily records about the person's fluid intake. There was nothing to indicate that staff were monitoring the fluid charts at the end of each day and there was nothing documented to indicate that staff had identified when people had not had enough to drink There was also nothing documented to indicate that any concerns had been escalated to a senior member of staff. This meant there was a risk that people might not receive enough to drink.

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

At our previous inspections, people who lacked capacity did not always have decisions made following the principles of the Mental Capacity Act 2005. 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. The provider's action plan told us by November 2016, "All care plans are being updated and this will include the best interest decisions and capacity assessments as required". Although improvements had made the provider had still not fully complied with the principles of the MCA.

Consent to care was not sought in line with legislation and guidance. Although staff had completed training on the Mental Capacity Act and understood how this related to their roles, care plans did not have capacity assessments in place that covered all aspects of people's care, such as the use of sensor mats for example. The assessments also did not detail the conversations that staff had with people in order to assess a person's capacity. Although best interest decisions had been documented, they only described the situation rather than detailing how the decision had been reached and what other less restrictive options had been considered. There were also no recorded names of other people involved in the decisions. We saw in one person's plan that this failing had been highlighted by a social worker on 31 March 2017 and had yet to actioned.

We saw information about Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. DOLs authorisations had been sought. Some of these had conditions attached, but these conditions had not

always been documented in the care plans. For example, in one plan, it had simply been documented; "A standard authorisation for DoLS has been issued with conditions", but the conditions were not listed. We asked care staff if they were aware of any conditions in place, but they said they were not. One said, "It's probably in the care plans." There was a risk that the person may have been unlawfully restricted

This is the third inspection that the provider has been in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe how they ensured that people who lacked capacity were still involved in simple decisions, such as what to wear or where to sit. One member of staff told us; "I always show people alternatives so that they can choose. Like clothes or food". Another said, "I always give people a choice. I know one person only likes tea, but I still offer them the choice of tea or coffee in case they change their mind".

Staff had not been consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. We were told by the manager, that this was currently "work in progress." Staff told us they were now having regular supervision sessions, although they added that these had not been happening before. The provider's supervision matrix supported this position.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, pressure care, understanding dementia and first aid awareness. The training records demonstrated that staff mandatory training was in the main up to date. People told us they were satisfied that all their needs were being met by staff who were knowledgeable and had received the necessary training. Comments included; "All my needs are being met by experienced staff, nothing more they could do to improve"; "All staff know what they are talking about, they suit me"; and "Staff are good at their job, they ask me what I need."

People had access to on-going healthcare. Wound care plans we looked at were clear and detailed how the wound should be treated and how often. There were photographs in place, which provided a measureable record of how wounds were progressing or deteriorating. Specialist advice from the tissue viability nurse had been sought when required. Other records showed that people were reviewed by the GP, the Speech and Language Team, social worker, and dentist.

Requires Improvement

Is the service caring?

Our findings

People and their relatives felt that the staff were caring. Comments included; "Staff are very good here, they care"; "Staff are attentive, kind and very caring"; "My [relative] likes staff, they get on very well and they are caring in their attitude"; "Staff are amazing, always smiling, I like the way they look after [relative's name]"; and "I get on well with the staff, they are easy to talk to, we have a laugh and a joke, they are mostly kind and treat me with courtesy; they look after me as I wish."

The observed dining experience was mixed. It did not consistently enhance social interaction between people or fully enable choices. People were not asked whether they would like to sit at the dining room table and were routinely sat in lounge chairs with tables placed in front of them. If people were offered the choice to sit at a dining room table during lunch there were inadequate seating arrangements in both units to allow for this. Staff put aprons on people without asking if that was their preference. At lunch people living with dementia were not shown pictorial indicators of the food. This would have supported them to make a decision and is good practice in dementia care. Condiments were not offered and in some cases staff were putting gravy on people's food without asking. However, people were offered choices of drinks. Alternatives were offered when requested, such as sandwiches and eggs on toast. One person was celebrating their birthday so was given the meal of their choice, gammon, egg and chips.

We observed some positive interactions between staff and people. People responded well to staff, there was laughter and people appeared relaxed. Staff chatted with people about everyday things, asking them if they had visitors at the weekend and pointing out a new gardener had started to work in the grounds. Staff were heard to refer to people by their preferred name, using appropriate volume and tone of voice; people appeared to be comfortable when staff approached, terms of endearment were used appropriately and residents responded well to this.

Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. They were aware of people's personal histories and interests. Staff spoke passionately about their roles. One member of staff told us; "The care here is brilliant. I lay on the bed with one person and read them a story until they fell asleep the other day and I've taken a few residents to my house for lunch before." In one person's daily records one staff member had documented that the person was upset and crying. They had documented "I asked what was wrong and they just cried some more, so I put Elvis on my phone and we had a sing song, which seemed to help". This person's musical preferences were rock and roll and so this demonstrated that the staff member knew the person well.

People said they were treated with respect and dignity during personal care. People told us that doors are closed and curtains drawn before staff commenced with personal care. We observed staff knocking before entering people's rooms.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found that people were not always receiving responsive care. At this inspection, insufficient improvements had been made. Care plans were not consistently detailed to help staff provide personalised care based on current needs. They were not consistently written in conjunction with people or their representatives. The service was at the preliminary stages of inviting people and their representatives to participate in reviews. Some people we spoke with were not aware of their care plan nor could they recall having a formal review. Others told us they had been involved in their care plan review.

One person who had been assessed as being at risk of neglect because they often forgot to have a shower. The care plan guided staff to "prompt" the person to wash or shower with assistance. The plan had been reviewed during March 2017 and the guidance for staff was to document when the person had a shower and to prompt them to have a shower "most days." However, the records in relation to this person's personal hygiene did not reflect the care plan. Records showed that the person had a shower on 01/07/2017 but did not have another one for eleven days and during June there was a gap of nine days when they did not appear to have a shower. There was nothing documented to indicate that staff had attempted to persuade the person to have a shower or whether the person had refused. In addition, the form used to document when personal hygiene took place had a note at the front informing staff that this person "needs support from a member of staff to able to wash or shower each day" and "please write if refused". The same form had several gaps in relation to other people using the service too; for example, on some days it appeared that nobody had a bath or shower and some people had nothing documented at all which implied that some people did not have their hygiene needs met every day.

People not able to use their call bells, had care plans in place stating they should be checked every two hours when in their rooms. This had not always been documented. For example on 8 July 2017, the entry for one person on the relevant chart said the person checked at 00:35 with the next at 08:30.

One person's plan also stated their continence pad should be checked every 2-3 hours and if found to be dry to be checked in an hour. We found this had not been recorded as done. For example, on 12 July 2017 at 00:15 pad was recorded as dry, the next check was then recorded for 03:15. On 11 July 2017 at 00:00 pad was recorded as dry, the next check was then recorded for 03:00. On 10 July 2017, there was no record of checking the pad at all between 06:50 and 12:05. This meant there was no evidence of the person's care plan being implemented consistently.

The same person had a detailed epilepsy profile in place. This had been drawn up with the involvement of a community nurse and had been reviewed regularly. A monitor was in place to alert staff if they had a seizure. However, some care staff were not aware this was in place. We were told the monitor when activated set off the usual call bell system. This meant the urgency of the call would not be apparent to staff. Their care plan also stated; '[Person's name] has no ability to communicate his choices.' This was not correct. Staff described clearly to us how they made their views known. We asked why this was not written down as being supported to make their own choices and decisions was such an important aspect of their wellbeing. Staff were not able to tell us why this was not detailed in their care plan. This meant if staff who did not know the

person well were providing care, they may not know how they make their choices and decisions known.

Care plans in relation to people's health needs were not specific to the person's needs. For example, we looked at care plans for two people with diabetes. These plans had the risks to people documented as "hypo/hyperglycaemia" but there were no symptoms listed and no related actions for staff to take. This meant there was a risk that staff would not recognise when intervention was required. Additionally, when we spoke to staff, three did not know that one person was diabetic, which increased the risks further.

During conversations with staff they demonstrated how well they knew people and were able to discuss how they provided support to people. However, some of the detail that staff told us was not documented within the plans. For example, one person we discussed with staff sometimes declined help with their care and could become verbally and physically aggressive with staff. The care plan guidance was for staff to "speak to her in the manner she speaks, responds well to humour, better with 1:1." However, care staff spoke of other ways of persuading the person to engage in personal care, which they said they had learnt through experience. Care staff said they were not involved in writing care plans, which was demonstrated in the fact that the plans did not always reflect the way care was provided, including these alternative ways that staff had described.

This was the fourth inspection the provider had failed to provide person-centred care. The provider continues to in breach of Regulation 9 of the Health and Social Cate Act 2008 (Regulated Activities) Regulations 2014.

The provider had a protocol in place to receive and monitor any complaints that were made. We reviewed the complaints received. Two formal complaints had been received in 2017. One complaint had been received anonymously and the clinical director told us that it had been mentioned in our previous inspection report. The complaint had been received anonymously. No recorded action had been taken following the concerns raised. At our previous inspection, the provider said they would review how they document actions taken for this complaint and any raised in the future. At this inspection, we saw no documentation regarding the anonymous complaint held on the file. The other complaint related to a relative's welfare. The issues were taken forward and actioned. People told us they knew how to make a complaint.

People had access to activities. On the first day of our inspection people were participating in movement to music. It was very popular, and the activities coordinator had a good rapport with people. It was a positive activity to help keep people mobile, and maintain their ability to balance and co-ordinate. On the second day of our inspection, entertainment had been organised by the family member for their relative who was celebrating a birthday. This was enjoyed by everyone in the unit. In the Cherries Unit, people were looking at books with staff members and there was age appropriate background music. There was at least one member of staff present in the communal lounges at all times. An activities coordinator had recently been appointed and was compiling a new activities programme.

Relatives were welcomed to the service and could visit people at times that were convenient to them. There were facilities for family members to make drinks for themselves. People maintained contact with their family and were therefore not isolated from those people closest to them.

Inadequate

Is the service well-led?

Our findings

Although some improvements had been made since the previous inspection this is the fifth inspection that the provider has failed to fully meet all the regulations. Since the previous inspection in February 2017, there have also been repeated breaches of the same regulations. These include: safe care and treatment; need for consent; person centred care; and good governance. The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their audit systems had not identified that the continued breaches of the regulations had failed to be sufficiently rectified. Breaches relating to safe care and treatment and good governance were first identified in our inspection report published in February 2016. The service was also placed in special measures at this time. When placed in special measures the expectation is that providers found to have been providing inadequate care should have made significant improvements within twelve months. The provider has failed to make significant improvements.

Effective systems had not been put in place by the provider to identify the concerns found at our previous inspections. Following the first day of our inspection the operations director added our initial feedback findings to their improvement plan. They had failed to identify the initial identified issues of concern.

We noted that where their internal audits identified similar concerns found at our inspections they had failed to be addressed in a timely manner. At our inspection conducted in October 2015, we identified that falls risks were not adequately managed. In a report dated on 7 July 2017, they identified that falls risk assessments were still incomplete. The staff member responsible for care plan audits reported their concerns to the manager and operations director about the responses from the staff team regarding their documentation of care planning and updates. Staff had failed to take forward the care plan audit recommendations. On the 1 June they stated in their report; "The results of the monthly audit were again unsatisfactory, this is a path we cannot continue."

At the same inspection conducted on October 2015 we reported that people were not safe and protected from risks to their health and welfare because parts of the premises and equipment were not clean. Infection control audits conducted in October and June 2017 continued to identify similar concerns regarding the cleanliness of both units.

The leadership meeting held on the 10 July 2017 advised that the last Independent Certified Fire Risk Assessment (2015) had been found. The meeting was attended by the provider and the senior management team. The operations director advised when investigating the content of the report that the old boiler store in the Elms was viewed and was still presented with clutter, paint pots, waste paper and limited access to the hot boiler. The door to the room was not compliant and the room needed urgent attention to make safe. Despite conducting fire maintenance checks this had failed to be addressed by the provider within a reasonable time scale. Their internal maintenance audits had failed to ensure that the premises were safe. The issue was finally addressed following the leadership meeting. However, this hazard placed people at risk for a considerable period of time.

The provider continues to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found a failure to notify CQC of all incidents that affected the health, safety and welfare of people who use the service. At this inspection, sufficient improvements had been made. Statutory notifications are now being submitted when required.

Staff felt well supported by the manager. Comments included; "The manager is alright. We can go to her with any problems"; "We've had lots of changes, lots of different management. Its hard work, morale is quite low. We want to make it right"; and "The care is better now. I know we've had problems with the paperwork, but the care is brilliant."

The manager held a regular programme of staff meetings to advise them of operational issues and actions required. A recent staff questionnaire asked what they would like improved at the service. Their answers included; managing performance, staff morale, improve décor, bathroom and wet room improvements. They felt their involvement in a dementia project improved dignity, choice and respect. Staff also believed that they provided good care, empowerment and special moments for people and they had good interaction. Following staff comments, the manager had produced an action plan. Actions taken to date included the completion of the kitchenette and ensuring that on-going supervisions and appraisals were taking place.

People and their relatives also spoke highly of the manager and the provider. Comments included; "I can talk to the owner, he listens, they do their best"; "I have got great hopes for the new manager, I feel she is someone who will get things done"; "I know the owner, he is very approachable, on the whole everything is OK"; and "I think the home is very family orientated, well run and well organised, all staff seem to have a good relationship."

People were encouraged to provide feedback on their experience of the service. Feedback from the most recent questionnaire highlight that some people had not been made aware of the complaints procedures. They felt that the décor could be improved and more drinks should be offered to relatives when they visit. The manager had implemented an action plan to take issues forward. This will include the complaints procedure in the next newsletter alongside displaying the procedure in the service. People are now able to help themselves to drinks in the Elms Unit. Relatives meetings were also held to discuss on-going issues such as staffing, menus and activities.