Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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07 October 2016

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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

Abbeville Residential Care Home provides accommodation and care for up to 38 older people, some of whom may be living with dementia. At the time of our inspection there were 17 people living in the home.

A registered manager was 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.

This inspection took place on 06 and 07 October 2016 and was unannounced.

Prior to this October 2016 inspection the service had been inspected in May 2016 and six breaches in regulations had been identified.

This October 2016 inspection found that some improvements had been made, but that concerns remained in some areas and new concerns had been identified. We found that there were breaches of seven regulations, five of which had also been identified as breaches at the May inspection.

Some people were not safely supported with their nutrition. One person had been given drink and food that was not in accordance with advice provided by the Speech and Language Therapist. Another person's weight loss had not been followed up from May 2016 when staff had last raised concerns with the GP.

Other issues relating to nutrition included inaccurate care plans, poor knowledge of dysphagia diets in the kitchen, poor adherence to dietary guidance and poor recording of people's nutritional intake for people identified as at risk.

Risks had been identified, but the actions taken to mitigate the risks often provided unclear guidance for staff. This contributed to people receiving inappropriate support, particularly in respect of nutrition.

The risks from legionella had not been adequately addressed. There was no routine analysis of accidents and incidents taking place. Again, these had both been identified during the May 2016 inspection.

This inspection found concerns in relation to cleanliness and hygiene in the home. We identified two people who were not effectively supported with their personal care.

The service had introduced a computerised care plan system. People care plans had not been sufficiently personalised and did not contain clear guidance for staff. This meant that people may not have received appropriate care and support.

The service was not well managed on a day to day level. This was evidenced by issues identified at the May

2016 inspection not being rectified. The manager had over relied on the computerised care system and had not adapted audits on it to be more meaningful. Consequently, the same issues remained. Some audits had not been carried out with a high level of scrutiny and there was little or no sampling to evidence the assertions made.

There was no system in place to ensure that charts required to monitor dietary intake or reposition people who had or were at risk of pressure areas were routinely completed. Therefore the provider could not be sure that the actions staff took were effective in supporting people's welfare.

The provider had failed to be open with people living in the home, their relatives and visitors because they had failed to make the report from the May 2016 readily available in the home.

Some improvements had been made. Staff training was now up to date and staff were receiving supervisions. However, two new catering staff members had not received the training necessary for them to carry out their role effectively.

The provider had engaged a management consultant who worked one day a week in supporting the managers of the provider's three homes. Consequently, the manager was receiving supervisions and monthly reviews were carried out on behalf of the provider in relation to the service provider for people.

Newly appointed staff had commenced duties without robust recruitment checks having been made. People living in the home were happy any concerns they had would be dealt with, but this did not extend to people's relatives. The regulations covering recruitment and complaints had also been in breach at the May 2016 inspection.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Both environmental risks to people living in the home and risks specific to individuals were not mitigated and acted upon.

Recruitment processes were not safe.

Some medicines were not secured, however people received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

A combination of factors meant that people did not receive effective nutritional support.

Improvements had been made and most staff now received suitable training and support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff supported people in a relaxed and kindly manner.

Some people were not suitably supported with personal care which put them at risk of infection and did not promote their dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain specific detail for staff to follow which meant people may not have received appropriate care.

Concerns were not always responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Whilst provider oversight had improved with the assistance of a management consultant, the management of the service was not identifying or remedying issues. Several concerns had not been rectified that had been identified at the May 2016 inspection.

The service had not displayed their previous report from the May 2016 inspection. This was indicative of a lack of openness and transparency.

Abbeville Residential 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 06 and 07 October 2016 and was unannounced. The inspection team comprised of two inspectors.

Prior to this inspection we reviewed information we held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During the inspection we spoke with six people living in the home and relatives of four people. We made general observations of the care and support people received at the service throughout the day. We also spoke with the provider, the manager, the provider's management consultant, three care staff, a domestic assistant and both cooks.

We reviewed seven people's care records and the medication records of four people. We viewed two records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our last inspection in May 2016 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's welfare were not always identified or mitigated.

This October 2016 inspection found that some improvements had been made, but that concerns remained in some areas and new concerns had been identified.

One person had a portable electric heater in their room. They told us that they were cold. A label on the heater showed that it had been due for a PAT (Portable Appliance Test) in December 2014. We could not establish whether the heater had been tested at this time or subsequently. This was because whilst records held showed that several heaters had been checked on an annual basis, there was no way of distinguishing between heaters other than by any PAT labels on individual appliances. The manager told us that the next round of PAT checking was due in November 2016 and that they would ensure that the heater was tested then. We did not consider this to be a satisfactory response to mitigate the risk of harm to the person and asked that the heater was exchanged for one that had a current PAT.

No risk assessment had been put in place for the use of the heater prior to our inspection. However, a risk assessment was completed for the safe use of this heater during our inspection. When we looked at the risk assessment, we found that it did not consider the person's comprehension of risks the heater could present, for example, in relation to clothing being in close proximity.

Neither of the two communal bathrooms on the first floor were in use but they had not been sealed off. The manager told us that this was because they were waiting for new bath chair seats which had been found to be soiled during our May 2016 inspection. The toilet had been used in one of the two bathrooms but the flush was not working so the toilet could not be cleaned. The end of the bath panel was hanging loose with a sharp edge. Due to the position of the bath in the room it would have been easy to brush against it which could cause injury.

Our May 2016 inspection found that there was no legionella risk assessment or actions being taken to reduce risks. The water system had last been sampled in May 2013. This October 2016 inspection found that the water system had been sampled in June 2016 and no traces of legionella had been found. However, there was still no risk assessment in place or maintenance tasks such as routine water temperature testing being done. The manager could not provide a policy or procedures for the control of legionella.

The ripped flooring in one person's room that we had noted from our May 2016 inspection had still not been satisfactorily repaired or replaced. This continued to place the person living in the room and staff at risk of harm.

One person who required thickener in their drinks was observed to be drinking a non-thickened drink over the lunch time period on one day of our visit. A letter from the Speech and Language Therapist in the kitchen

showed that the person required 1.5 scoops of thickener per 200 mls of liquid. However, their care plan stated that they required 2.5 scoops of thickener. The lack of accurate information for staff to ensure that the person had their fluids thickened appropriately placed this person at continued risk of choking and aspiration. Suitable arrangements were not in place to ensure the person was supported to drink safely.

The same person had been assessed by a Speech and Language Therapist (SALT) as also requiring a fork mashable diet. We observed them eating sausages which were not consistent with the diet recommended by the SALT and placed the person at risk of choking.

Staff had raised concerns with a GP in May 2016 regarding one person who had been losing weight. The GP had provided a leaflet regarding fortification of food. Whilst the records were not completely clear they did suggest that the GP would be making an onward referral for specialist support. The person had since continued to lose weight, albeit slowly. Until we raised a query during this inspection with the service there had been no follow up with the person's GP in relation to the person's dietary requirements.

Risks assessments were in place and reviewed on a monthly basis in relation to people's welfare, for example, their risk of developing pressure areas or not eating or drinking enough. However, the guidance for staff was sometimes unclear or incorrect and as a consequence could put people's welfare at risk. One person's action plan to help reduce the likelihood of falls stated that 'The correct sling should be used and the correct coloured loop.' However, there was no clarification of what the 'correct' equipment was. Another person's risk assessment for medication stated that 'possible' risks in relation to their medication included refusal and swallowing difficulties. However, there were no plans in place to mitigate these risks.

Our previous inspection found that records of accidents, which were mainly falls, were kept. The records had provided insufficient detail and no analysis had been undertaken to identify whether there were any patterns in the falls people sustained. No determination had been made about whether the service could make operational changes, for example, a staff presence in certain areas at certain times that would help reduce any re-occurrences.

Since our last inspection the service had implemented a computerised care records system which was used to record incidents and accidents. We reviewed four accident/injury forms. These recorded when the incident was logged, but not what time the person had been found or when the incident had occurred. The manager told us that they reviewed each form and that they could interrogate the system to see what falls had occurred. However, there was still no routine analysis of incidents taking place that could be used to make improvements in how the service was organised to help reduce incidents.

This inspection found that there were concerns regarding the cleanliness of the home which presented a risk of infection from cross contamination. At our May 2016 inspection bedrooms were in use across three floors and two cleaners were employed. This October inspection found that the top floor was not in use and that one cleaner was now employed during the day. They told us, "I have enough time to do the cleaning, but not to do everything as thoroughly as I would like."

One person was using a urine bottle that was unclean and heavily scaled. Both bathroom floors on the ground floor had excessive amounts of dirt and debris on them. One toilet contained a waste bin holding used hair dye and clumps of hair that had been there since the hairdresser had visited three days previously. The laundry room was unclean and the flooring was not intact. Some rooms contained cobwebs. One person's relative told us, "There's often rubbish all over [family member's] room. I'm always told that it's because the cleaner hasn't been round yet, but I go in at different times." Another person's relative told us that there were often no pillowcases on their family member's pillows and that sometimes they had to pick

up used gloves from the floor.

Prescribed topical creams were left in trolleys with the keys in the locks on both floors of the home. This meant that there was a risk of inappropriate access and accidental harm. We had also found creams unsecured during our May 2016 inspection.

These findings meant that the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some improvements had been made since our May 2016 inspection. Window restrictors were now in place on the upper floors and the fire detection and alarm system testing was now up to date. Drink thickener in the kitchen had been secured. Consequently, there was no longer a risk of people accidentally ingesting this hazardous substance.

Our last inspection in May 2016 identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the recruitment processes in place were not robust and did not fully mitigate the risks of employing staff unsuitable to their role.

We reviewed the recruitment files for two people employed since our previous inspection in May 2016. We found that proof of identity and photographs of each person were in place.

One person had commenced work before any references had been received or a DBS (Disclosure and Barring Service) check had been completed. A DBS check determines whether a person has a criminal record or is on a barred list for working in the care sector.

The second staff member had commenced duties when only one reference had been received. The second reference had subsequently been provided by the manager who told us that they had gone to school with the person so felt able to give them a personal reference. This person also commenced duties before a DBS check had been completed. The manager told us that because they were able to provide a personal reference that the person could commence duties before a DBS check had been completed.

These findings meant that the provider was still in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prescribed topical creams were kept in a trolley on each floor. However, both trolleys had the keys in the locks. One person's relative told us that their family member required pain relief patches to be administered and that one staff member did this. Pain relief patches are deemed as high risk medicines so a second staff member needed to be present to witness this. The relative told us, "For a while there were two staff doing this, now we're back to one again like there used to be." The administration record for these pain patches showed that two staff were routinely signing to say the patches had been administered.

Body maps were used to ensure that the position of pain relief patches applied to the skin were rotated in order not to cause skin irritation. We sampled stock levels of people's medicines and found that stock levels agreed with the documentary records. People's Medicine Administration Record (MAR) charts were correctly completed and frequent checks were carried out to ensure that people received their medicines in a timely manner. Guidance was in place for staff to help ensure that safe medicines administration took place for medicines prescribed on an 'as required' basis for people.

Two people we spoke with living in the home felt that there was not enough staff. One of them said, "The

care is good, but there are only two night staff on when there used to be three. I'm not sure that staff have time to do everything." The other three people had no concerns in this regard. One person told us, "I don't have to wait too long."

Staff told us that there were enough of them available to make sure that people's needs were met and that the deputy manager or manager would help out if necessary. During our inspection we observed that people were responded to within a reasonable time frame if they required assistance.

Staff we spoke with understood their responsibilities in relation to safeguarding. They knew which signs could indicate that someone was at risk of abuse and what action they would need to take. The majority of staff had now received training in this area.

Requires Improvement

Is the service effective?

Our findings

Since our May 2016 inspection the service had employed new cooks. The service had also implemented a computerised care records system. In the kitchen there were printouts from the care record system for people who required a particular diet. However, these were dated May 2016. One printout stated that a person required 'Three small high calorie meals with two to three nourishing snacks or drinks in between. Monitor intake.' However, the updated care records system showed 'Provide access to snacks, consider food record chart and consider frequency of re-screening.' There was no definitive guidance for staff to follow to ensure that the person was appropriately supported with their nutrition.

For one person there was only a SALT assessment letter which showed that the person required a fork mashable diet. There was no guidance in the kitchen about what foods constituted a fork mashable diet or any other specialised diet. This was kept in the manager's office. The manager told us that the guidance was "….available for all." Neither cook had experience of or training in catering for special diets.

Some records showed that people required snacks outside of main meal times to help encourage weight gain. However, only biscuits were offered mid-morning. One of the cooks told us that snacks were not usually offered in the afternoons. People's food records rarely showed any food offered or consumed outside of regular mealtimes.

The manager told us that five people required food and or fluid charts to be used to monitor their intake. However, no food charts had been completed for anyone since 30 September. Some staff recorded food and fluid intake on a different part of the system. However, food and drink quantities were not always recorded. This meant that that the service could not be sure that they were meeting people's nutritional needs.

We found inaccuracies and a lack of clarity in people's care plans about their nutritional requirements. There was also a poor understanding of specialised diets and a lack of adherence to guidance designed to support people nutritionally. These factors meant that some people may not have had their nutritional needs met.

Tomato ketchup and brown sauce were kept un-refrigerated in the dining room despite there being manufacturer's guidance on the bottles stating that the product should be refrigerated after opening. An external shed held additional freezers. One of the freezers didn't close properly. In the freezers we found bread rolls and sausages which had not been sealed properly, putting the food at risk of freezer burn which would have rendered them unpalatable.

These concerns meant that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The cook demonstrated that people were offered a choice of foods. People told us that their dietary preferences were discussed with them. One person had been insistent that it was 'fish and chip' day. Although it was not Friday, they were provided with fish fingers and chips. The second day of our inspection

was a Friday. We heard the cook on duty offering people a choice of either fish fingers or fishcakes. The cook told us that battered fish was not available, but that they intended to raise this as a query at an upcoming meeting.

Our last inspection in May 2016 identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received sufficient training and support to carry out their duties effectively.

A training programme had been implemented. The manager and the deputy had completed training to enable them to train staff in emergency first aid, infection control, medicines administration and moving and handling. There was due to be further training for them to train staff in dementia, mental capacity, safeguarding and health and safety.

Most staff training was up to date. Some general staff training had been done through DVD awareness sessions, but this would in future be enhanced with more face to face training as the manager and deputy became more proficient with their subjects. However, the newly recruited cooks had not received training appropriate to their role.

Staff were now receiving supervisions on a quarterly basis. We reviewed a sample of these and found that staff had ample opportunity to discuss their training and support requirements as well as make suggestions or raise queries.

We judged that whilst improvements still needed to be made the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). We checked whether the service was working within the principles of the MCA.

Most people were able to make their own decisions on a day to day basis. Where they were not staff supported them to make their own decisions were possible, for example by providing choices or rephrasing questions so that they could be more easily understood. If people were then unable to decide for themselves staff made decisions for them in the person's best interests by utilising their knowledge of the person and their preferences. We observed staff seeking consent from people before carrying out tasks and, if necessary, talking them through the actions that were being taken.

The manager told us that some applications had been made to the local authority to seek permission to deprive people of their liberty in order to keep them safe. They were awaiting outcomes of these applications.

Records showed that people had access to the health professionals necessary to help support them with their wellbeing. Records showed that people were visited by their GP, a dentist, optician, and chiropodist

when necessary. Referrals were made to appropriate health and social care professionals when required. However, people were reliant upon staff to ensure that health appointments and follow ups were facilitated. We identified one instance where this had not been followed up effectively. This meant that the person had waited longer for an appointment than had been necessary.

Requires Improvement

Is the service caring?

Our findings

Our previous inspection found that one person had faecal matter under their nails. This same person had clean nails when we saw them during this October inspection. However, we observed that another person had long nails with faecal matter underneath them. This person's records showed that they required staff support to go to the bathroom. We spoke with the relative of another person who told us, "Nine times out of ten [family member's] hands aren't washed properly after going to the bathroom." This person also required staff assistance to go to the toilet. As well as having their dignity compromised this put the people concerned at risk of infection.

Concerns were raised by two people in relation to items of clothing going missing. One person told us they hadn't seen some pairs of trousers since they moved rooms. Another person's relative told us how they had purchased a large quantity of underwear for their family member but that there were only a few items left. They did their family member's washing because of previous issues with clothing going missing. However, this had not resolved the issue of missing clothing.

People living in the home were positive about the care they received from staff. One person told us staff kept reminding them that they needed to use their walking frame when walking. Another person said, "I think the caring has improved." A third person told us, "Staff here are good." A relative told us, "Staff are good at encouraging [family member] to mix with people."

We observed that staff were cheerful, kind and respectful when supporting people. One person took a while to get up out of their chair and a staff member discreetly kept an eye on them in case they needed some assistance. On this occasion the person required no help from staff. The staff member had enabled the person to retain their independence whilst ensuring they didn't struggle unduly.

Some people whose bedrooms had been on the top floor during our last inspection had moved down to the first floor. We spoke with two people who had moved rooms and a relative of a third person who had changed rooms. One person told us they had not been asked whether they wanted to move rooms, but were happy with their new room. They told us, "I have a nice view here." However, they told us that the wardrobe in the new room was too small and that initially staff had rolled their winter coats up and put them on top of the wardrobe because they were bulky and took up more space than was available.

The second person told us that they had been asked to consider a move to the first floor. They said they had been shown a few available rooms and were happy to have one of them. A relative of the third person told us that both they and their family member had been consulted about the move and were satisfied with the outcome.

People were able to make their own decisions and could have privacy when they wanted. We heard staff giving people choices throughout the day. These ranged from what they would like to eat, where they wished to sit or what they wanted to do. We saw that one person who smoked was frequently supported to go out into the garden.

People we spoke with told us that they were involved in discussions about their care and wellbeing. One person told us, "Staff will speak with me and we'll decide whether I should see the GP." Another person said, "They discuss what care I need with me." People's views about their care requirements were noted in their care records.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection in May 2016 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not assessed people's needs on an individual basis or ensured that these needs were met.

The service had implemented a computerised care records system shortly after our previous inspection in May 2016. This had resulted in some improvement, but the service was often reliant upon the content generated by the system and had not always personalised it in relation to people's specific health needs. There were frequent references for staff to 'consider' courses of action to support people with their health or to 'consider' possible risks to people's wellbeing. These were generic prompts on the computer system that had not been amended to reflect what care and support people actually needed or received or what risks they were actually exposed to.

One person required regular re-positioning because a pressure area had developed. One part of their care records stated that they required two hourly repositioning in the day. However, another part of their care records stated that they required hourly repositioning during the day. Repositioning records we reviewed for a five day period were variable. However on each of the five days there was at least one gap in excess of three hours between repositioning records. One day there was a six hour gap in recording. The records of a second person who required repositioning to reduce the risk of them developing a pressure area also contained considerable gaps. Consequently, the provider could not be sure that people's repositioning needs were being met. A staff member told us that staff carried around notebooks where they recorded information that they could input into the computer system later on in the day which would include repositioning details.

One person's nutritional care plan which covered diabetes stated three 'actions'. These were detailed as 'Check glucose details, When GP requires this to be done and [Person] does not require insulin.' Blood glucose records suggested that the person's blood glucose levels were being checked weekly. However, there was no information for staff on when in the day the checks needed to be done in relation to mealtimes, what range of blood glucose readings would be considered within a normal range for the person, what symptoms could indicate possible high or low blood sugar and what action staff would need to take if they had any concerns. There was insufficient guidance for staff to respond appropriately to this person's needs relating to this health condition.

This October 2016 inspection found that time set aside for a specific staff member to support people socially was still restricted to two or three, four hourly sessions a week. A weekly activities calendar was on the wall in the dining room. On one day of our inspection the calendar showed that the hairdresser was due. However this was incorrect as the hairdresser regularly attended on another day. The manager told us that the calendar was wrong and needed updating. There was an activity shown for every day of the week. However, no time or location was given. Some activities shown were what people might normally be doing anyway, such as reading or watching a DVD. Given the limited time that the activities staff member had available care staff were required to support people on the other days. However, they had limited time to do

this. Some people, who had high levels of emotional need and communication difficulties received little attention from staff other than to ensure their physical wellbeing.

These findings meant that the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they had particularly enjoyed a 'fun day' that had been held in September. Another person said, "There's a few events when people have gotten together." One relative told us, "I thought people were going to be taken out in the summer for fish and chips, but this never happened."

Our last inspection in May 2016 identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not taking appropriate steps to deal with complaints.

The manager had re-designed the complaints form. However, there was no information available for people to see how their complaint would be managed or what the escalation process was in case they were not satisfied with the outcome. The complaints form stated that the service might be obligated to notify CQC about complaints. There is no such obligation.

People living in the home told us that they had nothing to complain about but they knew how to make a complaint if they needed to. However one relative told us that when they raised concerns with the manager that the manager shrugged or said that they'd raise the issue at the next meeting. They said that another family member had written a long letter of complaint to the home about six months ago. We did not see this complaint recorded either at this inspection or our previous inspection in May 2016.

Another relative told us that they had raised a concern with a senior carer recently but that the staff member had 'shrugged off' their concern.

These findings meant that the provider was still in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had logged two complaints since our May 2016 inspection. One was a complaint from a staff member about a personal matter. The other was a minor incident that the person had not wanted to make a formal complaint about but agreed that the matter could be left on record.

Inadequate

Is the service well-led?

Our findings

Our last inspection in May 2016 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance arrangements in the service were poor.

This October 2016 inspection found that some improvements had been made, but that concerns remained in some areas and new concerns had been identified.

The service had begun using the audits that were built in to the computerised care system. However these had not been reviewed for effectiveness. For example, the infection control audit asked about procedures, cleaning equipment, refuse arrangements and protective clothing. It did not ask whether the home was visibly clean. We found considerable concerns in this area. No physical checks of the premises had taken place. Inadequate checking of the premises in relation to infection control had also been found during the May 2016 inspection.

The provider had not implemented robust systems in relation to the risk of legionella. There was no risk assessment in place and routine temperature recording was not taking place. The management of the risk of legionella was raised at the May 2016 inspection, but this had not been fully resolved. This was not covered in the maintenance and grounds audit.

A 'Care Overview' audit asked whether all charts and forms were completed with appropriate information. The answer to this in the September 2016 audit was 'yes'. However, we found inconsistent recording of food and fluid intake and repositioning for people who were at risk. Some of these people had considerable health concerns. Most days there were gaps in these records for most people. There was no system in place to ensure that these charts were completed as necessary despite the provider's management consultant having raised this as in issue in their report of the service for June 2016.

A health and safety audit concluded in September 2016 that all electrical appliances had been PAT checked. However, due to records not identifying individual appliances this could not be confirmed. One electric heater we looked at which was in use had not been recorded as checked for safety since December 2013. Bedrooms and bathrooms not in use on the first floor were cluttered with furniture and equipment but had not been secured.

The manager was over reliant on the computerised care system and felt that use of the system equated with the home providing a good service for people. However, the system did not ensure that people's dietary needs were met, accident and incident forms were fully completed, that care plans were clear about what support people needed, what staff needed to do or that the home was clean. This required a level of scrutiny, judgement and insight about the day to day running of the service that was not evident during this inspection.

The manager's understanding about safe recruitment was poor. We had previously found concerns relating

to recruitment at our May 2016 inspection. This inspection found further issues.

Whilst people were now being weighed regularly there was no start to finish oversight of people's nutrition and there were numerous and varied issues that had not been identified or rectified. This covered food storage, the knowledge of specialised diets and supporting information available to the cooks, the consistency of food and fluid people received, the accuracy of nutritional care plans, supporting people with snacks outside of mealtimes, accurate completion of food and fluid charts and chasing up referrals to health professionals to support people with their nutrition.

Evacuation plans were in place for each person on the computer system. However, there was no documentary back up system that would be easy to access in the event of an emergency if there was no power.

These concerns meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we arrived on the first day of our inspection the report from our May 2016 inspection was not available for people. However, by lunchtime we saw that it was available in the foyer. We spoke with three relatives each of whom visited family members in the home at least twice a week. Each of them told us that they had never seen the report in foyer.

The failure to display the rating from the inspection of May 2016 constitutes a breach of Regulation 20A of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our May inspection the provider had engaged the services of a management consultant for one day a week. The consultant's main duties were to support and supervise the managers of all three of the provider's services, facilitate service manager meetings, to conduct service visits and carry out reviews on behalf of the provider. This had resulted in improvements that had meant that the managers now had some support, albeit for one day at week.

Meetings for people living in the home were now taking place. We saw from the minutes that people were able to raise queries and their opinions obtained. No surveys had been carried out since our last inspection to gather people's views. The annual survey was not yet due.

Staff meetings were also taking place and staff told us that they felt listened to. They felt that the computerised care system had been a positive change and that team morale and communication had improved in the last few months.