Amicus Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The unannounced inspection was carried out on 23, 24 and 26 August 2016.

Amicus Care Home Limited provides accommodation and personal care for up to 18 people. Some were older people living with dementia, some had mobility difficulties and sensory impairments. Some people received their care in bed. Accommodation is arranged over two floors. There is a stair lift to access bedrooms and a bathroom on the top floor. There were 18 people living at the home on the days of our inspection.

The service had a registered manager. The registered manager was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider of the service had recently changed their legal entity. The change meant that this was the first inspection for the new provider. However the home had been inspected before. We inspected the home on 02, 06 and 16 March 2015, and rated the home inadequate overall.

At our previous inspection on 02, 06 and 16 March 2015 we found breaches of Regulation 9, Regulation 12, Regulation 13, Regulation 14 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to Regulation 12. We asked the provider to meet the regulations by 22 June 2015. We also asked the provider to take action in relation to Regulation 9, Regulation 13, Regulation 14 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to resolve these breaches, and new breaches were also identified.

At this inspection people gave us mixed feedback about the service they received. People told us they felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Most of the relatives who we spoke with during our visit were satisfied with the service.

Medicines had not been administered, recorded, stored or monitored effectively. People had not received medicines that had been prescribed for them which put them at risk of harm. We reported this to the local authority safeguarding team.

The provider did not have an effective system to assess how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times. There was not enough staff deployed to meet people's care and support needs.

The provider did not follow safe recruitment practice. Essential documentation was not available for all staff

employed. Gaps in employment history had not been explored to check staff suitability for their role.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. Risk assessments had not always been reviewed and updated when people's health needs changed.

Fire escape routes were not suitable for people living in the home, one fire escape was blocked with laundry and one fire escape was not safe to use. We reported our concerns to the fire service.

Several areas of the home smelt of stale urine, the flooring in one of these areas was not suitable.

We were unable to ascertain if all staff had received the training they needed to provide care and support to people as we were not provided with the training records that we had requested. Staff files we viewed contained some training certificates. Staff we spoke with were knowledgeable about subjects such as safeguarding and food hygiene but practice evidenced that they had not received training in all areas to enable them to meet people's assessed needs. Staff did not receive regular supervision and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had submitted Deprivation of Liberty Safeguards (DoLS) applications for some people, but had failed to reapply for these in a timely manner when these had expired and had failed to meet conditions within these.

Staff had mixed understanding of the Mental Capacity Act 2005, however they could describe and demonstrate how they provided people with choice and respected decisions.

Decoration of the home did not follow good practice guidelines for supporting people who live with dementia.

People did not receive suitable nutrition and hydration that met their needs. People did not always received food and drink in a safe way following guidance that had been given by healthcare professionals. Records did not evidence what action had been taken when people had lost weight. Food stocks were low, staff told us this was a frequent problem.

People had not always been treated with dignity and respect. People's preferences had not been listened to.

People who were able to voice their own views and opinions were consulted through resident's meetings. However their views had not always been taken into account. Complaints had not always been appropriately managed, investigated and responded to. Action had not always been taken to resolve issues such as complaints about lack of staffing. The provider's complaints procedure did not give people the right information about who they could raise concerns with.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. The provider was not aware of the concerns we found at the inspection. Action taken by the provider to make improvements after our previous inspection had not been timely or effective.

Records relating to people's care and the management of the home were not well organised, adequately maintained or stored securely.

People were not always provided with personalised care. They were not provided with sufficient, meaningful

activities to promote their wellbeing.

Staff had a good understanding of what their roles and responsibilities were in preventing abuse. The safeguarding policy did not give staff all of the information they needed to report safeguarding concerns to external agencies.

People's health needs were not always met quickly so they did not always have access to health professionals when they needed it.

Staff were cheerful, kind and patient in their approach and had a good rapport with people. The atmosphere in the home was generally calm and relaxed.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time and were complimentary about the care their family member's received.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve

•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

You can see what action we told the provider to take at the back of the full version of this report.

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.

There were not enough staff to meet people's needs. The provider had not always followed safe recruitment practices.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

Medicines had not been appropriately administered, recorded and stored. Medicines were not monitored effectively to ensure that they had been kept at the correct temperature.

Staff understood the various types of abuse to look out for to ensure people were protected. They knew who to report any concerns to. The safeguarding policy available to staff was out of date and did not contain up to date numbers of the local government and other agencies.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the training and support they needed to meet people's needs.

Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority by the provider. However, systems to track and monitor these were not robust.

People's food and fluid had not been recorded effectively to evidence that they had sufficient food and drink to keep them well. People's specialist guidance had not been followed to ensure they received their food and drink in a safe way. People had a choice of food.

People were not always well supported with their health care needs. People saw healthcare professionals when they needed to, however, some people experienced delays.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect because their preferences and choices were not always listened to.

Staff respected people's privacy. Care records were not stored securely to maintain confidentiality.

Staff were kind, caring and patient in their approach and supported people in a calm and relaxed manner. Staff were discreet in their conversations with people, relatives and other staff.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

People knew who to complain to but did not feel confident their complaint would be listened to. Complaints made had not always been dealt with or responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not effectively assessed the quality of the service and therefore failed to identify where improvements could be made. The provider was not aware of the quality concerns within the service.

Records relating to people's care and the day to day running of the service had not been completed effectively. There were gaps in records.

There was a culture of mistrust and staff reported they were bullied.

The provider had notified CQC about important events such as serious accidents and deaths.

Amicus Care Home Limited

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 was carried out on 23, 24 and 26 August 2016. Our inspection was unannounced.

The inspection team included two inspectors. The team also included an expert-by-experience who had personal experience of caring for older people and people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An additional inspector made calls to staff members after the inspection.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications we had received and previous inspection reports. A notification is information about important events which the service is required to send us by law. We also reviewed information of concern that we had received.

During our inspection we observed care in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We examined records including staff rotas; management records, care records for seven people, medicines records for 17 people and five staff files. We looked around the premises and spoke with 12 people, five staff including the provider (who was also the registered manager). We also spoke with six relatives, one visitor, one volunteer and one visiting nurse. We made telephone calls to a further nine members of staff after the inspection.

We asked the provider to send us staff telephone numbers, training records and evidence to show that action had been taken to address safety concerns in relation to a wheelchair. The staff numbers and

confirmation of action was sent through to us in a timely manner, however the training records were not sent through despite repeated requests.

Inadequate

Is the service safe?

Our findings

At the last inspection (when the service was previously known as Amicus Care Home) we found three breaches in regulations relating to safeguarding people from harm, responding to emergencies, medicines management, managing risk and infection control. We served a warning notice to the provider in relation to risk, medicines and infection control and told the provider to comply with the regulations by 22 June 2015. We also asked the provider to take action to ensure people were safeguarded from abuse. At this inspection we found that some improvements had been made to safeguarding people from abuse but we found no improvements in the other areas.

People told us they felt safe. Some people told us there were not enough staff working in the home. Comments included, "I feel safe because there is always someone around all the time but I do think they could do with some more people as there are quite a lot of us"; "I have had one fall but there are people around which made me feel better, not so frightening as being at home" and "I feel comfortable living here, I do have a Zimmer frame to help me get around and this makes me feel safe and I don't think I will fall over with it but I could do with a stronger one".

Relatives give us mixed feedback about whether their family members received safe care. One relative felt their family member would be better off in a hospital to get their health needs met. Relatives we spoke with felt that there were not enough staff to keep people safe at all times Comments included, "The care here is very good but there are not enough people [staff] around. I do help anyone who needs it, if I can but if not I call for someone"; "The home always is clean and tidy and I always feel welcome when I come in but they don't really like you to be here at lunchtimes as they are very busy"; "I don't think there's enough staff in the evening. There is only two on. If there was a problem there is not enough staff on" and "The home is always clean, rarely unpleasant odours".

Medicines were not well managed in a way that kept people safe. People were at risk as they were not receiving their medicines as they had been prescribed by their Doctor. There were delays to medicines being given which meant people had to wait up to four and a half hours for their pain killers and medicines to treat their diagnosed health conditions. Medicines administration records (MAR) had been signed to show that medicines had been given at their expected times and not the time they were actually given. For example, Paracetamol had been signed for at 08:00 but had been given after 12:00; there was a risk that people would receive their next dose too close together and cause an adverse reaction.

Bottles of liquid medicines, solutions and eye drops had not been dated when they had been opened, which meant that there was a risk of using them beyond their safe use by date. These medicines had short use by dates. For example use within 28 days of opening. One medicine to treat Angina did not have a prescription label on, a person's name had been hand written on. Therefore the prescribers' instructions were not clear for staff and there were no instructions with the MAR.

We found a number of medicines for six people still in the multi-dose compliance aid packaging for weeks one and two, when the medicines cycle was in week three. Medicines records confirmed that these had not

been administered. No notes had been made as to why these medicines had not been administered. This meant that these six people had not had their medicines, which meant people's medical needs were not being met effectively to keep them healthy. Gaps in administration records were found on the MAR charts for a number of other people, which meant it was not possible to check that people had received their medicines at those times.

One person's MAR chart showed they had been prescribed some antibiotics which would have interacted with another medicine they were taking. The person's GP had advised that this medicine should be stopped whilst the person took the antibiotic. Records showed that staff had signed for both medicines, indicating staff had administered both of them, on four occasions in a one week period. We spoke with the provider about this and they told us that they had left a note for staff not to give the medicines. This was written in the diary for 15 August 2016. It stated '[Person] on a/b [antibiotics]. Stopped [other medicine] whilst taking a/b.' The provider told us they had removed the medicines from the multi-dose compliance aids. However the MAR chart did not evidence this.

Medicines were not always securely stored. One person's liquid medicine was found in another person's box. We found medicines on shelving in the unlocked office. The keys to the medicines cupboards and trolley were also not securely stored away. This included the keys to medicines which required safer storage by law. This meant that medicines could be accessed by unauthorised staff or people living in the home. Temperatures of medicines storage areas were not effectively monitored. The temperature record for August 2016 showed that nine days had not been recorded at all. There was no monitoring sheet for July 2016 and the record for June 2016 also showed nine days where the temperatures had not been monitored. Medicines stored in a different area of the building were not monitored to check they were being stored at the right temperature. Storing medicines outside of the manufacturers recommended range for a long period of time will affect the efficacy of that medicine and might mean they were not effective.

Photographs were not in place on all MAR charts to assist staff to identify people when giving medicines. This may lead to people being mistaken for others, especially as there were two people with the same name. Body maps were not in place to detail where prescribed creams should be applied on the body. Staff did not have guidance about where and how often to apply topical creams. This meant that people's treatment for conditions was not effective or their skin integrity may not be maintained. Some people had pain relief patches prescribed. There was no system in place to ensure that these were administered on to different areas of the body as recommended by the manufacturer and people were at increased risk of skin irritation from pain patches repeatedly administered to the same site.

This failure to ensure that medicines were suitably stored, administered and recorded was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety had not always been suitably assessed. Some risk assessments were incomplete. Risk assessments had not been reviewed and updated when risk levels had changed. For example, following falls that people had in the home or when people's health had changed. One person had been assessed as requiring a weekly review of their risk assessment in relation to their moving and handling needs. This has last been reviewed on 22 July 2016. The provider and staff told us this person's needs had changed greatly. Some people's bedroom environments had not been assessed. When we last inspected we reported about risks to one person's safety in relation to their bedroom. We checked that this had been addressed and found it had not. The person lived in a ground floor bedroom which had a patio door onto the garden. This was left open throughout the day to allow air flow. There was no restrictor on the patio door to prevent people walking out or strangers walking in. The side gate to the home was not locked, which meant that people were at an increased risk of harm from intruders and there was an increased risk of people leaving

the home undetected. The risk assessment for this person dated 18 August 2016 asked 'Do all windows open and do they pose a risk to the person?' The provider had ticked yes and written 'Restrictors in place'. This was incorrect, the person's diagnosis, environment and safety had not been considered when the risk assessment had been completed.

At our last inspection we reported that staff did not know how to safely evacuate people in the event of a fire. At this inspection, staff knew how to evacuate people, personal emergency evacuation plans (PEEPs) were in place within an easy to reach 'Fire grab file'. We found that one fire escape was blocked by wet and drying laundry and another was not suitable as it had steps without a rail and a steep ramp that was not wide enough for a wheelchair. People were at risk of harm because there was no safe way to exit the service for people whose nearest fire exits were the two fire exits which were either blocked or unsafe. Two people had been added to the PEEPs file on the 23 August 2016 (the first day of this inspection) which a staff member said they had added during the inspection. The people had lived at the home for a number of weeks. This meant that if there had been a fire during that time staff may not have known how to evacuate them and the fire service would not have had up to date information about who lived in the home.

The home was mainly clean and tidy, however two areas of the home smelt strongly of stale urine, the flooring in one of these areas was not suitable for people's assessed continence needs and could not be cleaned effectively. At our last inspection we reported one bath hoist seat was rusty underneath, making it hard to keep clean. We found this to be the case during this inspection, which meant appropriate action had not been taken to address the infection control issues.

The failure to ensure care was delivered in a safe way was a breach of Regulation 12 (1)(2) (a)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practice was not safe. Four out of five staff files did not have photographs to confirm staff identity, and four of the staff files did not have a full employment history. The provider had employed new staff since the last inspection and had not checked reasons for gaps in employment. Two new staff members had gaps of nine years in their employment history which had not been explored. Other applications showed repeated gaps. Two staff files did not have dates that the staff left school or college so it was not possible to know if there were further gaps that had not been explored. The provider had not carried out sufficient checks to explore the staff member's employment history to ensure the staff member was suitable to work around people who needed safeguarding from harm. References had been received by the provider for all new employees. The provider had not carried out their own disclosure barring service (DBS) checks or risk assessed volunteers who were working unsupervised in the home with people. This put people at risk of harm.

This was a breach of Regulation 19 (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not enough staff deployed to meet people's needs. The staffing rota did not adequately identify which staff were on shift. On each day of the inspection there were three staff working in the morning and two staff in the afternoon. On the first day of the inspection, two extra staff arrived at the service, they had been brought in because of the inspection. One person told us that the staff were being brought in from their annual leave because we were there. One staff member confirmed this. Staff were very busy and stretched to provide care and support. At least six people required two staff to assist them with repositioning or personal care. This meant that in the afternoons, evenings and at night whilst two staff supported one person the remaining 17 people were not monitored effectively to keep them safe while the two staff on duty provided support to others. Some people had to wait for their care needs to be met as the staff were busy

helping others. One person told us there was not enough staff to support them to have a bath. They said, "I have asked them for a bath but they are short staffed as usual". The person also said they had to use a continence aid because there was not enough staff to enable them to be transferred to a toilet or use a urine bottle. They said, "It's degrading" having to urinate in a continence pad. Agency staff were being used to cover vacancies and sickness, this added to the pressures on staff. For example on the 26 August 2016, two agency staff were working in the morning with one member of permanent staff. One of the agency staff was male and could not work with some people in the home to assist them with their personal care, the agency staff members did not know people well and this led to lots of questions and support from the permanent staff member. This in turn caused delays to medicines being administered. A staff member confirmed that when the service was short staffed and only two staff worked in the morning, medicines were frequently given late.

We observed that people who received care in bed received minimal contact from staff unless it was to carry out a task such as assisting with drinking, eating or personal care. One person who was living with dementia received very little contact from staff unless it was in relation to a task, such as giving the person a drink of taking away an empty cup. We observed this happening on each of the days we inspected for long periods of time (more than three hours on one occasion). One staff member told us they were, "Absolutely exhausted". Some staff were upset and tearful when telling us that they could only spend limited time with people as they hadn't got time. One staff member said, "I'd like to be able to do more, I haven't always got time to chat and sit with people". Another staff member said, "My main concern is staffing levels. There just aren't enough of us".

The provider told us that they were advertising for staff, they had recognised that the current method of advertising was not successful. The provider and registered manager had met with staff on the 18 August 2016 to discuss staffing and stress levels and agreed that they would put an advert in the local paper. The provider told us they had not done this yet. The provider did not review and amend their staffing levels according to people's needs. There was no assessment tool to determine safe staffing levels. During the inspection several people were unwell and needed more staffing support than usual, the staffing levels had not been increased to support the people and the staff. When we spoke with the provider about our concerns regarding staffing levels they stated that the home was adequately staffed because they were present in the home on a daily basis and helped out when needed.

The provider failed to deploy sufficient staff to meet people's needs. This was a breach of Regulation 18 (1) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Cobwebs were visible throughout the home at head height and above. The home was in need of some redecoration and updating, carpets in the main hallway were worn, paintwork throughout the home was chipped and scuffed. We spoke with the provider about this and they told us they planned to carry out a schedule of works within the communal areas. A contractor was contacted whilst we were present and visited to look at the work required. Since we last inspected radiator covers had been made to protect people from the risks of burning themselves, the radiator covers had not been painted or sealed and were bare wood which meant they may not be able to be effectively cleaned. Records showed that regular checks were made on the gas safety within the home, electrical equipment and fire extinguishers. Regular fire drills had taken place. The water was monitored to prevent legionella. The provider could not provide documentation to evidence that fire alarm tests were carried out frequently and could not provide evidence that the stair lift had been regularly serviced. Staff told us that the fire alarm was tested regularly. One person told us that the stair lift sometimes broke down. We requested the documentation a number of times during the inspection. We could not be sure that these had been tested and checked as they should be.

The failure to clean and maintain premises was a breach of Regulation 15 (1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not given clear information about how to report abuse. The provider had a safeguarding policy that was dated February 2016. This detailed the responsibilities of staff to report abuse. It told staff to report concerns to CQC and gave a telephone number that was incorrect. The policy did not link to the local authority safeguarding adults policy, protocols and procedures which would have provided detailed and clear guidance to staff about signs and symptoms of abuse. We found a copy of the local authority safeguarding policy, protocols and procedures in the staff office it was dated 2014. This contained telephone numbers that were no longer in use and out of date information. The local authority rewrote their policy in April 2015. Staff we spoke with had a good understanding of abuse and how to report safeguarding concerns. Staff told us they would report safeguarding issues to the provider, they told us they had confidence that concerns would be reported appropriately. One member of staff said, "I would report to the manager, the council and CQC".

This failure to establish systems and processes to safeguard people from abuse was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the last inspection (when the service was previously known as Amicus Care Home) we found a breach in regulation relating to meeting people's nutrition and hydration needs. We asked the provider to take action to ensure people had sufficient food and drink to sustain life and good health. At this inspection we found the provider had not done this, and people remained at risk of not having their nutrition or hydration needs met.

People gave us positive feedback about the food. Comments included, "The food is good and there is plenty of it, you get a choice"; "I do go to lunch every day but it's a bit difficult as I can't hear what anyone is saying, the food is ok though"; "I like the food and you can always ask for more if you want it"; "I like the food but I don't want to join others at lunch, no-one talks to you"; "I enjoy the food, there is always plenty of it"; "The food is satisfactory, its basic cooking, nothing fancy but it's hot and there is plenty of it, sometimes too much but if it's not enough I ask for more and they will find me a bar of chocolate".

Relatives told us the food was good and their family member's health needs were met. One relative told us, "They are good at getting the Doctor, they do contact me if she's had a fall". One relative contacted us after the inspection and told us, 'Over the years my mother has received exceptional care at Amicus. They have liaised closely with the GP and other medical authorities to ensure the best possible care having regard to my mother's complex mental and physical needs'.

We carried out a discreet observation during lunch time. Several people waited for their meals for up to 20 minutes whilst other people on the same table, or sat close by ate their dinner. People who needed assistance to eat their meal did not always get consistent help. One person only ate their meal when prompted or when staff supported them to load their cutlery. They became distracted and stopped eating when the staff were not helping them. On the 24 August we observed that this person had been left in their bedroom with their meal. They had been given their meal at 13:00 and were still pushing it around their plate at 14:50.

When we checked the kitchen, fridges, freezers and store cupboards we found a selection of out of date food. This included cakes, tinned sausages, tinned spaghetti hoops, milk, and clotted cream. On days one and two of our inspection food stocks were low. There was very little fresh fruit. The fridges and freezers were full again on day three of our inspection. All the staff we spoke with told us that food stocks often ran low during the week and shopping was only delivered on a Friday. Staff told us they often bought food out of their own money and time to ensure people had food and a variety. They gave us examples of when they had done this to make sure there were enough fillings available for tea time for sandwiches. They also brought in other things like sausage rolls and pork pie because not everyone wanted sandwiches every evening. Staff told us this happened frequently mid-week. However, one staff member said the provider popped out frequently to purchase items they were running short of. We did not see evidence to show that the provider had gone out to stock up with fruit following the first day of our inspection. Staff told us that people with a diagnosis of diabetes were regularly given tinned fruit for their dessert, however the tinned fruit was in syrup. Two staff told us one person's blood sugar levels were often very high as a result. One

person's care records detailed their blood sugar levels were tested monthly. Care plans stated that if the blood sugar reading went above 20 then staff must call the GP surgery or out of hours emergency GP. We found records that showed on three occasions this person's blood sugar level was over 20 but there was no record of what action had been taken. The cooks employed by the provider were agency cooks; they did not know people well and had not prepared food to meet people's diabetic needs.

This failure to provide care and support to meet people's assessed needs was a breach of Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had been assessed as at high risk of choking due to their medical diagnosis. They had been assessed as requiring thickened fluids and soft food. We observed that the person was given a drink by agency staff that had not been thickened, which meant that the person was at high risk of choking. A staff member told us that this had happened a number of times when agency staff had been working. The person's care plan detailed that the person must have mashed food and must be assisted to eat using a teaspoon and food must be washed down every two to three spoonful's with sips of thickened fluids. It also stated that they must be fully alert and upright. We observed one occasion where this person was left in the lounge with sandwiches cut up in front of them they were sitting in a high backed chair, leaning backwards and no staff were in the room. This meant that the person was at increased risk of choking.

We inspected the service during a heatwave, the reported high temperatures on the first day of our inspection were 31 degrees Celsius, the second day was 34 degrees Celsius and the third day it was 28 degrees Celsius. The provider had not followed their '26 degree Celsius hot weather action policy' which stated that when temperatures exceeded 26 degrees Celsius, the provider would provide cool foot baths, wet towels, encourage loose light clothing, provide iced drinks and offer cold foods such as fruit and salads. This did not happen. People had the choice of chicken casserole and vegetables or sausages, mashed potatoes and vegetables on day one. Shepherd's pie was available on day two and fish, chips and peas or ham, egg and chips were available on day three. There were no iced drinks available during the three days. The only fruit available on day one and two was a pack of six bananas. We observed one person cared for in bed had drink available to them which was not in reach. At 11.35 on the 26 August we observed one person was assisted by their relatives to drink a thickened drink. We asked staff how much thickener had been added to the drink to check that it had been made following the person's guidelines. None of the staff on shift had made the drink and one staff member confirmed that the night staff had made the person the drink before they had left in the morning. This meant this person had not been supported to stay suitably hydrated in the hot weather.

The provider's food and nutrition policy was dated March 2016 detailed that food safety guidelines would be followed to protect staff and people from food related illnesses. The policy included a template food and fluid chart for staff to use to document people's food and drink intake. The policy clearly stated 'The quantity of liquids each service user consumes (for example by fluid ounce/teaspoon full etc.) will be recorded to ensure that the risks of dehydration are minimised'. Staff were not recording the quantity of drinks in people's fluid charts. Charts were often incomplete.

One person had been assessed at risk of weight loss, and the care plan detailed that they needed to be weighed weekly. The person's records evidenced that they had only been weighed monthly, which meant they were at risk of further weight loss and delays in taking appropriate action. Another person's care plan detailed that they required a high calorie diet and staff should use full fat milk. They had been losing weight and had lost 2.7kg in three months. We checked with the cook whether this person's food had been fortified with additional calories and using full fat milk. The cook was not aware of anyone on high calorie diet; this meant that this person was at risk of further weight loss. Another person's care records showed they had lost

7.59 kg between November 2015 and July 2016. They had last been weighed on the 15 July 2016. There was no evidence to show that they had been referred to their GP or a dietician, however the provider assured us that the person had been referred online to a nutritionist. We did not see evidence to support this.

The provider has failed to ensure peoples nutritional and hydration needs have been met in a safe way. This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a menu board in the corridor which detailed what food was on offer, this was not in an easy to read format which may have helped people living with dementia when choosing what meal they would like.

We were not able to ascertain if staff had received all the relevant training to enable them to meet people's needs as the provider could not produce any records to show what training staff had undertaken. The five staff files contained some training certificates. These showed that three staff had attended medicines training and health and safety training. Two staff had attended moving and handling, first aid, safeguarding, fire and food hygiene training. One staff member had attended diabetes training, one had attended dementia training and one had attended infection control training. Several staff told us that they had not received any training. Some staff told us they had completed some such as infection control and safeguarding. Staff we spoke with were knowledgeable about some subjects such as safeguarding people from abuse and infection control. People had received poor care in relation to meeting their diabetes, dementia and nutrition/hydration needs, which evidenced that staff had not been given adequate training to meet people's assessed needs.

Staff supervision is a one to one meeting with a manager or senior member of staff. It is intended to enable managers to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This assists in ensuring clear communication and expectations between managers and staff. Supervision processes should link to disciplinary procedures where needed to address any areas of poor practice, performance or attendance. The provider's supervision policy stated that staff would be provided with supervision at least six times a year. Staff did not receive regular supervision with their line manager. We found only three records of staff supervision meetings that had taken place in 2016. Staff gave us mixed feedback about the support they received from the provider. One member of staff said they felt well supported; one staff member said "I am supported by other staff, not by the manager not all the time. No supervision ever". Another staff member told us, "I feel I am supported by other staff but not always by the manager". Another staff member said, "I do not feel supported, there are no staff meetings, I saw my name down as being at a meeting I never knew about, let alone be there. I have never attended a meeting. Also I have never had supervision". One member of staff told us they had received one supervision in the last year. The staff member told us that the provider had met with staff to discuss stress levels and suggestions were made about staff changing their hours, however "No action was taken as a result". There were records that this meeting had taken place on the 18 August 2016. We found records of two other meetings in which four staff attended to discuss door security and procedures for letting people in.

This failure to provide training and support for staff relating to people's needs is a breach of Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff had received an induction. There was inconsistent practice in relation to staff induction procedures. Some staffing records showed that staff had had an introduction into people's care routines and routines of the home. One staff file contained a blank care certificate workbook and one staff file contained a completed workbook with records to evidence that the provider and the registered manager had discussed practice in these areas. We spoke with the provider and about staff undertaking the care

certificate. They told us that only one staff member had completed this and that the workbooks had put people off. The provider had not yet developed systems to assess staff progress and competency in each of the areas covered by the care certificate. Staff had been supported to undertake qualifications relevant to their role, such as diplomas and National Vocational Qualifications (NVQ's) in health and social care.

The environment did not meet the needs of people living with dementia. The provider had told us when they completed their provider information return (PIR) that they had improved signage within the home. There were no signs to help people find their way around the home. Some bedroom doors had numbers on, some did not. A number of the doors looked the same which could cause confusion. One hallway had a patterned carpet. The provider told us that some people struggled to walk on this because they were confused by the pattern. One hallway in the home had been repainted and plain flooring had been laid which made it easier for the three people that lived in this part of the home. Whilst the provider had made links with external organisations for advice, guidance and information about best practice this had not been reflected in practice in the home.

The premises were not suitable for the needs of people living with dementia. This was a breach of Regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that systems to monitor DoLS authorisations were not robust. Two DoLS authorisations had expired and the provider and the registered manager had not reapplied to the local authority for several months. This meant during this period people were unlawfully deprived of their liberty. We spoke with the provider about this and they told us there had been some issues with DoLS monitoring, they said "We have had some issues with some [DoLS] lapsing, I won't let it happen twice". Two DoLS authorisations had conditions in place, which the provider had been asked to meet. The conditions had not been met. One condition was to ensure there was a best interest meeting to review and update a person's Do Not Attempt Resuscitation (DNAR) order. There was no best interest meeting record to evidence family involvement in a decision relating to the revised and updated DNAR which meant that decisions had not been made in line with the Mental Capacity Act 2005.

Failing to lawfully deprive a person of their liberty was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was mixed understanding of the Mental Capacity Act 2005 (MCA) by staff. Staff described how they encouraged people to make choices about their care and life such as choosing clothes and food. We observed people being offered choices throughout the inspection. One staff member said, "[Person] has dementia, issues are around not wanting personal care, so we and daughter make decisions for him". Other staff gave us examples of how they supported people to make choices which included coming back at a later time to offer choices again.

People did not always receive medical assistance from healthcare professionals when they needed to. On the first day of our inspection one person was not well, they needed medical assistance and relatives were concerned about their welfare. The provider did not to assure the relatives that medical attention would be requested. The provider told the relatives that the person was suffering with indigestion. On day two of the inspection the person was still unwell. The symptoms were the same as the day before, staff told us that the GP had been called and they were waiting for a visit. Following the GP consultation, the person was admitted to hospital.

This was a breach of Regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. We observed staff reassuring people who were in pain and discomfort that medical help was on its way. We also observed staff checking people when they had fallen to make sure they had not injured themselves. People were supported to see the GP when they needed it. District nurses visited the home daily to provide nursing care and treatment to several people. Records evidenced that staff had also contacted paramedics, out of hours GP services, dentists, opticians, chiropodists, Speech and Language teams (SALT), social services, community psychiatric nurses, hospitals and relatives when necessary. The visiting nurse told us, "We have a good relationship with the manager here, she's responsive and always helpful". One person told us, "The girls make my hospital appointments for me but my daughter takes me".

Requires Improvement

Is the service caring?

Our findings

At the last inspection (when the service was previously known as Amicus Care Home) we made recommendations to the provider about improving engagement with people living with dementia and improving language used to describe people's needs. At this inspection we found that further improvements were needed.

People told us staff were kind and caring. Comments included, "The staff are kind, I have a call bell which I can use at any time and they know how I like things done" ; "The care is very good here I get help with personal things but choose what I want to wear"; "The staff are kind and do look after me, they know I like a regular bath and they are polite and knock on my door even if it is just to say hello"; "The staff are very kind"; "I try to keep my independence but they do ask if I need any help, so they do keep an eye on me"; "I like it here because it's a home not a big place so you get to know people and they [staff] know you"; "They are very good to me here" and "They treat me with respect, they are lovely".

Relatives said that staff were kind and caring towards their family members. One relative said, "I can't fault the staff here. It feels like an extended family. I go away from here happy she is going to be looked after"; "I chose this home because it's like an extended family. They do look after her. They are so kind. Here, you are a person" and "They talk to her nicely, knock on her door before entering. They always speak directly to her. They're so loving. I'm confident she is well cared for. I'd never want to move her from here". One relative who contacted us after the inspection told us, 'I cannot praise the carers at Amicus enough for the continuing care provided to my mother'.

Despite the positive comments we received from people and their relatives. We found that people were not always treated with dignity and respect. One person had told us they were not treated with dignity and respect as they felt degraded by having to go to the toilet in a continence pad. They told us they could easily use a continence aid such as a bottle to urinate in. The person's continence assessment did not detail the person's wishes or abilities in relation to using a urine bottle and had not been reviewed since July 2016. They told us they didn't get support to have a bath or shower very often. We heard them asking throughout the inspection for a bath. They told us they were in pain and had asked staff for a bath as they felt it may relieve some of the pain. They detailed that they had not received frequent baths at all. Records confirmed this. They preferred to have a bath daily, but went on to say "I don't expect it daily here; at home I had a bath daily, cleanliness is so important".

A relative told us that staff could not respond quickly to the call bell due to the staffing levels. People's requests for help and reassurance were not always met. Another relative told us, "The staff are always very busy. They do help people (I come in several times a week) but there are just not enough of them and sometimes if (like today) someone wants the toilet they want it now not later on, she has sat heir wriggling and getting more uncomfortable". We observed this happened during the inspection.

We observed that one person was laid on their bed partially clothed with their underwear half on, they were in discomfort and were waiting for a nurse. The person's bedroom door was open which meant that other

people and visitors to the service were able to see them partially dressed.

People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff being caring and considerate when speaking with people. For example one staff member was seen supporting a person with preparing for a bath, they asked which bathroom the person wished to use, what toiletries they wanted and said they would go and run the bath first. The staff member had a good rapport with the person and others. Permanent staff knew people well. They knew their likes and dislikes and preferences. One person said, "The staff are kind and know how I like things done, they don't ask me if I want a bath because I don't, I'm quite happy with a strip wash". Another person told us, "I get up and go to bed when I like, they know I like to go by 8.00 as I get up early, which I have always done".

During the inspection we observed staff knocking on doors and asking permission to enter. One person told us, "They are polite and do knock on my door". Another person said, "Staff knock on doors and know when I am washing or changing so leave me alone to do it".

Staff told us how they promoted people's dignity by ensuring that doors were closed when they provided personal care and that they covered people with towels when supporting them so they did not feel exposed. We noted that staff closed the curtains when providing personal care in people's bedrooms when visitors were in the garden. Staff had a good understanding of the need to maintain confidentiality.

People told us they had been involved in making decisions and planning their care. They were asked how they want to be cared for and about their likes and dislikes. People told us they had been given choices about whether they were supported by male or female staff and these choices had been respected. People told us "I can go to bed and get up when I like"; "I was offered care from a man but I refused that and said I wanted a lady, well you do don't you for the personal things, I would have been embarrassed, anyway that was ok because they let me have a lady anyway"; "It's a good idea to have some men as there are men here who do need help"; "I don't need help as I prefer to do it myself but I know they are around and I will tell then if I am going to wash or do my hair in the wash basin in my room so they are aware in case I need them".

People told us they were as independent as they could be. One person said, "I have nothing bad to say about living here, I have everything I need and am still very independent". Another person said, "I can still be independent, although I do need some help, I can get up from a chair by myself to use the Zimmer frame, although that is a bit cumbersome". A third person said, "I am very independent and prefer to do everything for myself, I could ask for help if I want it but I don't".

Relatives told us that they were able to visit their family members at any reasonable time, however visiting at meal times was discouraged. One relative explained that they visited their family member at different times of the day and they were always made to feel welcome. We observed relatives spending time in the garden and in people's rooms when they visited, which meant that people had space to talk privately with their relatives. People told us, "Visitors come in whenever they want. I have two friends that come and visit me"; "I do have visitors and it is nice to sit in the garden which we often do, it's very nice out there, I do love gardens and miss my own"; "I do get visitors and have been able to go home to my son and daughter and do go for Christmas time with the family. It's nice to sit in the garden here it's very good and there are seats in the shade if it's too hot".

Independent advocates were in place and were working with some people. This ensured that people had

additional professionals in their lives to monitor the care and support they received to ensure that their choices and decisions were being respected.

Inadequate

Is the service responsive?

Our findings

At the last inspection (when the service was previously known as Amicus Care Home) we found a breach in regulation relating to people not receiving care which met their needs or preferences. People were also at risk of becoming socially isolated with little activity to stimulate or interest them in order to meet their needs. We asked the provider to take action to make improvements to care plans and activities. We also made recommendation to the provider in relation to improving care for people living with dementia and the complaints process. At this inspection we found that sufficient improvements to care plans had not been made; people's care plans had not always been updated when their needs changed. There had been no improvements to activities, care for people living with dementia and the complaints processes.

People gave us mixed feedback about the activities on offer at the home. Some people told us they were bored. Comments included, "I do get very bored here, there is not a lot to do, residents are very many, so I spend time in my room. I like the television but I can't get it to work"; "There is not a lot going on here and I do like to have an interesting talk as it stimulates my mind and gives me something to think about. [Person] and myself talk about all sorts of things from the Olympics to politics and we do that every day"; "I like quizzes which we sometimes have, because they keep my brain going. Each Sunday we do have a man come in and play music, stuff we sing along to which I enjoy, they do have a small exercise class but it's very simple and not for me" and "There are sometimes activities going on but I am not really that interested so don't bother with them. There is nothing bad about being here but it's not home".

Relatives told us that there were some activities on offer. Relatives knew who to complain to if they needed to. Comments included, "There are not a lot of activities going on but they are always busy so they don't really have the time"; "They play bingo and there is an exercise lady. Not sure what she gets up to when I'm not here"; "Mum doesn't really want to do anything, she watches TV, she liked knitting. I might bring in some cards. She did activities once, she played bowls. Someone came at Christmas to sing" and "I would complain if I saw something I didn't like and I do try to help people if they need it".

A visitor said, "On a Sunday afternoon they have a man who comes in to play tunes. The girls [staff] sit and chat with him"; "If I'm worried they are very approachable, both [registered manager] and the girls [staff]" and "He is isolated but it's unavoidable. We used to take him out but his mobility is poor".

The provider had told us in their provider information return that they had an activities coordinator at the service. There was not an activities coordinator employed by the provider. The activities coordinator the PIR referred to was a volunteer who visited the service once a week for one hour. We observed that no activities took place at all on the 23 and 24 August 2016. Some people were able to move around the home themselves and provide their own stimulation such as reading, listening to the radio and talking. However we observed that many people sat in the lounge area or dining area or their bedroom, with no interaction, stimulation or activity to keep them active and engaged. One person living with dementia spent long periods of time sitting with no interaction and nothing to do. Activities for people living with dementia had not been considered.

We spoke with the provider about the activities and lack of stimulation for people. They told us that volunteers visited the home on a Friday and Sunday each week. We observed on the 26 August that a volunteer did arrive and spent one hour in the home talking with people in the lounge area about current affairs and talked people through doing some gentle exercises. The provider told us that the volunteer that visited on a Sunday played music, no other planned activities took place outside of this time. This meant that people only received activities for two hours per week. People did not always have enough to keep them occupied, especially people that were cared for in bed. There was no scheduled activity plan detailing what was activities were on offer. When we discussed the lack of activities on offer in the home the provider did not agree and stated that there were activities. They told us that a motivation activity took place once a month and an opera singer visited the home five times per year as well as the hair dresser visiting weekly. The provider also told us that staff ran quiz activities. People were not supported to frequently access their local community, unless they had relatives that took them out.

There had been improvements to care plans since we last inspected the service as these now contained information about people's life history, preferences, likes and dislikes. However, one person had been diagnosed with dementia in May 2016, but their care plan and documentation had not been reviewed and amended to give staff updated guidelines and information about how to meet their care needs. This person frequently became confused about their ability to walk unaided, we observed that other people living in the home tried to remind the person not to stand or walk and to use the call bell to summon assistance, this did not always work and frequently led to the person falling. People's preferences and choices were not always respected. For example, people had not received baths as frequently as they wanted.

The provider was not providing care or activities for people in a responsive or person centred way. This was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives knew who to talk to if they were unhappy about the service they were receiving. One person said, "I have never had to complain but I would if I was not happy with things, although I would think about what action I should take before complaining". We had mixed feedback about people's and relatives confidence in the process. People knew who to complain to. One person said, "She won't like that" when we offered to pass on a concern for them. We asked who they were talking about. They explained they were talking about the provider, they added "She's always right". A relative told us how defensive the provider had been when they had raised concerns. Another relative told us, "I know the official complaints system but I generally speak to [Provider]". When people or their representatives had made complaints, these had not always been acted on. The provider had received 23 complaints since our last inspection in March 2015. The complaints were recorded in a book which the provider kept in their office. It was not possible to check whether all the complaints had been appropriately actioned or responded to following the timescales within the provider's policy as we only saw two complaint outcome letters. However there had been complaints from people living in the home in January 2016 with regards to staffing levels, which had not been effectively resolved as we had found there were not enough staff deployed on shift to keep people safe.

The provider had a complaints policy and procedure which included clear guidelines on how and by when issues should be resolved. The complaint procedure was on display in the hallway. The procedure detailed that people should take their complaint forward to the Care Quality Commission (CQC) if they were not happy with the response from the home. This was incorrect, CQC do not investigate individual complaints people should be directed to the local authority or the local government ombudsman (LGO). Staff were clear about their responsibilities to report concerns and complaints, they told us they would report to the provider and CQC if necessary.

People's views and opinions about the service they received had not been dealt with appropriately. People had opportunities to voice their feedback about the service in meetings but their views were not acted upon. We viewed the records of a meeting that had taken place on the 2 June 2016, people had raised they were experiencing delays in receiving their care and delays in receiving their breakfast. Whilst the meeting records evidenced there was a discussion about why there were delays no action had been taken to reduce the delays as the staffing levels had remained the same.

The failure to establish and operate an effective system for receiving, handling, recording and responding to complaints was a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Compliments had been received. One read, 'This is to thank you all so much for everything you all did for our lovely mum treating her with much love and kindness'. Another read, 'A big thank you for all the care and attention you have given our dear friend and neighbour'. A third read, 'We would like to thank you all for everything you did for our friend'.

Inadequate

Is the service well-led?

Our findings

At the last inspection (when the service was previously known as Amicus Care Home) we found a breach in regulation relating to lack of effective systems in place for monitoring the quality and safety of the service and inaccurate and incomplete records. We asked the provider to take action to make improvements. We also made a recommendation for the provider to seek further guidance on management and analysis of accidents and incidents. At this inspection we found that systems had been implemented to analyse accidents/incidents but actions taken to reduce risks had not been carried out. Systems to monitor the quality of the service had been implemented. These systems were not robust and people receive unsafe care as a result.

This inspection has identified nine breached regulations, many of which were multiple and continuing breaches of those previously notified (at the inspection in March 2015 when the service was previously known as Amicus Care Home). Leadership of the service remained poor. The provider did not ensure that care was safe, that staff were trained effectively or that care was person centred. The provider had failed to ensure they took the necessary action to fully meet the serious concerns and breached regulations previously notified to them.

The provider had employed the services of an external consultant to help them develop a quality assurance tool to raise standards and make improvements. Following this the provider had employed a staff member responsible for quality assurance. The staff member had been reviewing and revising policies, procedures and guidance and carrying out audits of the service such as; audits of housekeeping, infection control and checks on the environment such as the laundry, sluice room, kitchen, visual inspections of emergency lighting, fire fighting equipment such as extinguishers. The staff member also reviewed and analysed all of the accident and incident records on a monthly basis to identify any trends or concerns and reported these to the provider. The staff member also reviewed care plans to ensure they were complete. There was no evidence to show that this was checked and monitored regularly to ensure that changes and amendments were made in a timely manner.

Some checks and audits did not show what action had been taken. For example, when the checks had identified water temperatures over 44 degrees Celsius, no action had been taken to call in a plumber to check the thermostatic mixer valve. The quality audits had led to a schedule of work that being put in place. The schedule detailed that some repairs and maintenance had already taken place but there was a long list of other repairs that were needed. Some timescales were not reasonable. For example repairs to communal areas identified in April 2016 had not yet been completed and repairs to people's bedrooms identified in May 2016 had not been completed.

The quality checks and audits mainly focussed on building related issues. Audits had not identified concerns we found during the inspection relating to equipment, recruitment, staffing levels, risk, medicines, training, lack of structured and meaningful activities and complaints monitoring.

Medicines audits had been completed in June 2015 and one in March 2016. None had been completed

since. The provider showed us medicines stock count records dated August 2016. We asked the provider when in August 2016 these had been completed. They told us they had been completed after our first day of inspection on the 23 August 2016. The stock records did not tally up. It stated that 100 Codeine tablets had been received, 52 had been administered and there were 62 remaining in stock. The balance of Codeine tablets in stock should have been 48. The provider had documented 'No Action' on the stock form. We asked the provider to get the Codeine medicine from the medicines trolley so that we could count this together. We counted the Codeine tablets and found that the stock records showed there was a difference of 14 tablets. The provider told us they must have made a mistake when adding them up. Failure to carry out effective medicines audits of practice, records and stock has put people at risk of harm.

There were no records of checks carried out on people's wheelchairs to make sure they were suitably maintained and working as they should be. We spoke with the provider about this and they told us that the night staff completed these checks and wrote in people's daily records when these had been done. We did not find any entry within the daily records to evidence that these checks had been completed which had led to a delay in identifying that one person's wheelchair was dangerous and in need of replacing or repair.

People and their relatives had not been asked for feedback in the form of a questionnaire since we last inspected the service. This meant that people had not been given opportunities to provide feedback about the service they received. The provider explained that they had recently sent out surveys to people's GP's to ask for feedback, responses had not yet be received. The provider had not yet developed the questionnaire for people living in the home and their relatives.

At out last inspection we found that records relating to people's care and the management of the service were not well organised, adequately maintained or stored securely. This had not improved. At this inspection we found inaccurate and incomplete records and records that conflicted. For example, one person's care records showed they had been referred to the dietician because they had not been eating well however their food and fluid charts detailed that they had eaten well for a period of months. Records relating to food safety had not effectively been maintained, fridge, freezer temperatures had only been recorded on 20 July 2016, 23 July 2016, 05 August 2016, 09 August 2016 and 10 August 2016. Food temperatures were recorded on 18 August and 23 August 2016. Cleaning records for the kitchen had not been maintained since 13 August 2016. There were many missing records. One person's records were not accurate which meant that the staff didn't know it was a person's birthday until their relatives turned up at the home with a cake and cards. The person's care records had two different dates of birth. Other people's food and fluid charts were incomplete, some days only snacks or drinks had been documented and no records of the meals eaten.

People's information was not always treated confidentially. People's personal records were stored in the staff office, they were not kept secure as the cabinet was left open and the door was open throughout the inspection.

The culture of the service was not positive, person centred, open, inclusive or empowering. People and staff were not asked for their views on the quality of care provided, and staff told us they were not always confident with raising concerns and making suggestions to the provider. They gave us examples when the provider didn't listen, became angry and shouted at staff. Staff said, "I have to watch what I say to manager, depends on her mood"; "The culture is not always open depends on the mood of the manager"; "Can raise concerns, sometimes dealt with but not always"; "Think there is an open culture within staff team but lack of morale, inspection in past not handled well, it caused a lack of confidence" and "[Provider] doesn't listen to staff at times, she will see things in a different way, sometimes it is best to keep it to yourself". Staff told us that they were aware of the home's whistleblowing policy and that they could contact other organisations

such as the Care Quality Commission (CQC) and the local authority if they needed to blow the whistle about concerns. We had received information of concern from whistle blowers before our inspection.

Staff told us about a bullying culture within the home. they said, "I don't feel supported all the time"; "We are not really supported, it is difficult, the manager is intimidating, she bullies some staff and families if she does not like them then she bullies staff until they leave. Why families put up with it I don't know"; "I am not supported by the manager, she can be really nasty if she doesn't like you"; "She [Provider] doesn't agree annual leave until last minute then says you can't have it not enough staff" and "Does bully staff. Often staff cry".

Staff told us they received good support from each other. Comments included, "Mostly good communication but manager not good about the way she receives information"; "Don't get told the same thing, get info in dribs and drabs"; "Staff to staff is good, talk amongst team is good that's how we manage" and "Communication between staff is fine, but not from management. Some staff told things but others not, some listened to others not".

The provider's statement of purpose for the service stated the aims were, 'To provide personal care to elderly people over the age of 65. To foster an atmosphere of care and support which both enables and encourages our service users to live as full, interesting and independent a lifestyle as possible with rules being kept to a minimum within a risk management scheme. To deliver individual high quality care in an unobtrusive way respecting privacy and dignity. To enable each service user to realise their own aims and helping them achieve these goals in their daily living. We aim to achieve this by keeping ourselves informed as fully as each service user wishes about their individual histories and characteristics'. The provider had failed to embed this statement into practice within the home.

The provider has failed to operate an effective quality assurance system, had not sought or acted on feedback from people or staff and failed to maintain accurate records and store them securely. This was a breach of Regulation 17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, serious injuries and deaths.

We observed people knew the provider/registered manager well. The provider was seen to answer the call bell a number of times when staff were busy providing personal care to other people. We observed the provider assisting people to the toilet, administering medicines and supporting people to eat their meals.

Staff files and other records were securely locked in cabinets within the provider's office to ensure that they were only accessible to those authorised to view them.

Although most relatives told us they thought the service was well led, evidence gathered at this inspection demonstrated that the leadership and management of the service remains inadequate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to lawfully deprive a person of their liberty because they had not met conditions of a DoLS authorisation and had not reapplied for DoLS applications when they had expired in a timely manner. Systems were not established and operated effectively to protect people from abuse. Regulation 13(2)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to clean and maintain premises and equipment. Regulation 15(1)(a)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate an effective system for receiving,

handling, recording and responding to complaints.
Regulation 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not in place. There were gaps in recruitment records. Regulation 19(1)(b)(3)(a)