Pinebird Ventures Limited

Fermoyle House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 28 July 2016 and was unannounced.

Fermoyle House Nursing Home provides accommodation, nursing and personal care for up to 32 older people, some of whom are living with dementia. There were 27 people living at the service at the time of our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At our last inspection in July 2015 we found breaches of Regulation 9, Regulation 12, Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us how they would make improvements in order to meet the relevant legal requirements.

At this inspection, we found the provider had taken insufficient action to meet the relevant legal requirements and was continuing to breach Regulation 9, Regulation 12, Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified that the provider was also breaching Regulation 10 and Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system used to administer medicines had improved but shortfalls existed in other aspects of medicines management. People were at risk because medicines were left unattended for long periods of time. There were no protocols in place to support staff to know when to administer medicines prescribed 'as required'.' There was no process for recording and checking the administration of topical medicines. Staff did not have an understanding of how to report medicines errors.

There had been no increase in the number of nursing staff deployed on each shift since our last inspection. The registered manager told us that additional nurses were deployed only when a nurse attended a healthcare review. We found evidence of the impact of nurses' time being limited, such as deterioration in people's health not being acted upon.

People were at risk because potentially harmful substances were not stored securely. Cupboards containing products including bleach and bait used for pest control had been left open and therefore accessible to people.

People were not protected against the risk of abuse because incidents were not appropriately reported. Six safeguarding referrals had been made to the local safeguarding authority in 2016 by professionals that had contact with people living at the service. In none of these cases had the provider recognised that people

were at risk of abuse and reported the incidents themselves to the local safeguarding authority.

Staff had not been appropriately supported through training, supervision and appraisal or had opportunities to discuss their professional development needs.

Restrictions had been imposed without legal authority on people who had the capacity to make their own decisions. We also found there were restrictions on people's freedom of movement within the service.

People were not supported to maintain adequate nutrition. No action had been taken when people lost significant amounts of weight. Where people had been identified as severely underweight, no referrals for advice and guidance had been made to healthcare specialists, such as a speech and language therapist or dietitian.

Overall, people enjoyed the food provided but they told us there was an insufficient choice of hot meals.

People were not supported to access treatment when they needed it. Staff had failed to arrange an appointment with a doctor for a person who had been unwell for several weeks. We told the registered manager to arrange an urgent appointment with a GP.

People were not always treated with dignity. Staff did not always respect or maintain people's privacy when providing personal care.

There were not enough activities arranged to keep people occupied and meaningfully engaged. The activities that did take place were inappropriate.

There was inadequate management oversight of the service. The registered manager had been unaware of the concerns identified during our inspection until these were outlined during feedback. Some areas of the service were audited periodically but there was no service improvement plan in place to address any shortfalls identified. The provider did not carry out or record monitoring visits to the service.

The culture within the service did not promote effective communication or information sharing. Concerns about people's health and welfare were not shared amongst the staff team. Where feedback was given by people and their relatives, this was not always acted upon.

The quality of recording was not always adequate. Records failed to demonstrate that people were receiving the care they needed. The training record indicated that no staff had attended record-keeping training in the last three years.

There were sufficient numbers of care staff deployed to provide people's care. There were plans in place to ensure people's care would not be interrupted in the event of an emergency. Accidents and incidents were recorded, including details of any action taken following an event. The provider had made appropriate recruitment checks on new staff.

Most staff were kind and caring. People said they had good relationships with almost all the staff who cared for them.

There were appropriate procedures for handling complaints. People and their relatives told us the registered manager was approachable and willing to meet with them if they wished. Staff told us the registered manager was available for support if they needed it.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely.

There were insufficient nursing staff on duty to ensure people's safety and well-being.

People were at risk because potentially harmful substances were not stored securely.

Concerns were not notified to the local safeguarding authority when people were at risk.

People were protected by the provider's recruitment procedures.

There were plans in place to ensure that people's care would not be interrupted in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

Staff had not been adequately trained, supported or had opportunities to discuss their professional development needs.

Restrictions had been imposed without justification on people who had the capacity to make their own decisions and there were restrictions on people's freedom of movement within the service.

Staff did not respond appropriately if people became unwell or support them to obtain treatment when they needed it.

Staff did not refer concerns about to healthcare professionals where necessary to maintain people's health and wellbeing.

People did not have access to an appropriate choice of hot meals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and their privacy was not always respected.

People told us they liked almost all the staff who supported them. They said most staff were kind and caring.

Relatives told us that most staff knew their family members well and had developed positive relationships with them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People did not have sufficient opportunities to take part in meaningful activities.

Activities that did take place were inappropriate for people's needs.

Some people were at risk of social isolation.

There were appropriate procedures for managing complaints.

Is the service well-led?

Inadequate

The service was not well- led.

There was insufficient management oversight and monitoring of the service.

Where feedback was given by people and their relatives, this was not always acted upon.

Some care records were incomplete and did not provide clear information about people's care and treatment.

People told us the registered manager was approachable and available if they wished to speak with them.

Fermoyle House Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 July 2016 and was unannounced. The inspection was carried out by three inspectors and a pharmacist inspector.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. 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. This was because we were following up concerns identified at the previous inspection. We also spoke with health and social care professionals that had an involvement with the service.

During the inspection we spoke with seven people and three relatives. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff. We spoke with seven staff, including the registered manager, registered nurse, care, catering and domestic staff.

We looked at the care records of four people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at four staff recruitment files and records relating to staff supervision, appraisal and training. We also looked at records

used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

Inadequate

Is the service safe?

Our findings

At our inspection in July 2015, we found that people's medicines were not managed safely. Medicines were dispensed into medicine pots prior to administration, a practice referred to as 'secondary dispensing'. Secondary dispensing presents an increased risk of medicines errors as staff are unable to check the medicine, strength and dose at the time they administer people's medicines. The member of staff responsible for administration did not sign the medicines administration records (MAR) until all medicines had been administered. This presented a risk as each person's MAR should be signed immediately they have received their medicines to ensure accurate recording.

At this inspection we found the system used to administer medicines had improved but that shortfalls existed in other aspects of medicines management.

People were at risk because medicines were left unattended for long periods of time. A cabinet used to store medicines was left unlocked throughout the day, including at times when no staff were present.

Several people had medicines prescribed to be used 'as required'. Information about why, when and how these medicines should be administered to the individual person must be available with the regular MAR chart. There were no protocols in place to support staff to know when to administer these medicines or to identify, for example, whether people were able to verbally ask for their medicine when they needed it. This included medicines for use when people's conditions deteriorated, such as breathlessness in people with respiratory conditions or low blood sugar levels in people administered insulin for diabetes.

There was no process for recording and checking the administration of topical medicines that had been prescribed, such as creams or ointments, and no information available for the staff applying the creams. This presented a risk that people would not receive their topical medicines as prescribed.

Staff did not have a clear understanding of what to do in the event of a medicine error, and there was no process in place for reporting incidents involving medicines. This poor reporting culture meant there was no record of how incidents, and near misses, had occurred or actions taken to minimise the risk of repeated incidents.

Waste medicines were segregated for disposal but were not stored securely in a tamper-proof container until they were collected. There was no record of the medicines awaiting disposal. This practice did not reflect current recommended guidelines.

Items were stored in a fridge where necessary and fridge temperatures were recorded daily and found to be within the required temperature range. However, there was poor availability of space for the storage of people's medicines, which meant that storage was divided across a variety of locations. Room temperatures were not monitored in all these storage areas. We also saw that several medicines with reduced expiry had no dates of opening recorded, including eye drops, insulins and liquid medicines. This meant it was not possible to tell if all medicines being given to people were suitable for use.

The failure to manage medicines safely meant that the provider was breaching Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015, we found there were enough care staff available to meet people's needs but that there were insufficient nursing staff on duty to ensure people's safety. There was one nurse on duty, who was working a 12-hour shift. The nurse told us that being the sole member of nursing staff on duty meant that they could not complete all the tasks required of them to a satisfactory standard. The nurse said that they could not ensure best practice in standards of wound management and change dressings as often as they should.

At this inspection we found there had been no increase in the number of nursing staff deployed on each shift. The registered manager told us there was one nurse on duty on each shift unless a care review was scheduled to take place, in which case an additional nurse was deployed to ensure a nurse was available to attend the review.

The nurse told us that being the sole member of nursing staff on duty meant they could not fulfil their role to the standard they wished. They said they could not provide "hands on" care to people in the way they would like. The nurse told us, "I want to provide tender, loving care but it's hard to do if you're the only nurse; you're so busy doing other things. I don't tend to meet the other nurses that much so it's hard." The nurse also said they would like to support and develop care staff in their roles but this was not possible due to the demands of their role. We found evidence of the impact of nurses' time being limited. For example, significant weight loss was not appropriately acted upon and people were not supported to see healthcare professionals when they became unwell.

Failure to deploy sufficient numbers of suitably qualified, skilled and experienced staff was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015, we found that people were not protected by the provider's recruitment procedures. Staff recruitment files did not contain all the information required by the Health and Social Care Act 2008, such as criminal record checks and references from previous employers. At this inspection we found that recruitment files contained all the information required, including references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate. The DBS helps providers ensure only suitable people are employed in health and social care services.

People were at risk because potentially harmful substances were not stored securely. We observed that the cupboard used to store cleaning products, including bleach, was open and therefore accessible to people. It was not possible to lock the cupboard as the door frame was broken. An open linen cupboard contained two bait trays, which had been left by a contracted pest control company. We requested the registered manager to address these issues urgently. The registered manager contacted us the day after the inspection to advise that the cupboard door had been repaired and made secure and the bait trays removed.

Failure to ensure that the premises were safe to use was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not adequately protected against the risk of abuse because incidents were not appropriately reported. The provider had a legal duty to report any incidents of potential abuse to the local safeguarding authority. Six safeguarding referrals had been made to the local safeguarding authority in 2016 by professionals that had contact with people living at the service. These referrals had been made by social workers, ambulance crew members and hospital staff who had concerns about people's care and

treatment. In none of these cases had the provider recognised these incidents constituted potential abuse and reported them to the local safeguarding authority.

We found that a concern raised about the conduct of a member of staff had not been investigated or managed appropriately. One person told us they had recently been distressed by the language used towards them by a member of staff on two consecutive days. They said they had reported their concerns to the nurse on duty. There was no evidence that the allegation had been investigated or discussed with the member of staff responsible or that any disciplinary action had been taken as a result. The registered manager told us the nurse had informed them about the allegation but had not provided details of the incident. The registered manager said a disciplinary meeting had not been held as the nurse had dealt with the issue, "On the spot."

Staff were not regularly trained in safeguarding. The registered manager told us that staff were required to attend safeguarding training every three years but the training record indicated that only two of 19 staff had attended safeguarding training within this timeframe. Some of the staff we spoke with had an appropriate understanding of their responsibilities in relation to reporting abuse. They were able to describe the signs of potential abuse and the action they would take if they suspected abuse. However other staff told us they had not attended training in safeguarding and were unable to describe the process to be followed should they have concerns about potential abuse.

Failure to investigate an allegation of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. Health and safety checks had been carried out to ensure that the gas, electrical and water supplies were safe for use. Risks to people had been assessed and control measures had been put in place to mitigate against these risks. Accidents and incidents were recorded, including the action taken following an event to minimise the likelihood of recurrence.

Inadequate

Is the service effective?

Our findings

At our inspection in July 2015, we found staff had not received regular supervision and appraisal, which meant that they did not receive feedback about their performance or have opportunities to discuss their training and development needs.

At this inspection we found there had been no improvement in the provision of supervision for staff.

The provider's supervision policy stated that staff should have a minimum of four individual supervision sessions and an annual appraisal each year. The policy stated, "The care service is committed to providing its care staff with formal supervision at least four times a year." The policy further stated that supervision was designed to achieve the following: "Achieve optimum outcomes for residents. Ensure best practice and the attainment of required standards of care. Ensure compliance with policies and procedures. Enable staff to feel valued and supported. Continuously improve and develop their skills."

We checked supervision records for ten staff for the last 12 months. One member of staff had received three supervision sessions, two staff had received two supervision sessions, five staff had received one supervision session and two staff had received no supervision sessions. Only one member of staff had evidence of an annual appraisal.

People were being supported by staff who had did not have the opportunity to maintain their skills and knowledge. The registered manager told us the provider's training policy required staff to attend courses in all elements of mandatory training every three years. We asked the registered manager to provide us with the most up to date training record for the service. The training record listed 19 staff, including the registered manager and six registered nurses.

The training record indicated that, in the last three years, three staff had attended training in the Mental Capacity Act 2005, three staff had attended training in improving outcomes for people with dementia, two staff had attended safeguarding training, one member of staff had attended diet and nutrition training and one member of staff had attended training in the administration of medicines. Record keeping and falls prevention were also listed on the mandatory training record but no staff had attended this training.

We asked the registered manager what training was provided for registered nurses to keep their professional development up to date, such as wound care, male catheterisation and the management of syringe drivers. The registered manager told us no training specifically for registered nurses was offered by the provider. The training record did not contain any evidence that nurses had attended training necessary to keep their nursing skills up to date.

Failure to provide appropriate support for staff through training, professional development, supervision and appraisal was a continuing 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our inspection in July 2015, we found people's choice and freedom of movement was being restricted without lawful authorisation. For example all the people sitting in the lounge had tables placed in front of their chairs which prevented them from getting up should they wish to do so.
Restrictions were being imposed on people who had been assessed as having capacity without their consent.

At this inspection we found these issues had not been addressed. People still had tables placed in front of their chairs which prevented them from getting up should they wish to do so. There were other restrictions placed upon people that had not been authorised. For example, the front door of the service was locked and people did not have access to the key. People were subject to constant supervision. Care staff said they used bedrails for all the people in the service. They told us this was to keep people safe. Staff were unaware that this constituted a restriction that required an assessment and recorded decision before it could be imposed.

Restricting people's choice and freedom of movement without lawful authorisation was a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence of a lack of understanding of the Act and its principles at all levels. Staff did not receive training in the MCA to enable them to understand its purpose and how they should apply it in their work. The registered manager told us that all the people currently living at the service had mental capacity. However the records we checked indicated this was not the case. A nurse had completed mental capacity assessments for 11 people and had recorded that none of them had capacity to make any decisions about their care or treatment. In one person's case, a nurse completing a mental capacity assessment in June 2015 indicated "Yes" to the questions, "Does the person have a disturbance or impairment of the brain?" and, "Does this disturbance make the person unable to understand the decision?" However, the person's file also contained a mental capacity assessment completed by the registered manager in December 2015 that indicated "No" to these questions.

One of the principles of the Act is that people's capacity should be assessed at the time of making each individual decision as their capacity may fluctuate due to their condition. Staff had carried out generic mental capacity assessments rather than assessments regarding specific decisions. The MCA states a person's best interests must be the basis for all decisions made and actions carried out on their behalf in situations where they lack capacity to make those particular decisions for themselves. Where people had been assessed as lacking capacity, no best meetings had been arranged to ensure that decisions taken about them were made in their best interests.

Failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

People were not supported to maintain adequate nutrition. Staff weighed people regularly but did not respond appropriately when people lost significant amounts of weight. Three people's care records contained evidence they had lost a significant proportion of their bodyweight in recent months. As a result of serious concerns about the amount of weight lost by one of these people, we required the provider to make a referral to the local safeguarding authority. The nutritional assessments that had been carried out by staff recorded that these people were 'severely underweight' but no referrals for advice had been made to healthcare specialists, such as a speech and language therapist or dietitian. One person had been assessed by a speech and language therapist during a hospital admission in June 2016. The speech and language therapist issued guidance recommending that a food recording chart be implemented for this person on their return to the service. This guidance had not been followed and no food chart had been implemented. We also found that staff's own assessments of people's nutritional needs indicated that food charts should be introduced for people due to their assessment scores but that this measure had not been implemented.

Most people said they liked the food at the service but several people told us there was an insufficient choice of hot meals. One person said, "If I don't like it I will say so but then I can only have something cold, like a sandwich or a salad." Another person told us, "The food is pretty fair usually but there is a lot of stuff I don't like; then they'll do me a salad." Both people told us they would prefer to have an alternative hot meal available. They said that the evening meal was usually a cold meal, which meant that they sometimes did not get a hot meal all day.

Failure to provide suitable and nutritious food which was adequate to sustain life and good health or to provide food that reflected reasonable requirements about people's preferences was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The cook was able to demonstrate that information about people's dietary needs was provided by care staff. This included information about food intolerances and texture-modified diets. We observed that people who required a texture-modified diet received this and that staff were available for people who needed support to eat and drink.

People were not supported to access treatment when they needed it. One person told us they had felt unwell for several weeks but had not seen a doctor. A care worker told us they had advised the nurse on duty earlier in the week that the person was unwell and an appointment with a GP should be arranged. No appointment had been made for the person. A GP visited on the day of our inspection but was not asked to see this person. We asked the nurse on duty about this person's condition. The nurse told us that no information about the person feeling unwell had been passed on at handover and that the person appeared well that day. We told the registered manager to arrange an urgent appointment with a GP and to inform us of the outcome. The registered manager contacted us after the inspection to advise that a GP had visited the person and prescribed antibiotics for a chest infection.

Failure to ensure people received safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and their privacy was not always respected. One person was supported by two staff to use the toilet. The toilet door was broken and was not able to be fully closed. As a result, the person using the toilet was visible to people in the corridor. The two staff supporting the person to use the toilet had placed a "Do not enter, in use" sign next to the bathroom door. Whilst the person was using the toilet, a third member of staff knocked and opened the door to speak to their colleagues.

Failure to ensure people's privacy was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked almost all the staff who supported them. They said most staff were kind and caring. One person told us, "You couldn't wish for nicer people." Another person said, "Most of the carers are very kind. They make sure I'm all right before they go off duty." A third person said, "They are lovely, they do their best and it's not an easy job." We observed that the majority of staff were caring in their interactions with people and treated them in a kind and considerate way.

Relatives told us that most staff knew their family members well and had developed positive relationships with them. They said they could visit their family members at any time and they were made welcome when they visited. This reflected the feedback recorded in the relatives' surveys returned in 2016. One relative told us, "Staff have always been lovely."

The atmosphere in the communal areas of the service was relaxed and staff spoke to people in a friendly way. Staff made conversation with people and shared jokes. They offered assistance if people needed support to mobilise or to eat or drink.

People had access to information about their care and the provider had produced information about the service. The provider had a confidentiality policy, which detailed how people's private and confidential information would be managed.

Inadequate

Is the service responsive?

Our findings

At our inspection in July 2015, we found that people did not have access to meaningful activities. There was no activities co-ordinator employed and there was a lack of appropriate activities to keep people occupied and engaged.

At this inspection, we found insufficient action had been taken to address this issue.

People told us there was little to do during the day and that most people slept for most of the time. This was confirmed by our observations. One person told us, "There's not much going on, although there is singing sometimes. I love to read so I don't care but most people just sleep all the time." A member of staff said, "There could be more to keep people entertained. When there are no activities, people are just sleeping."

The registered manager told us that a member of care staff had been allocated 1.5 hours each weekday to provide activities between 1pm and 2.30 pm. The registered manager said this member of staff was only able to work during school term time due to personal commitments. On the day of our inspection this member of staff left work at 1pm and therefore did not provide any activities.

The activity that did take place was inappropriate. Without explaining to people what was happening, a member of staff handed people plastic toy musical instruments, such as tambourines and castanets, and turned on very loud music. The member of staff shook a tambourine to the music and encouraged people to do the same. There was nothing to suggest that people, most of whom had been asleep at the time, had wanted to take part in this activity or enjoyed their participation in it.

Staff had completed 'Activities' care plans for people but these contained little information about people's interests or hobbies. One person's activities care plan recorded only 'watching television' and 'receiving calls from relatives' as their preferred activities.

People who were nursed in bed were at risk of social isolation. We observed that people who remained in bed did not have adequate opportunities to engage with others during the day. One person who was nursed in bed told us they were unable to join in any activities because those that did take place happened in the lounge. The person said staff did not visit them in their bedroom to provide meaningful activities and did not have time to chat with them when they provided their care. The person told us, "I do get bored. I just watch the television. Or I just watch people come and go as they pass my door."

Failure to provide appropriate activities that met people's needs was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies complainants could contact if they were not satisfied with the provider's response. The last entry on the service complaints log was made in March 2008. The registered manager told us there had been no formal complaints since that date.

Inadequate

Is the service well-led?

Our findings

At our inspection in July 2015, we found some care records were incomplete and thus did not provide all necessary information about people's care and treatment. Daily care notes did not demonstrate the care people received each day. We also found that the provider was failing to assess, monitor and improve the quality and safety of the service.

At this inspection, we found insufficient action had been taken to address the concerns about record-keeping and management oversight.

One person told us they had a pressure ulcer and were unable to reposition themselves in bed. They said they had been told staff should be doing this for them to maintain the integrity of their skin. With the person's permission, we checked their care records and found that staff had not implemented a repositioning chart for this person. Another person who had a pressure ulcer had a 'skin integrity plan' in place. However this had not been updated since April 2016 and it was not possible from the information recorded on the plan to understand the current situation in relation to the care the person needed. The service training record showed that no staff had attended the record-keeping element of their core training in the last three years.

There was no evidence that the management oversight of the service had improved. The registered manager had been unaware of the concerns identified during our inspection until these were outlined during feedback at the end of the inspection. For example, the registered manager had been unaware that a member of staff had raised concerns about one person's health and requested a GP appointment. The registered manager carried out audits of some areas of the service, such as infection control and medicines, but there was no service improvement plan in place to address shortfalls or areas of concern. The provider did not carry out or record monitoring visits to the service. As a result, the registered manager and provider were not always aware when people were receiving inadequate care and treatment.

The culture within the service did not promote effective communication or information sharing. Concerns identified about people's health and welfare were not shared amongst the staff team. For example staff had not passed on information about one person who needed to see a doctor, which resulted in no appointment being made. This resulted in a poor outcome for this person.

Where feedback was given by people and their relatives, this was not always acted upon. The satisfaction surveys distributed by the provider asked relatives for their ideas about areas that could be improved. One suggestion was, "Give residents more variety of food." Our findings about the choice of food available indicated no action had been taken to consider or implement this suggestion.

Failure to effectively assess, monitor and improve the quality and safety of the service or to maintain an accurate, complete and contemporaneous record in respect of each person was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the registered manager was approachable and available if they wished to speak with them. Relatives said the registered manager was willing to meet with them if they wished to discuss their family members' care. Staff told us the registered manager was available for support if they needed it. One member of staff said, "I feel supported by my manager; any problems I can go to her. I think I feel valued."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to design care with a way to achieving service users' preferences and ensuring all their needs are met. Regulation 9(3)(b)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure service users were treated with dignity and respect. Regulation 10(1)(a) The registered provider had failed to ensure service users' privacy. Regulation 10(2)(a)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure that medicines were managed safely and properly. Regulation 12(2)(g) The registered provider failed to ensure that the premises were safe to use for their intended purpose and were used in a safe way. Regulation 12(2)(d) The registered provider had failed to ensure that service users received safe care and treatment. Regulation 12(1)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure that systems and processes were operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13(3) The provider had restricted service users' freedom of choice and liberty of movement without legal authorisation. Regulation 13(7)(b)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to provide suitable and nutritious food which was adequate to sustain life and good health. Regulation 14(4)(a) The registered provider had failed to meet the reasonable requirements of service users for food arising from their preferences. Regulation 14(4)(c)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish effective systems to act on feedback from relevant persons. Regulation 17(2)(e) The provider failed to effectively assess, monitor and improve quality and safety of the services provided. Regulation 17(2)(a) The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided. Regulation 17(2)(c)

The enforcement action we took:

Issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to deploy

Diagnostic and screening procedures Treatment of disease, disorder or injury	sufficient numbers of suitably qualified, skilled and experienced staff. Regulation 18(1) The registered provider had failed to ensure that staff received appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)

The enforcement action we took:

Issued NOP