Farrington Care Homes Limited

Brookside House Care Home

Inspection report

35 Wagstaff Lane
Jacksdale
Nottingham
Nottinghamshire
NG16 5JL

Tel: 01773608527
Website: www.farringtoncare.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 October 2016 and was unannounced.

Accommodation for up to 26 people is provided in the home on two floors. There were 15 people using the service at the time of our inspection. The home provides personal care for older people. At the time of our inspection, the service was not accepting any new admissions.

A registered manager was in post, however, at the time of the inspection they were not working as the manager. An acting manager had been in post for a week and was present during the inspection. However, no application to register a new manager, or cancel the registration of the previous registered manager, had been received by the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Appropriate action was not taken in response to potential safeguarding issues. Staff did not always safely manage identified risks to people. Sufficient numbers of staff were on duty to meet people's needs during our inspection, however, systems were not robust to ensure that sufficient staff were on duty at all times.

Safe infection control and medicines practices were not always followed. Staff were not recruited through safe recruitment processes.

People's needs were not fully met by the adaptation, design and decoration of the service. Staff did not receive appropriate induction, training and appraisal. People's rights were not always protected under the Mental Capacity Act 2005.

People received sufficient amounts to eat and drink and external professionals were generally involved in people's care as appropriate.

Staff were kind but did not always respect people's privacy and dignity. People and their relatives were not fully involved in decisions about their care. Advocacy information was not easily available to people.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective. People and their relatives were not involved nor had opportunities to be involved in the development of the service. The provider was not meeting their regulatory requirements.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate action was not taken in response to potential safeguarding issues. Staff did not always safely manage identified risks to people.

Sufficient numbers of staff were on duty to meet people's needs during our inspection, however, systems were not robust to ensure that sufficient staff were on duty at all times.

Safe infection control and medicines practices were not always followed. Staff were not recruited through safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were not fully met by the adaptation, design and decoration of the service.

Staff did not receive appropriate induction, training and appraisal.

People's rights were not always protected under the Mental Capacity Act 2005.

People received sufficient amounts to eat and drink and external professionals were generally involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind but did not always respect people's privacy and dignity.

People and their relatives were not fully involved in decisions about their care. Advocacy information was not easily available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement.

Care records did not always contain information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective.

People and their relatives were not involved nor had opportunities to be involved in the development of the service.

The provider was not meeting their regulatory requirements.

Brookside House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 18 October 2016 and was unannounced. The inspection team consisted of an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with three people who used the service, two visitors, the activities coordinator, a housekeeper, two care staff, two representatives of the provider and the acting manager. We looked at the relevant parts of the care records of four people, three staff recruitment files and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People did not raise any concerns about their safety. However, at lunchtime, we observed a person who used the service calling another person who used the service a "pig" and a "greedy bugger." Other people who used the service sitting nearby heard the comments and said to each other that it was not very nice. Staff in the dining room did not respond to the situation.

Feedback questionnaire responses from relatives in April 2016 contained comments raising potential safeguarding issues. One questionnaire response stated, "Residents can be bullied and upset by other residents." Another response stated, "Safeguarding is a big issue." A third response stated, "Safeguarding is definitely an issue, with my relative being attacked by other service users."

The service's commentary on the questionnaire responses stated, "There were some concerns of safeguarding issues, residents being attacked, this has been investigated …" The acting manager told us that there had been a person who used the service, no longer living at the service, who had displayed challenging behaviour towards other people who used the service and staff. They told us there had been lots of incidents between the person and staff and other people who used the service. We saw no completed incident forms, no documentation showing that investigations had taken place or that safeguarding referrals had been made by the service. Potential safeguarding issues should be referred to the local authority and appropriate documentation should be kept by the service. This meant that the service had not responded appropriately to potential safeguarding issues.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety. Staff were aware of the signs of abuse and the actions they would take if they suspected abuse.

Individual risk assessments had been completed to assess people's risks of developing pressure ulcers, falls and nutritional issues. However, these had not all been reviewed regularly, one person's risk assessments had not been reviewed for six months. When another person had been identified as being at high risk of falls, the action documented to prevent further falls was very limited. We also saw that falls had not been analysed to identify patterns and any actions that could be taken to prevent them happening. This meant that there was a greater risk that appropriate action would not have been identified and taken to minimise the risk of people being put at risk of avoidable harm.

Actions were not always taken to minimise the risk of people suffering avoidable harm. We saw two people sitting on wheelchairs in the dining room with their moving and handling sling still in place. The acting manager confirmed that these were not slings that should be left in place with a person sitting on it. Slings left in place may increase the risk of the development of pressure ulcers.

The premises were not secure and people were put at risk of avoidable harm. It was possible to access parts of the building from the outside, including people's bedrooms, without being observed by staff. The garden area was not fully secure and people who used the service could also leave the premises without being observed. On the second day of inspection we were able to enter the home and walk into the acting manager's office unobserved by staff

Parts of the premises were not safe and people were placed at risk of avoidable harm. The laundry room, hot water tank room and sluice were not locked. The kitchen stores room was open which contained a number of bottles of bleach. Some lights near emergency exits were not working and one person's bedroom door closed too fast which would put the person and staff at risk of it slamming on them.

Maintenance checks were generally taking place. However, a legionella risk assessment had been carried out in September 2015 which had identified a number of actions that needed to be taken. None of these actions had been signed off as completed. There were also no records to show that regular flushes of water outlets had taken place to minimise the risks of legionella. We were informed that emergency lighting was working but it was not possible to regularly test it due to the way it had been fitted. We also saw that no fire drills had been recorded as having taken place for over six months.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people had been identified as at high risk of skin damage. Records showed that they had been assisted to change their position regularly to minimise this risk.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People did not raise any concerns regarding how their medicines were managed. However, a relative told us that there had been an incident with their family member's medication. They told us that it had not been clear whether or not their family member had received their medication on one occasion. Staff had told them that it had not been recorded as given but told them that as the tablet was not there the person must have had it. The relative told us that this had bothered them.

We observed the administration of medicines and saw that, on one occasion, the staff member administering medicines did not stay with a person who used the service until they had taken their medicines. They left the tablets on the dining table in front of the person and another staff member supervised the person to ensure that they took their medicines. However, the staff member handled each medicine, without wearing gloves, in order to put them directly in front of the person to take. This was not safe practice and put the person at risk of infection.

Medicines were not always stored securely. There had been a recent medicines delivery and a box of creams had been left in an unlocked room. We also saw that the medicines key was not stored securely and had been left in a kitchen drawer. During the inspection we saw that the refrigerator used to store medicines was unlocked and the room where the fridge was stored was open.

There were no temperature records for the medicines fridge to demonstrate that staff were checking to

ensure that medicines were stored at an appropriate temperature. Liquid medicines and creams were not always labelled with the date of opening to ensure they were only used for a period of time when they were most effective. This had been identified as an issue at our last inspection.

Most of the Medicine Administration Records (MAR) did not have a photograph of the person to aid identification and there was no indication on any of the MARs about the person's preferences for taking their medicines or whether they had any allergies. This had been identified as an issue at our last inspection. Handwritten additions to the MAR charts had not been signed by two staff members to ensure that no errors had been made when copying the medication label. This had been identified as an issue at our last inspection. The controlled drugs register was not stored securely and had not been completed to show when medicines had been returned to the pharmacy.

One person's stock of one medicine was not correct indicating that the medicine had either not been administered or the stock records were incorrect. We found there were gaps on a number of people's MAR charts indicating a medicine had either not been administered or the administration had not been signed for. This could lead to a person being given their medicines twice. Creams had not always been signed for when administered. PRN protocols were not in place to provide staff with guidance on when to administer 'as required' medicines. This had been identified as an issue at our last inspection.

A number of people had not been given some medicines due to the service running out of stock. We were told people's regular medicines were not normally received in time to ensure that people did not miss medicines due to a lack of availability. We also saw that two people were regularly not receiving a medicine as prescribed. Staff were treating them as medicines to be given only 'as required'. This was of particular concern for one person whose condition could seriously deteriorate if they didn't receive their medicines on a regular basis. The acting manager agreed to investigate this immediately. This meant that medicines were not being effectively managed to ensure that people received them safely.

Records were not available to provide assurance that all staff had their competence assessed to administer medicines safely. Medicines audits had also not been carried out since October 2015. This meant that processes were not in place to ensure that medicines issues were promptly identified and addressed.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment and selection processes were not followed. We looked at recruitment files for staff employed by the service. The files did not contain all relevant information and appropriate checks had not been carried out before staff members started work.

One recruitment file did not include any references and there was no evidence that a Disclosure Barring Service check had taken place. This is a check of whether a potential staff member has any criminal convictions that might affect their suitability for the role. A second recruitment file did not include any references and there was no evidence that a staff member had been asked to provide evidence of a health and social care qualification that they referred to in their application form. The third recruitment file contained two references; however, one reference was a personal reference and the other reference had been given by the staff member who interviewed the person. Their previous social care employer had not been approached for a reference. This meant that safe recruitment processes were not followed which put people at risk of receiving care from staff that were not fit to work.

These were breaches of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

A staff member said, "There needs to be more cleaning in the home. Night staff are not doing sufficient cleaning." Not all areas of the home were clean. This included bathrooms, toilets and the medicines room. Not all equipment was clean. This included wheelchairs, dining room chairs and tables, pressure cushions, commode frames and pots and the medicines fridge.

Staff did not always follow safe infection control practices. Cloths, mops and buckets were not safely managed to minimise the risk of infection. We saw a stained pair of gloves in a drawer full of clean gloves. We observed the cook touching a person's tablets before they took them. The laundry area was not organised in a way that would minimise the risk of infection.

Detailed cleaning schedules were not in place to ensure that all areas of the home, including all equipment, were cleaned regularly. Cleaning charts displayed on toilet and bathroom doors were not regularly completed to show that they had been cleaned and checked by staff. Only 18 of 28 staff had received infection control training.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not raise any concerns regarding whether there were enough staff to meet their needs. Staff told us there were sufficient staff to meet people's needs. During our inspection the main lounge area was supervised by staff most of the time. There were enough staff to assist people at lunchtime in order to ensure they were served in a timely way. We saw that staff provided support in a timely manner throughout our inspection.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely at all times. Staffing levels were calculated according to the amount of people who used the service. However, no documentation was in place to show whether people's differing dependency levels had been considered when calculating staffing levels. This meant it was unclear if the staffing levels were appropriate for people's dependency needs.

Requires Improvement

Is the service effective?

Our findings

We overheard a relative informing the acting manager that one of their family member's relatives had not been able to access the home when they visited and had been unable to contact staff for assistance. As a result, they had not been able to visit their family member.

One member of our inspection team, who had not visited the service before, had to call the home to get directions on how to get into the home when they arrived at what appeared to be the front of the home. The main entrance was not clearly signed and directions to the home's car park were not clear. There were also no clear directions from the home's car park to the main entrance of the home. This had been identified as an issue at previous inspections.

A relative told us that it worried them how their family member got to the toilet or their room when they were not there. The relative was concerned that there were no adaptations to help the person because of their visual impairment.

We saw that not all people's bedrooms were clearly identified. Most people we spoke with were not able to describe where their bedroom was located. Directional signage was in place but there were a lot of other pictures and pictoral signs on the walls which could make it more difficult to follow the signage.

The general environment required redecoration. A number of the displays or pictures on the walls were tatty or damaged. We also observed damaged plaster on some walls. Staff told us that redecoration of the home would be taking place shortly.

One person told us that they only really saw the garden when they were going out somewhere. The home had a lawn area and a yard area. Neither was welcoming or easily accessible for people who used the service. The yard area appeared to also be used as a smoking area.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported, however, induction documentation was very limited and there was no evidence of a comprehensive induction taking place to ensure that staff had the skills to meet people's needs.

Records showed that most staff had received a recent supervision; however, no one had received an appraisal. These are important to allow an effective review of a staff member's performance over a period of time and to identify any support required to ensure the staff member is capable of providing support that meets people's needs. Training figures showed significant gaps in the attendance of all courses. Less than 50% of staff were recorded as having attended health and safety training, moving and handling, safeguarding and equality and diversity training. There was no training plan in place to address this issue. This meant that staff had not received sufficient training to meet people's needs in these areas.

The Mental Capacity Act (MCA) 2005 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 to 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).

People did not raise any concerns regarding consent. We saw that staff talked to people before providing support and where people expressed a preference staff respected them.

Staff told us they had received training in the MCA and DoLS. They were able to discuss issues in relation to this and the requirement to act in the person's best interests. DoLS applications had been made appropriately.

We saw that mental capacity assessments and best interests documentation were generally in place when people did not have the capacity make a decision. However we saw that this documentation was not in place for one person who had bedrails in place. This had been identified as an issue at our last inspection. This meant that there was a greater risk that their rights had not been protected in this area.

One relative said, "Some [people who use the service] can get a bit aggressive or nasty, staff deal with it as best they can." Care plans for people with behaviours that might challenge did not have sufficient guidance for staff to effectively support those people. We saw that one person had been given PRN medication on 15 of the last 17 days to "reduce agitation or "aid sleep." Their care plan did not give sufficient guidance for staff on other techniques to use to support the person before administering the medicine.

We observed a person shouting at other people who used the service and staff tried to calm them down by talking to them as they passed by. One staff member suggested they brought the person into the lounge to watch television and said to the person, "You like western films don't you, let's see what's on." There was a modern American film that appeared to be halfway through and that was left on the television. We observed the person was quieter for a short period, but then began shouting again. Their care record did not contain sufficient guidance for staff to effectively support the person.

We saw care records for some people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and all had been completed appropriately.

People told us they were happy with breakfasts provided by the home. A person said, "You can have anything, I had marmalade on toast and a cup of tea."

The lunchtime experience could be improved. We observed the lunchtime meal in the main dining room and lounge. Most people received appropriate assistance from staff if they required it, however, we did see one person did not eat their meal. Staff walked past and asked the person to eat it but did not sit down to encourage them.

People's meals were not always explained to them and food choices were written on a whiteboard which was not generally visible to people seated in either room. We did not see people offered a choice of whether they wanted gravy on their meal or the size of portion they received. When given their food, one person said,

"Ooh that's too much." Staff replied, "Don't worry, just leave what you don't want."

We saw a staff member gave one person some chocolate cake and cream and then went away to get a spoon. The person started eating it with their fingers before the spoon was brought to them. Another person was also given a pudding without a spoon and they got up, went to a trolley with used cutlery and crockery, found a spoon and wiped it on their cardigan before using it.

We saw people being offered hot drinks and snacks. We also saw people being offered lemonade or shandy at lunchtime. However, we did not see people offered water and a relative told us that they had never seen their family member offered water by staff and felt they needed to drink more water.

One person said that they had put some weight on since they had been at the home and that their family had been pleased about that. We saw that food and fluid charts were completed and we saw that people's weights were being regularly recorded.

People told us that they saw external health professionals. A person told us that staff always made sure the doctor came if the person needed them.

We saw evidence of the involvement of other professionals; however, it was not always easy to find documentation in care records to confirm whether professionals had been involved. Staff also told us that it was difficult to arrange for a dentist to visit the service to ensure that preventative dental checks were made available for people if they wanted them.

Requires Improvement

Is the service caring?

Our findings

People did not raise any concerns regarding their privacy and dignity. However, we observed a number of instances where people's privacy were not respected. We saw that people's mail had been left on a shelf in the acting manager's office. We found this office unattended and open on the second day of inspection. We also saw that people's care records were not always stored securely.

There were a number of instances where people's dignity was not respected. We saw that staff had left a person's bedroom open when that person was sitting on the edge of their bed with no clothes on the lower part of their body. We also observed a staff member holding a door ajar when a person was using the toilet. The staff member was holding the door ajar because there was no working light in that bathroom; however, there was a bathroom with a working light nearby.

We also observed that when people required personal care due to incontinence they were taken into one specific bedroom, not their own. This bedroom had been previously occupied by a male person who used the service and their photo and name was still displayed on the bedroom door. This could have caused confusion and alarm for the people, mostly female, being taken into the room to receive personal care. These actions did not respect people's dignity.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had not been involved in making decisions about their care. A person said, "I've not seen a care plan, but they get it right." A relative said that they had seen their family member's care plan. However they had never been to a review or a meeting about their family member's care.

We did not see any evidence of the involvement of people in their care plans. Advocacy information was not easily available for people if they required support or advice from an independent person.

All of the staff we spoke with were kind and welcoming. Throughout the inspection, we observed all staff speaking to people in a kind and respectful manner, usually using the person's name when talking to them. One person described the staff as, "A good lot."

Staff interacted with people in a friendly, caring manner. We saw staff talking kindly to people with gentle touch such a touch to the hand, a stroke of the hair or a kiss on the cheek as they left at the end of their shift.

People's views were mixed on whether they were supported to be as independent as possible. One person described staff supporting them to have a wash each morning, "They get me to do it myself, I am happy with that." A relative told us that they were worried about their family member who had poor sight and how well they are supported at mealtimes. They said, "I wonder if there is a plate with a sort of ridge to make it easier for them to eat." We observed that their food was not served on an adapted plate at lunchtime.

People could visit the home without unnecessary restriction. One person said that their family visit regularly and that the family get on with everyone at the care home. A relative said, "You feel welcome." However, another relative said, "Most staff are nice, but some staff look at you in a way that makes you feel unwelcome."

Requires Improvement

Is the service responsive?

Our findings

People commented that they did not always receive personalised care that was responsive to their needs. One person said that staff, "Put the food on the plate for you. I don't like the potatoes but they still put them on my plate. They know I don't like them so they don't mind if I leave them." At lunchtime, we saw that the person had potato on their plate and left it. Another person said, "I would like to lie in a bit later in the morning, but [staff] prefer you to get up and go early at night instead."

A relative said that their family member liked a shave every day and that they had put a notice in their family member's room to advise staff. The family member said that they visited two to three times a week and their relative has not always had a shave. The family member told us that some staff will do it and some did not.

Activities required improvement. A person described going out in their wheelchair to a garden centre or for Sunday lunch. The person said, "One of the [staff] take me." A relative said, "What bothers me is that there is nothing to do. They just sit here. I have asked staff to take [my family member] out, but I don't know if they do."

We observed one person doing a word search book which they said their family brings in for them. In the dining room there was a table which had board games, jigsaws, books and tambourines on it. We did not observe any person picking up or looking at any of these things. We did not see staff offer them to anyone. In the 'quiet lounge' there were many soft toys displayed on a trunk. We did not see any person pick one up or staff offer them to anyone.

We observed the activities co-ordinator doing some colouring with a person. The co-ordinator chatted to the person in a kind and respectful way throughout. The activities coordinator communicated well with people on a one to one basis but most of the people they were not interacting with had not been left with any activities for them to carry out by themselves.

Activities records were in place and we saw that recent entries had been made for all people who used the service. There was one external person who visited each week to provide fitness activities. There was also a church service advertised as taking place each month. Management of the home told us that they would be arranging for additional outside entertainers to visit the home.

Care plans did not always contain sufficient accurate information to support staff to provide personalised care for people that met their individual needs. Information regarding people's life histories, likes and dislikes was generally limited. The acting manager told us that care records were in the process of being re-written to better reflect people's individual needs.

We reviewed the care records for a person with diabetes and found their main care plan referred to their diabetes, however, there was no specific guidance about how their diabetes was controlled and the symptoms of low or high blood sugar levels. There was no mention of the need for an annual diabetes review or eye screening.

There were two people who had pressure ulcers and their care records did not provide sufficient guidance for staff on how to manage them. Another person was at risk of falling and information was inconsistent whether they used a walking frame or a wheelchair when mobilising and there was limited guidance for staff on managing the person's risk of falls. Their care plan also did not reflect guidance provided by an external healthcare professional regarding their support when eating and drinking.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not raise any concerns about making complaints. One relative said that their family member liked to sit by a window and that staff had said the person would be better in the main lounge. The person did not like being moved so the relative complained to the staff and the person has since sat in their preferred seat.

We saw that complaints had been handled appropriately. However, guidance on how to make a complaint was displayed on one of the corridors but was not easily accessible for people who used the service. The complaints procedure did not make any reference to the local authority complaints procedure or the local government ombudsman. It was also not set out in the information guide for people who used the service.

Inadequate

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received. However it was not effective as it had not identified and addressed the issues we found at this inspection. This had also been identified as an issue at our last inspection.

The manager completed a weekly checklist. This contained very basic detail regarding the condition and cleanliness of the premises. This checklist did not contain sufficient detail to evidence that the manager was assessing and monitoring the quality of service that people received.

An external auditor had completed an internal quality check in December 2015. This identified issues in the areas of training, risk assessments, infection control audits and staff supervisions. There was no action plan in place to address these issues and three of the areas remained concerns at our inspection.

The external auditor had also carried out a health and safety inspection in March 2016 and had identified that they would be carrying out another inspection in September 2016. It was not clear whether this visit took place. Medication audits had not taken place recently. The last recorded medication audit was in October 2015. There were significant medicines issues identified at this inspection.

An infection control visit had been carried out by the local clinical commissioning group in February 2016. An action plan was in place but not all actions had been completed by the stated timescales and infection control issues remained at the time of our inspection.

Improvements to the service had not been made and sustained following inspections by us. The CQC inspections in 2011, 2013 and 2014 identified breaches in regulations. At our previous inspection in October 2015, we found that all regulations had been complied with, however, the service was rated 'Requires Improvement'. A number of areas had been identified as requiring improvement at that inspection but had still not been fully addressed by the time of this inspection. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

People did not feel involved in the development of the service. A person told us that there were no meetings for people who used the service. One relative told us that there had not been a relatives meeting for over a year.

No recent meetings for people who used the service and their relatives had taken place. There were no notices displayed in the home to inform people and their relatives of any upcoming dates for meetings. No surveys were in place to obtain the views of people who used the service on the quality of care provided to them. This meant that people were not actively involved in developing the service.

We also had concerns regarding staff understanding of shortcomings at the home and the service's ability to make sustained improvements as a result. At a staff meeting on the second day of inspection, a representative of the provider and the acting manager set out issues identified on the first day of inspection.

Following the meeting, we overheard a staff member describing those concerns as, "All about paperwork." This was not correct. We were also concerned to overhear a staff member saying, "Nothing's going to change."

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The current CQC rating was not clearly displayed in the home which meant that the provider was not meeting their regulatory responsibilities.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that statutory notifications had not been sent to the CQC when required. We had not been informed of the change of registered manager, safeguarding incidents or deaths. This had been identified as an issue at our last inspection.

These were breaches of Regulations 15, 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

A registered manager was in post, however, was not working as the manager. They had been replaced a few months earlier by a different manager. That manager had subsequently been replaced by the current acting manager. The acting manager had been in post for a week and was present during the inspection. However, no application to register a new manager, or cancel the registration of the previous registered manager, had been received by the CQC.

People's views on the atmosphere of the home were mixed. One person described the home as, "I have a warm feeling, I feel part of it." A relative said, "If I'm honest, I don't think it's the best home, but if I move [my family member] would it do more harm than good? They are settled here." A staff member said, "It's a happy and nice atmosphere. I love the residents and listening to their stories." Another staff member said, "Everything feels up in the air but it's getting sorted."

The provider's values and philosophy of care were in the guide provided for people who used the service. However we noted that one of these stated that, "We will always treat individual residents with dignity and respect." We did not find that this was the case at our inspection which meant that effective systems were not in place to ensure that the provider's values were being followed by staff so that people received a good quality of care.

The ground floor appeared unwelcoming, with corridors in poor decoration and lots of doors. However, the general atmosphere was welcoming and calm, with staff smiling and talking to people and visitors.

A whistleblowing policy was in place. Staff told us they would be prepared to raise issues using the processes set out in the policy. A staff member said, "At the end of the day you're looking after people's parents. I couldn't sit back and leave issues."

People were positive about the management team at the home, although they were not clear which person was in charge. One person said, "There are three bosses in charge, there is always one in the office downstairs." The person continued, "If I asked to see the lady in charge, they'd say 'yes' and she'd come and see me." One relative named all three recent managers and said they would feel comfortable to talk to any

of them.

Staff were positive about the acting manager. They told us she was approachable and responded to their concerns. A staff member said, "She works with you and you can contact her at any time."

Staff meetings had started to take place and the acting manager had set out their expectations of staff. A staff meeting was also held on the second day of our inspection which a representative of the provider attended with the acting manager to discuss issues with staff.

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 15 Registration Regulations 2009 Notifications – notices of change Statutory notifications had not been sent to the CQC when required. 15 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services Statutory notifications had not been sent to the CQC when required. 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been sent to the CQC when required. 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was responsive to their needs and activities required improvement. Care records contained some information to support staff to meet

people's individual needs but could be further improved.

9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always respect people's privacy and dignity. 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks to people were not always managed safely. Safe infection control practices were not followed. 12 (1) (2) (a) (b) (c) (d) (e) (h)

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 Appropriate action was not taken in response to potential safeguarding issues. 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People's needs were not fully met by the adaptation, design and decoration of the service. 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not recruited safely. 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The current CQC rating was not clearly displayed in the home. 20A (1) (3) (7)

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe infection control practices were not followed. 12 (2) (g)

The enforcement action we took:

We served a warning notice with a date for compliance of 9 December 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service. 17 (1) (2) (a) (b) (c) (d) (ii) (e) (f)

The enforcement action we took:

We served a warning notice with a date for compliance of 30 December 2016.