Coseley Systems Limited

Meadow Lodge Care Home

Inspection report

445-447 Hagley Road
Edgbaston
Birmingham
West Midlands
B17 8BL

Tel: 01214202004
Website: www.meadowlodgecarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on the 20 and 21 June 2017. Meadow Lodge care home is registered to provide care to 22 older people with a variety of needs including the care of people living with dementia. At the time of our inspection 20 people were living at the home.

At our last comprehensive inspection in April 2016, we found that the registered provider was in breach of regulations. This was because the registered provider's systems and audits had failed to identify the shortfalls we found related to staff practice and competency. These were related to the prevention of infection, compliance with the requirements of the Mental Capacity Act 2005 and protection and promotion of people's privacy. We were advised that there were systems in place to audit the safety and quality of the kitchen equipment and routines. However, we saw that there had been inconsistencies with fridge and freezer temperatures there were no records to show what action had been taken to ensure that food storage was still safe. In addition we found that whilst feedback from people about their experiences of the home had been sought it had not been analysed or used to inform practice or to drive up improvements to the service. Following the inspection we met with the registered provider and they submitted an action plan detailing how they would improve to ensure they met the needs of the people they were supporting and the legal requirements.

We undertook this unannounced inspection on the 20 and 21 June 2017 to check that the registered provider had followed their own plans to meet the breaches of regulations and legal requirements. Although the registered provider had started work to address the areas of improvement as identified in their plan, some actions were still outstanding or had not been completed as had been planned. The provider remains in breach of regulations as they had not taken the action required to ensure that effective systems would be in place to assess and monitor that the service would consistently deliver high quality, safe care. There were areas of further improvement required in respect of risk management, infection prevention, management of medicines, compliance and understanding of The Mental Capacity Act (2005) and The Deprivation of Liberty Safeguards (DoLS), nutrition, activities, the complaints procedure and the leadership and governance of the service.

The home had a registered manager who was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Whilst staff knew how to protect people and reduce risks associated with their specific conditions but the management of risk was not robust. The management of infection control and prevention and the cleanliness of the environment did not protect people from the risk of harm. Staff were not consistent with their explanations of the fire evacuation procedures. The management of medicines was not robust and always safe. People we spoke with told us they felt safe living at the home. Staff knew how to report any

concerns so that people were kept safe from abuse.

People's capacity was not always assessed and considered when decisions needed to be made to ensure their rights were protected in line with legislation. The registered provider had not ensured that the staff team knew which people were subject to a Deprivation of Liberty Safeguards (DoLS).
People who lived at the home told us they were not happy with the quality and variety of food provided. People were not consistently supported by staff to access health care when needed. Health care records did not contain sufficient information and guidance for staff to follow. Staff told us that they received regular training to enhance their knowledge and skills.

People were supported by staff who they described as kind and caring and we saw some caring and compassionate practice. Staff demonstrated a positive approach for people they supported; however, we saw instances when people's privacy and dignity were compromised.

People and their relatives told us that they had not been actively involved in their care plan and the reviewing process. Care plans had not been updated in line with people's changing needs. There was a lack of person centred activities available for people. People and their relatives told us they felt confident to raise concerns but most people told us that their concerns were not responded to and changes were not made. There were no effective systems in place to ensure complaints were responded to in an appropriate and timely manner.

The quality and monitoring checks in place were not robust or effective and this had resulted in a number of shortfalls not being identified and resolved. Leadership within the home was inconsistent and had failed to ensure positive outcomes for people who lived there. Some people, their relatives and staff were not confident that the home was well-led. Whilst the home had improved the way they sought feedback from people, concerns raised had not been utilised to drive continual improvement and actions had not consistently been taken.

We identified that there were breaches of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected by effective risk management to help keep them safe and well. We received mixed comments from staff about the location of the fire assembly point and the evacuation procedures to follow.

Systems and some practices in the home failed to ensure that people lived in a clean home and that they were fully protected from the risk of infection.

People were not always protected by safe medicines management at the service.

People told us there were enough staff available to support them with their individual needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People could not be confident that their human and civil rights would be protected as the principles of the Mental Capacity Act 2005 had not been followed.

People who lived at the home told us they were not happy with the quality and variety of food provided.

People told us that they had access to other health professionals. However, health care records did not contain information needed to maintain people's well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always supported and maintained.

People told us that they were supported by staff who were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were supported by staff who knew them well. However, this knowledge was not well documented and records to guide staff were not up to date.

People had not received the opportunity to undertake a range of interesting and stimulating activities that they enjoyed.

People told us they knew how to complain but the registered provider had failed to record or act on all complaints and concerns raised.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance and governance systems were not effective. Audits had failed to identify shortfalls identified during this inspection.

An action plan developed by the registered provider had not been effective in addressing the on-going breaches of regulations and driving forward improvements.

Opportunities for people to share their views and experiences of the home had improved, however this had not consistently been followed up and used to drive continual improvement to the home.

Meadow Lodge 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 unannounced inspection took place on the 20 and 21 June 2017. The inspection team consisted of one inspector and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of the inspection we looked at information we already had about the provider. The provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was returned within the timescale requested. We asked the Local Authority and Healthwatch if they had any information to share with us about the care provided by the service. We also checked if the provider had sent us any notifications since our last visit. These are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with 15 of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also spent time observing day to day life and the support people were offered. We spoke with seven relatives of people and one health care professional to get their views. In addition we spoke at length with the registered provider, the registered manager, one senior care assistant, the cook and four care assistants.

We sampled some records including six people's care plans and medication administration records to see if people were receiving their care as planned. We sampled two staff files and the way the provider had applied their recruitment process. We sampled records about training and quality assurance to see how the

provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the records showing how risks people faced had been assessed and managed. A health professional told us that they had found a sharps bin [A container to store used needles] overflowing with used needles. The risks associated with used needles are significant health and infection risks. The registered provider had not followed professional and good practice guidelines for the safe disposal of needles. Staff we spoke with described accurately how they used equipment to help people mobilise safely. However, we found there were no written risk assessments in place for people who required the use of specialist equipment. There were no risk management plans in place to guide the staff and to ensure the equipment was used safely. In addition we found some risk assessments had not been updated in line with people's changing needs. The registered manager advised us it was their intention to update risk assessments to rectify this. Failing to provide written guidance detailing the risks people face and how the risks are to be managed can increase the risk of needs not being met, or the needs being met inappropriately.

Staff were aware of the importance of reporting and recording accidents and had received first aid training. Staff we spoke with provided explanations of how they would support people in some potential harmful situations such as someone falling or when they were at risk of harm to themselves or others. A health professional we spoke with told us that they were concerned about people's catheter bags trailing which posed a serious risk to people. Failing to provide safe catheter care increases the risk of infection and chance of physical harm. We spoke with care staff about the procedures they needed to follow in the event of the fire alarms sounding. We received mixed comments from staff about the location of the fire assembly point and the evacuation procedures to follow and some staff told us that they had not participated in a fire drill. This put people at potential risk in the event of a fire. We received assurance from the registered provider that all staff had received additional information of what actions to taken in the event of a fire immediately following our inspection.

People did not enjoy a clean home and were not protected from the prevention and control of infection. A number of relatives expressed their concerns about the cleanliness of the home. One relative told us that their loved one's bedroom was not 'particularly clean'. Another relative told us that staff did not constantly apply safe infection control practices and that they had raised it as a concern on a number of occasions. We found that some practices in the home needed to be improved to protect against the spread of infection. The toilets within shower rooms on the ground floor of the home, which were frequently used, were not being maintained to an acceptable standard. The facilities had not been effectively cleaned and on the first day of the inspection there was an unpleasant odour in a number of bathrooms. Although there had been no outbreaks of infection the standards in place would not safeguard people against the risk of infection. A health professional we spoke with told us that they had concerns in relation to the cleanliness of the home and the lack of hand washing facilities. They advised that they were in the process of addressing these with the registered provider. The registered provider had identified a member of staff with lead responsibilities for the infection control champion who had made some impact on staff practice these changes had not been supported or audited by the registered manager to ensure they were being effective. The audits and checks conducted in the home had failed to identify the issues and concerns that we had identified during

our inspection.

Staff that we spoke with confirmed that they had access to personal protective equipment and we observed that this equipment was in use during the inspection. One the second day of the inspection we noted that having raised the issues with the provider and registered manager the home had been cleaned in response to our feedback, and the registered provider advised that further audits were planned.

Medicines were securely stored in lockable medicine cupboards in each person's bedroom. On the day of our inspection we observed staff administering medicines in a safe way. However, in one person's medicine cupboard we found a prescribed medicine that was not listed on the medicine administration record (MAR). Staff were unable to confirm if the person had received their prescribed medicine. On investigation staff told us that this medicine had been discontinued and had not been removed from the person's medicine cupboard. In another two records for people we saw records referred to prescribed medicines and creams that had also been discontinued. In this instance the medicines were no longer in the cupboard. In another person's bedroom supplementary drinks had been prescribed to enhance the person's appetite. However, these were not identified on the person's MAR. Whilst staff told us that the person was drinking them no records were being maintained and we were unable to determine by the records we viewed if the person had received them. The registered manager advised that this would be rectified following our inspection. One health professional we spoke with told us that the home had failed to ensure there was sufficient prescribed medicine in stock for one person as required to support the person's well-being. The failure to have adequate stocks of medication in place meant the person experienced ill health symptoms that would have been alleviated by the prescribed medication had it been available and administered to them. Shortfalls in the arrangements for administration and recording medicines were identified.

We saw that the registered manager had carried out regular medicine audits and on occasions they had identified shortfalls. Whilst these shortfalls had been recorded as medicine errors they had not been fully investigated. Failing to do this did not protect people from future medicines errors occurring.

The failure to ensure that safe care and support was provided, that infection control measures were effective and that medication management was safe represented a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us that they received their medicines on time. One person who lived at the home told us, "I get my medicines on time." Staff told us and records confirmed that staff responsible for administering medicines had received training and competency checks to ensure they were safe to administer medicines. The issues identified during the inspection had not been identified during the checks that had been conducted. The registered manager advised us that there plans to further improve the competency observation records.

People who lived at the home and their relatives told us that they felt safe and that staff knew how to keep them safe. One person told us, "I feel safe…security is good and staff's eyes are open." People were protected from potential harm by staff who recognised signs and suspicions of abuse. Staff we spoke with described what actions they would take in order to safeguard people they supported. We found that any concerns or allegations of potential abuse had been escalated to the appropriate external safeguarding bodies by the registered manager.

People who lived at the home and their relatives said that there were enough staff on duty to meet people's care needs. One person told us, "Enough staff around if I need them." Staff spoke positively about their experiences of the staffing arrangements in the home. The registered manager told us that they had

established how many staff were needed to meet people's care needs although no formal staffing tool had been used to determine the staffing requirement. We saw that there were enough staff on duty at the time of our inspection, to enable people to receive prompt support when they requested it.

We looked at the process used to ensure that new staff were recruited using robust checks. We looked at the files of two staff and saw evidence that pre-employment checks had been carried out prior to staff starting work. This included the obtaining of references and checks with the Disclosure and Barring Service (DBS). We did note that references did not confirm the validity of the people providing the information. The registered provider advised us that this had been done verbally but had not been recorded.

Requires Improvement

Is the service effective?

Our findings

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 who lived at the home told us that staff got their consent before supporting them with tasks. However, most of the staff we spoke with had limited knowledge in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what this meant for people living at the home. The registered manager was unable to describe the procedure they would follow to ensure people's rights were protected. Assessments of people's capacity to make decisions when there were concerns about their ability and determination of their best interests had not been undertaken.

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 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. We found a DoLS authorisation had been applied for one person but there was no record of any capacity assessment in the person's care records. The staff we spoke were inconsistent in relation to which people were subject to a DoLS and were unable to explain how they supported people in the least restrictive way. Some staff told us they did not know; others said they thought everyone was and others gave numbers and names of people but were unsure what the authorisation was for. Care records we reviewed lacked detail about the person's authorisation and there was no guidance available for staff to follow to enable them to support the person in the least restrictive way. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS.

The staff we spoke were not all aware of the people who had requested not to be resuscitated if they were unresponsive to immediate lifesaving treatment. This meant that people's wishes may not be respected. The registered provider advised that this concern would be rectified immediately and all staff would be informed. One person's end of life plans recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that although the documentation had been completed and was available in the person's care plan there had been no involvement or consultation with the person. The person's care records identified and we were told that the person had capacity to make their own decisions. This had not been identified as a concern as part of the registered managers care plan audits. Following our inspection we were informed that the home had escalated this concern to the relevant health professional to undertake an additional assessment. The person expressed their wishes to be resuscitated. This meant that the person's rights had not been properly considered initially and had not been protected.

These issues regarding the need for consent were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 11.

Out of the 15 people who used the service that we spoke with only one person told us they enjoyed the food provided. A person we spoke with told us, "Food…, that is a problem. It's dreadful and they don't abide by the menu." Another person said, "Some of the meals are horrendous." Some relatives also expressed their concerns in relation to the meals provided. One relative told us that they had sampled the food that had been provided to their loved one after they had shared their concerns with the relative. The relative who tasted the food said, "It was awful, soggy and cold." Another relative told us, "I bring food in to supplement [name of person] diet."

We observed one person taking their meal back to the kitchen and refusing to eat it. We clearly heard the person informing the staff that their meal was inedible. Whilst we did not see the cook offer the person an alternative meal, we were later advised that another member of staff had offered an alternative meal to the person. Another person we spoke with told us that the food was not to their liking and said, "I go out to town every day to get something to eat."

It was clear from the observation we undertook at lunch time that mealtimes were not a pleasurable time for social interaction. In one dining room we witnessed meals being served to people with no communication initiated by staff with the people using the service. The meals were served in silence and only one choice of drinks were offered. We observed that people were offered biscuits and hot and cold drinks throughout the day. We looked to see if people were maintaining a steady body weight. A reduction in weight can indicate that people are not being well nourished. The records of people's weights identified that a high number of people had lost weight during the four months prior to the inspection. Whilst the registered manager advised us that they had contacted people's doctors and that no concerns had been raised the weight loss experienced by people was not planned and no remedial action had been initiated to enrich the food offered or to monitor the food that had been served and if the meals were being eaten. Whilst staff were weighing people regularly a health professional told us that they had found it hard to monitor two people's weights correctly because weighing scales were not available in the home to use with people who were unable to stand.

The registered manager advised us that recent surveys had been undertaken to obtain people's views about the food provided. They advised us that generally the comments were positive. However, we saw lots of negative feedback contained in a daily comments book which clearly identified numerous complaints about food. This had not been noted and addressed by the registered manager. People's feedback had not been acted on to improve the food served.

The registered provider advised us that they had sought the advice from people's families in respect of how to prepare meals to meet their loved ones cultural dietary requirements. Two people and their relatives who had requested culturally appropriate meals told us that whilst the home had attempted to cook and provide meals that met their taste preferences it had not been successful. One relative said, "They just can't cater for multi-cultural diets." We found there were no alternative arrangements in place to ensure people received their dietary requirements.

The registered provider did not have suitable arrangements in place to make sure people's nutritional needs were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A person we spoke with told us, "The GP [doctor] comes out if necessary." We saw examples in people's care records where staff had made referrals to other professionals when it was appropriate to seek additional advice. However one relative we spoke with told us that their loved one was prone to water infections and said, "I know [name of person's] sign and symptoms and I had to ask the home to contact the doctor." One

health professional told us that they had to request that the staff contacted one person's doctor because they were unwell and staff had not recognised the person's health concern. Whilst we saw that people's care records contained details of any specific health condition there was no detailed guidance about how the person would need to be supported to keep them safe or detail of what staff should do in the event of a medical emergency. For example, some people were diabetic and we found that people's care records had not been completed with enough detail to guide staff in how to support them safely or in the event of a medical emergency.

Some people we spoke with told us that staff had the right knowledge and skills to support them with their individual needs. One person told us, "Staff know me and my needs." A relative said, "Staff seem knowledgeable around dementia." The staff we spoke with told us that they received regular training to enhance their knowledge. A member of staff told us, "Plenty of training provided and I'm up to date with all mine." Records we reviewed supported that training was offered and current. Staff we spoke with told us that they received regular supervision where they could discuss their practice and identify any training needs. We reviewed staff files and found that staff had been provided with supervision. We saw that the registered manager undertook some observations of staff's care practices to monitor and assess how the knowledge and skills gained by the staff were being put into practice and continually developed.

Staff told us and we saw that they were provided with and completed an induction before working for the home which continued into the early weeks of their employment. Staff told us that they were closely supported during their induction period and the registered manager had checked on their performance and progress throughout this time. We found that the registered provider had not yet introduced the Care Certificate that should be completed for staff who are new to the care sector but had plans to do so for the future.

Requires Improvement

Is the service caring?

Our findings

The privacy and dignity of people using the service was not consistently protected. One relative we spoke with told us about an incident when they felt their loved one was not treated respectfully or with dignity. We shared this concern with the registered provider who advised us that they would investigate the concerns raised. During the inspection we saw that the staff handover of information between shifts was conducted in a communal area where people could overhear what was being said. The registered manager had not ensured that arrangements were in place to protect the confidentiality, privacy and dignity of people living in the home. The registered manager advised us that they would ensure that a confidential room was used for future handovers.

Staff we spoke with told us that they enjoyed supporting people who lived at the home. Most staff described people's preferences and personal histories. One staff member told us that one person enjoyed watching the television and said, "[name of person] enjoys talking about our lives and giving us advice." Throughout our observation we generally observed positive interaction between people and staff. We heard staff asking people what they would like to do and explaining what was happening. During the inspection we saw that despite staff being present in the lounge there were periods of time where staff did not interact or engage with people. Staff were engaged in completing records.

Some aspects of the home were not helping people to orientate themselves. For example, all doors did not display dementia friendly signage indicating where bathrooms and personal rooms were. We also saw that there were limited activities or things to do for people who were living with dementia.
People who we spoke with told us that the staff who supported them were kind and caring. One person told us, "Staff are lovely." We saw several examples of good practice where staff were kind and caring in their approach and showed genuine concern for people's well-being.

Some people told us they had been asked how they would like to be supported. One person told us, "Staff ask me how I like things done." Some people told us how they liked to go out independently on a daily basis and that they preferred their own space. We saw that this was respected. At the time of our inspection one person had an advocate to support them. Advocates are trained to support and enable people to make decisions.

We asked members of staff what they did to protect people's dignity and privacy. All of the staff we spoke with were able to describe how they did this in practice when they provided personal care and support. One member of staff told us, "I always close the door when I'm supporting someone with their personal care." Staff referred in particular to how within double occupied rooms they ensured that privacy curtains were always used. This enhanced people's privacy within shared rooms.

People were encouraged to do things for themselves in their daily life. We observed one person collecting cups from the communal areas and taking them into the kitchen. One person told us, "I'm very independent and I like that." Staff told described the ways they promoted and valued people's independence.

A person we spoke with advised that there were no restrictions in place in respect of visitors and told us, "When my friends visit, they can come any time. We go to my room it's more private there." We also observed a member of the night staff team informing the senior on duty that a relative had visited late in the evening due to their work pattern. This demonstrated that staff valued and respected people's relationships.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with were aware of how to make a complaint. However, some people and relatives told us they had raised issues and concerns with the registered provider and registered manager and no action had been taken. One person told us, "I continually complain and nothing gets done." A relative we spoke with shared a number of concerns about a variety of things that they had already raised with the registered provider. We discussed this with the registered provider who told us they were unaware of some of the incidents and would investigate the concerns we raised.

Concerns and complaints made by people were not consistently well managed and were not consistently responded to or investigated. Records we looked at showed that the home had not received any complaints this year. However, we were informed by some people and three relatives that they had raised frequent complaints. Discussions with the registered manager confirmed that they had received some of the complaints but had failed to consistently recognise and record issues raised as complaints. In addition information from the complaints had not been utilised or used to enable continuous improvements to be made in the home. We saw that complaints from some people had been recorded, however not all of them had been monitored or responded to. The provider did not have robust arrangements in place for identifying, receiving and handling concerns and complaints.

We saw that the complaints procedure was displayed at the home. However, the contact details referred to a previous regulator and not to the Care Quality Commission. In addition there was no reference to the Local Authority or the ombudsman so that people and their relatives had access to contact numbers should they wish to raise a concern or complaint. The registered provider advised us of their intention to review their policy.

The lack of action to identify issues and the lack of an effective process to review all complaints and identify any trends or how to prevent negative experiences reoccurring again for people meant that opportunities to make changes as a result of any complaints received was missed. There was no effective system in place to ensure all complaints were responded to in a timely manner and recorded appropriately. This was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation16.

People who lived at the home told us they felt that staff knew their care needs well. One person told us, "Staff know my routine in a morning." The staff we spoke with had a good awareness of the support needs and preferences of the people they cared for. Most staff could describe people's likes and dislikes and their life histories. A member of staff told us, "[name of person] enjoys their smoking and their phone." However the registered manager had not ensured this knowledge was well documented or that records to guide staff were up to date. People and their relatives (if necessary) told us they had very limited involvement in the care planning and review process.

We looked at the arrangements for supporting people to participate in their expressed interests and hobbies. People shared different experiences around social activities. Some people told us they had opportunities to access their local community and enjoyed attending entertainment sessions; others told us

they were bored and didn't engage with activities offered. Limited activities were provided but this was not at a level which would meet the needs of most people who lived at the home. On the first day of our inspection we saw most people sitting in the lounge area watching television for most of the day; on the afternoon of our visit, some people were colouring pictures and one person was doing a word-search. There were no person centred activities or hobbies offered. On the second day of our inspection we saw people being offered books and magazines to read and some people were offered puzzle books. One staff member consulted with people to see if they would like the television switched off and offered to put music on of their choice. No other activities were observed during our inspection. We did see some feedback from a person requesting to do some baking. We saw a photograph of people baking and enjoying themselves. This activity had only taken place once. There were no consistent plans to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation.

One relative shared a positive experience about their loved one and said, "It was really lovely to see my dad outside chatting to the maintenance people. He was in that area of work so felt really involved. However, most of the relatives we spoke with felt more could be done, by the registered provider, to take people out and provide them with more 'meaningful things' to do with their time.

The registered provider advised us that there was an activities co-ordinator in place. However, we identified that there was no designated activity co-ordinator. A member of the care team had been given responsibilities to look at activities as part of their care duties. Staff we spoke with told us that they shared responsibility for providing activities for people to do. Staff told us that they 'do what they can' and acknowledged that activities could be improved. Following our inspection we were advised that the service had deployed a member of staff to undertake specific activities on a daily basis with immediate effect.

People were supported to maintain relationships that were important to them. We observed visitors calling into the home during our inspection. One person told us, "I so much look forward to my friends visiting and going out shopping with them." We saw some people had their own mobile phones to contact their family and friends. A number of people went out daily to meet their friends.

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2016 we identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems in place to monitor the quality and safety of the service provided. This was because the registered providers systems and audits had failed to identify the numerous shortfalls that impacted on the quality and safety of care that we found throughout our inspection. Following the inspection in April 2016 we met with the registered provider and they produced an action plan of how they would respond to concerns raised at our last inspection.

At this inspection in June 2017, we found that the provider had started work to address the areas of improvement as identified in their plan. However, some actions were still outstanding or had not been completed as had been planned. The issues had not been addressed by the planned date or to the required depth to ensure people received consistently good, safe care that was compliant with the legal regulations.

We found a number of audits were in place within the service, however these audits had not been effective in identifying the shortfalls we found and had not improved the quality and safety of the service delivered. The audits in place for the monitoring of infection prevention, health and safety and the safe management of medicines had not identified the shortfalls we had found during our inspection and noted throughout this report. Whilst we saw that some incidents had been recorded this was not consistent and they had not been analysed to identify any themes or patterns to prevent negative experiences reoccurring. The provider's representative and the registered manager acknowledged and agreed with the concerns noted during this inspection.

The provider remained in breach of this regulation as they had not taken the action required to ensure that effective systems would be in place to assess and monitor that the service would consistently deliver high quality, safe care. The management, leadership and governance of the service had not been effective.

The overall findings of this inspection specifically in relation to the on-going breaches of regulation noted throughout this report, do not support the providers own assessment of progress and completion of actions as detailed in their action plan.

The registered provider and registered manager have been unable to achieve compliance with the regulations since November 2014 or to ensure people consistently receive a good, safe service.

These issues regarding good governance of the service were a continued breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

We received mixed comments from people and their relatives in relation to their confidence in the management team. One person said, "[name of registered manager] is the manager. She does come down [to see people]." However a relative who we spoke with said, "I don't think the manager is very approachable." Another visitor told us, "The bosses stay in their offices most of the time." On the day of the

inspection we saw the registered manager and registered provider responding to requests from people and their visitors.

Although people we spoke with did not recall attending residents' meetings or being asked to give feedback via questionnaires. We saw records that demonstrated people had been invited to contribute suggestions about the development of their home. The views and experiences of people related to the meals had been sought. However the information had not been utilised to improve the provision of food. These shortfalls had failed to ensure that the views of people had contributed to improvements of the home.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. We found the registered provider had met their legal obligations around submitting notifications to CQC and the Local Safeguarding Authority. We also saw that the registered provider had ensured information about the home's inspection rating was displayed prominently as required by the law.

Most staff we spoke with told us that they felt supported in their job role. They were clear about the leadership structure within the home and were able to describe their roles and responsibilities and what was expected from them. Staff told us and we saw that they attended regular staff meetings and were asked for their views about the home. Information about raising concerns was displayed around the home. Staff we spoke with were knowledgeable about how to raise concerns. However some staff told us that their suggestions for improvement had not always been responded to.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring the care and treatment provided was with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring the safe care and treatment of people through appropriate management of medicines. Regulation 12 (2) (g) The provider had not assessed the risks to the health and safety of people who used the service and had not taken action to manage known or related risks. Regulation 12 (2) (a) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have suitable arrangements in place to make sure people's nutritional needs were met. Regulation 14.1 14.2 14.4 (a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not ensuring that all complaints were investigated and responded

to. Regulation 16 (1) (2)

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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)(c)

The enforcement action we took:

We served a Warning Notice requiring the provider to become compliant with this regulation by a set date.