Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

58-60 Wellesley Road
Great Yarmouth
Norfolk
NR30 1EX

Tel: 01493844864

Date of inspection visit:
04 May 2016
06 May 2016

Date of publication:
01 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Abbeville Residential Care Home provides accommodation and care for up to 38 older people, some of whom may be living with dementia. At the time of our inspection there were 19 people living in the home.

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

This inspection took place on 04 and 06 May 2016 and was unannounced. Prior to this May 2016 inspection the service had been inspected four times in 2015. On each occasion we had found breaches of regulations relating to the management of medicines. On two occasions, including the last inspection carried out in December 2015, we had found breaches of regulations relating to the governance of the service. The December 2015 inspection resulted in the service being rated as 'Inadequate' and being placed in to special measures.

This May 2016 inspection found that although a few improvements had been made since the December 2015 inspection, these were mainly around medicines management. However, other substantial and ongoing concerns remained.

There was poor understanding and management of risks to people's wellbeing. Risks to people of developing pressure areas were not regularly updated. Nutritional risk assessments were not in place and people were not always weighed regularly, even if a weight loss had been identified. Where people had experienced falls, risk assessment and risk management plans had not been reviewed.

The environment was not safe. Twenty windows required window restrictors which put people living with dementia and visual impairments at risk of falls. The fire risk assessment was out of date as was testing for legionella in the water system.

Whilst sufficient staff numbers were deployed to meet people's needs recruitment checks were not robust enough to significantly mitigate the risks of employing staff unsuitable for their role.

Staff training had expired and steps had only been taken to remedy this after we had inspected another of the provider's services and found similar concerns. This put people at risk of receiving care from staff that was inappropriate or unsafe.

Staff understood the day to day requirements of the Mental Capacity Act 2005. However, there was no clarity about when a mental capacity assessment would be needed. The service needed to make improvements in this area.

People liked the food. However, questionnaires completed suggested that sometimes it wasn't hot enough or the quantity wasn't right for individuals. These issues had not been acted upon by the manager.

People had good access to healthcare professionals, but the outcomes of visits or health appointments were not always updated to reflect changes to people's care needs. This put people at risk of receiving inappropriate or unsafe care or support.

Staff were friendly and people were at ease with them. However, some of the practices in the home did not take into account people's preferences or respect their dignity.

Care plans were not sufficiently personalised and did not contain specific guidance for staff to follow to support people with specific health and support needs. This meant that people may not have received appropriate care and support.

Some people and relatives were not confident when raising queries or concerns with service managers that they would be acted upon.

The service was not well managed. Audits were ineffective. The provider had poor oversight of the service. Sufficient improvements had not been made since our December 2015 inspection.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health were not always identified or reviewed. Actions were not always taken to mitigate identified risks.

Safety issues relating to the premises were not always identified or remedied.

Recruitment checks were not robust enough to significantly mitigate the risks of employing staff unsuitable for their role.

There had been improvements in the management and administration of people's medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The majority of staff training was out of date.

People's views about the food they received had not been acted upon to improve their mealtime experiences.

Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff engaged with people in a kind and caring manner.

The routines and practices of the home did not always take into account people's preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

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

support.

Care plans were not updated in a timely manner following changes to people's needs.

Concerns were not always responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider's systems for audit had not ensured that identified actions from the last inspection had been addressed.

The systems to assess the quality of the service provided were not always effective. Action was not always taken when areas for improvement had been identified.

Abbeville Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 04 and 06 May 2016 and was unannounced.

The inspection team comprised of three inspectors, one of whom specialised in the management of medicines.

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

During the inspection we spoke with nine people living in the home and relatives of two people. We made general observations of the care and support people received at the service throughout the day. We also spoke with the manager, five care staff, the cook and two visiting community nurses. We reviewed seven people's care records and medicines administration record (MAR) charts. We viewed three records relating to staff recruitment as well as training, induction and supervision records.

We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our last inspection in December 2015 had identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks to people's welfare were not always identified or mitigated and people's medicines were not being managed safely.

At this inspection we found considerable concerns regarding risks to people's welfare. However, there had been improvements in the management of medicines.

The home spans three floors and can accommodate a maximum of 38 people. At the time of our inspection there were 19 people living in the home. These vacant bedrooms were unlocked. During our walk around the premises we found that several bedrooms on the upper floors, vacant and occupied, had windows that did not have restrictors to ensure that they only opened to a safe distance. We also found that some windows in corridors on the upper floors lacked restrictors. There were people living with dementia who could mobilise independently around the home, as well as people with significant visual impairments. These people were at risk from the absence of window restrictors.

We raised this concern with the manager and asked them to survey the premises and advise us of the scale of the issue and what they would do to rectify it. They advised us that 20 windows required restrictors and that these would be in place within a week and they would look into securing the vacant rooms. The manager has subsequently advised us that this work has been completed.

We found other concerns relating the safety of the premises. The fire detection and alarm system had been due a service and inspection in March 2015 but this had not taken place. The fire risk assessment had been completed in September 2014 and this was now due a review. The water system had last been sampled for legionella in May 2013. There was no legionella risk assessment or action plan to reduce the risks in place. For example, little used water outlets needed to be flushed through on a regular basis, but this wasn't being done. Two bedrooms had ripped or rippling flooring, one of which was extensively damaged. The maintenance staff member told us that he would be repairing the flooring in one person's room so that when they used their recliner chair it wouldn't cause the flooring to bubble.

Our December 2015 inspection found that Waterlow assessments, which determined the risk of people developing pressure areas, were in place for each person. However, these had not been dated and had not been reviewed. This inspection found that no improvements had been made in this area. One person's Waterlow assessment had last been reviewed in October 2014 and they had been assessed as at high risk of developing pressure areas.

Of the records for six people that we reviewed in relation to Waterlow assessments, five people had been assessed as at risk, high risk or very high risk of developing pressure areas. There was no guidance in place for staff to advise them of the actions required to reduce the risks to people. We found that each person had pressure relieving equipment on their beds and chairs. One person had been assessed in February 2016 as being at risk of developing a pressure area. However, their pressure cushion on their bedroom chair had not

been sufficiently inflated and air only remained in the outer chambers of the cushion.

One person's relative told us that they were present when a staff member helped their family member to sit upright in bed so that they could be assisted with lunch. However, the staff member had moved their family member without the help from a second staff member and had not used slide sheets. Slide sheets protect people from skin damage caused by friction and help ensure staff do not injure themselves or the person they are supporting.

Our December 2015 inspection found that nutritional screening was not taking place in the home and people had not been weighed for a seven month period. This inspection found that minimal nutritional screening was taking place in the home. Of the records for six people we reviewed in relation to their nutrition, two had not been weighed since February 2016. Only one person had a nutritional screening assessment in place and this had been done after we raised concerns with the manager on the first day of this inspection.

The person with the nutritional screening assessment in place had last been weighed in February 2016. Their nutritional screening assessment had been incorrectly scored and had not factored into account their recent weight loss. In February 2016 a note had been made on their care plan to 'review with GP' but we could not find any evidence to show whether this had taken place and if so, what the outcome was. Food charts were not being kept to determine whether the person was eating sufficiently and no plan was in place to help determine how their nutritional needs could be most appropriately met. This presented a risk to the person's welfare and this concern was referred to the local authority's safeguarding team.

The cook told us about the nutritional needs of a person who had been visited by the Speech and Language Therapist (SALT) three weeks ago. Prior to this the person had been on thickened fluids and required one scoop of thickener per 200 mls of liquid. The cook told us that the SALT had advised that the person now required a soft diet as well. When we reviewed the person's care records we found that their dietary care plan referred to them requiring a thickener, but the quantity was not recorded. This had not been updated to show that the person now required a soft diet. The manager showed us that the SALT visit had been recorded in the person's daily notes, but neither their dietary care plan nor the professionals visit section had been updated. The manager said that they had not received a letter from the SALT following their visit, but then found that the letter, dated 21 April 2016, was in their office. As well as now requiring a soft diet, this letter stated that the person required 1.5 scoops of thickener per 200 mls of liquid. The chef told us that they had not been told about this increase in the person's thickener requirements. This presented a risk to the person's welfare and this concern was referred to the local authority's safeguarding team.

The tin of thickener was not kept securely and it was easily accessible to people using the service. When on duty there were periods of time when the cook was not present in the kitchen. At night we were told the thickener was kept in the cupboard beneath the counter. Some people living in the home were living with dementia. If accidentally ingested the thickening powder could form a solid mass and obstruct a person's airway. Failing to safely store it posed a risk to people's welfare.

The service operated a falls risk assessment process whereby assessments needed to be re-assessed whenever a person experienced a fall. This did not take into account that changes in a person's general health, mobility or medicines could in the meantime increase their risk of a fall. One person's falls assessment had been completed in February 2015. The person had experienced two falls in 2016 but their falls risk assessment had not been reviewed. The person had been using a walking frame since February 2016, but this was not reflected in their care plans.

Our December 2015 inspection found that records of accidents were kept. These were mainly falls incurred by people living in the home. However, these had not been analysed to identify patterns that could help the service reduce the number of accidents in the home. This inspection found that a list of accidents was maintained for each month, but there was still little analysis. Any analysis attempts would be hampered by insufficient detail being recorded on original accident reports. For example, we noted one accident report where it had not been recorded what time of day the fall occurred, whether it had been witnessed or what the person's account of the incident had been. The manager said that the he was working with staff to improve the content of accident reports. However, we found that appropriate referrals were made to the falls team when necessary.

One relative told us that sometimes their family member's bedding and towels were grubby. We found that some people's bedding although laundered, was not clean. We also found debris on people's bedding. Bath chair lift seats were made of a mesh-like plastic material which was unclean. One had a large hole in the seat. The carpet in the main lounge was heavily soiled. We found black mould had developed on the underside a one rubber bath mat.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We reviewed recruitment records for three staff members, two of whom were new to the service. We found that proof of identity and photographs of staff members were not on any of the files we looked at. Disclosure and barring service (DBS) checks had been made and the service had commenced the process of getting these updated where necessary. However, a risk assessment had not been carried out when one of the checks returned an adverse result. References had been taken up prior to staff commencing work in the home. Where a reference had been received that was not fully positive, no record of the rationale for the decision to employ the person was made. One applicant had given details of two previous employers in the care sector, but only one had been approached for a reference. No enquiry was made of the applicant about why they hadn't put the second employer down as a referee. The recruitment processes in the service were not robust and did not fully mitigate the risks of employing staff unsuitable to their role.

These concerns constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Our December 2015 inspection found that people's medicines were not being managed safely. We had found stock imbalances which meant that people may not have received their medicines and gaps in cream administration charts and pain relief patch administration records. This inspection found that whilst improvements were required, the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to medicines management.

During this inspection, our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

One person told us, "Staff are very good with doing my creams for me. They never miss." Another person told us, "I always get my medicines on time, there's never any mistake." However, one person's relative told us that they had recently found some tablets on the floor in their family member's bedroom.

Supporting information was available to assist staff when giving medicines to individual people. There was personal identification to help ensure medicines were administered to the right people and information about how they preferred to have their medicines given to them. Charts were in place to record the

application and removal of prescribed skin patches. When people were prescribed medicines on an as and when required basis, there was written information available to show staff how and when to give them these medicines consistently and appropriately. For people who managed their own medicines, records showed that the risks related to this had been assessed and reviewed.

Records showed that people living at the service were receiving their oral medicines as prescribed. Frequent audits were in place to enable staff to check records and monitor and account for medicines. However, for medicines prescribed for external application, there were gaps in records so the records did not confirm that these medicines were being applied appropriately and as prescribed.

Oral medicines were stored safely for the protection of people who used the service and at correct temperatures. However, we noted that some medicines prescribed for external application were not being stored safely to protect people against accidental harm.

One person told us, "There's enough staff around when I need some help." Another person said, "I don't have to wait long." Staff told us that they were able to meet people's needs with the current staffing arrangements. There were sufficient staff on duty during our inspection. The provider had implemented a dependency assessment tool which helped determine how many staff were required to meet people's individual needs. We saw from staff rotas that the required amount of staff had been on duty in the weeks preceding our inspection.

Staff were aware of their responsibilities in relation to safeguarding people from abuse. Whilst their training in this area had expired, staff were clear about what constituted abuse and what actions they would need to take if they had any concerns. Information on who to contact was readily available to staff. Where the service had made safeguarding referrals these had been reported to the appropriate authorities and the service had taken suitable steps to investigate concerns when appropriate to do so.

Requires Improvement

Is the service effective?

Our findings

Staff had not received sufficient training and support to carry out their duties effectively. Most of the provider's training programme was done through online training, with practical sessions on moving and handling for care staff and first aid for senior care staff. Only two staff had received moving and handling training in 2016, and these were both newly recruited staff. They had not received other training since joining the service. Both staff members had worked in the care sector previously. The manager told us that they had seen training certificates when the staff members had applied for their positions, but they had neglected to keep copies. Therefore, the manager did not know what training the staff members had received and could not reasonably satisfy themselves to what extent they had the skills and knowledge to carry out their roles. The manager supplied us with one certificate to show that one of the six senior care staff members had a current first aid qualification, but no other first aid certificates were supplied when requested.

Two further staff members were recorded as having received moving and handling training in 2015. This meant that the vast majority of staff had not received moving and handling training recently. Other training such as safeguarding, mental capacity, fire training, health and safety, infection control, food hygiene had expired for the vast majority of staff in October 2015. A staff member who was managing the provider's home care agency had been organising training, but they had been too busy with managing their service to be able to continue to do this, so staff training had fallen behind.

There were 31 staff members employed at the home that required supervisions from either the manager or deputy manager. The manager told us that they aimed to supervise staff once every two to three months. However, during 2016 so far there had only been 12 supervisions carried out in total.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "Staff are competent here." Staff told us that they knew what they were doing but that their training was out of date so they may not have been up to date with good practice. One staff member told us they felt they had carried their knowledge over from working in previous homes, rather than learning anything since joining the service. Following a recent inspection of another of the provider's services where training had also expired, the manager had begun to arrange staff training. We received mixed views from staff about the support provided to them by the service's management team. Some felt that they received adequate support and others felt that the managers did not support them sufficiently with input regarding their day to day duties.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff we spoke with understood the principles of the MCA and knew who had capacity to make their own decisions, who did not have capacity and whose capacity to make decisions fluctuated. They understood that they needed to obtain consent prior to supporting people. We saw that staff did this routinely throughout our inspection. Where people were not able to make decisions for themselves staff understood that they should try different approaches to make things easier for people to understand and support people to make their own decisions. When necessary staff would make day to day decisions in people's best interests.

The manager told us that they had submitted a DoLS application in respect of one person. A health professional had carried out a mental capacity assessment of the person and had determined that the person lacked the ability to make their own decisions in relation to their care. During this inspection we found second DoLs application on another person's care record. This set out the aspects of the person's care that they couldn't consent to which was considered to be a deprivation of their liberty.

Care records regarding people's mental capacity were inconsistent. Some people's records clearly set out whether people had capacity to make their own decisions and under which circumstances they would require support to do so. Other care plans made no reference to people's abilities in this area despite their records showing they were living with dementia.

People told us that the cook on duty came to see them daily to give them choices about what to have for their next meal. We saw this during our inspection. One person told us how their options for meals took into account their diabetes and plans to lose weight. Another person told us that the food was, "…very good." One person said, "The food is fine, I have a small appetite."

During our inspection we observed that people usually had drinks available within reach. However, we found that one person in their room did not have a drink available to them.

People who needed support to eat their meals received this. We observed one staff member who was assisting one person with their lunch. This person had a significant visual impairment. The staff member explained what was on their plate and what foods were on each spoonful that they assisted them with.

Most people did not have their meals in the dining room which was also used for activities. The dining area was centrally located in the home and adjacent to the kitchen. However, there was no natural light and it was gloomy. This meant that people with visual or cognitive impairments might find it difficult to navigate around. The tables and chairs were close together which did not promote a relaxing environment for meals as people were constantly needing to move to let others pass by. There were three other lounges nearby, all of a good size, any of which could have made a far more pleasant environment for people to have their meals in.

We saw that people had access to a range of health professionals to support them with their wellbeing. The registered manager told us they received very good support from the local GP surgery and the district nursing team. People were able to access specialist advice if necessary. This included the dietician, speech and language therapist and hospital consultants. People also had access to chiropody, dental care and optical care.

Requires Improvement

Is the service caring?

Our findings

People were positive about the staff that supported them. One person told us, "They couldn't do any more for me." Another person said, "I chat with staff when they come in to do my care. It makes me feel valued." A third person said, "The carers are generally fairly good." One person told us that, "Staff are great." One person's relative told us that staff were friendly and good natured.

Staff spoke with people in a respectful and kind manner that people responded well to. They were patient and gave people the time they needed to make a decision or move about the home at their own pace.

Whilst the staff interactions we observed were positive, there were routines in place in the home that did not always take into account people choices or preferences. We also observed instances where people's dignity was not supported.

One relative told us they were disappointed that their family member was only bought downstairs for lunch and that other than this, they spent a lot of time in their room. They said that when they visited they often found their family member in their bedroom with nothing to do and no radio or television on for them. They said that their relative had been a sociable person and felt that they would benefit from the stimulation of being around others.

During lunch time in the main part of the home there were two radios on at the same time, both played at a loud volume. In the living area opposite the dining area Prime Ministers Questions was on. In the dining area music was being played. The competing sounds did not make for a relaxed and pleasant lunch time experience.

On both days of our inspection we saw that two people, both of whom were living with dementia and significant visual impairments, spent most of their days asleep in the living area opposite the dining area. They also took their lunch in this living area. The radio was constantly on. There was no change in their environment to signify to them that it was lunchtime or to encourage a more wakeful state. They were not asked whether they wanted their lunch where they were sitting or whether they wished to eat elsewhere.

We saw feedback that people had given to the service. This showed that two people felt that they were unable to sleep in when they wanted and that staff did not always knock on their door, or give them time to answer before they entered their room. People's beds had been made with unclean linen.

People told us how staff supported their dignity when they assisted them with personal care. They were asked whether they preferred female or male carers. However, one person told us how they felt rushed during baths and showers. We saw that one person, who tended to eat with their fingers, had faecal matter under their nails. One staff member told us this was a frequent occurrence. This put the person at considerable risk of infection. We raised this with the manager at the end of the first day or our inspection. On the second day of our inspection we found that the person's nails were clean.

We saw that one person had been assisted to the bathroom from a lounge but their purse had been left behind on the table. Another person had gone to a health appointment. Their bedroom door had been left open with their television on. This did not ensure the security of people's belongings.

Where possible people were involved in the monthly reviews of their care. A relative told us that they had been waiting to speak with the manager to go through their family member's care plans, but had been waiting some time. Care records showed that staff spoke with people as part of their monthly care plan reviews to determine whether they were satisfied in how their care was being provided and to discuss and agree any changes necessary. The cook also took the time to speak with people and determine whether they enjoyed the food and what changes they might like as part of the person's monthly care plan review.

One person told us that the manager visited them frequently and asked for their views about the way their care was provided. They told us how staff encouraged them to be as independent as possible without leaving them to struggle. Another person said, "I try to be independent as much as possible. It's important to me."

Requires Improvement

Is the service responsive?

Our findings

People's care records contained person centred information about the person's preferences. For example, what they liked to eat and their night-time preferences. However, the information about people's assessed needs relating to health conditions they were living with and how staff could support them appropriately was insufficient. The care plans of four people stated that they were registered blind. However, there were no care plans to detail the extent of people's visual impairment and what actions staff needed to take to help support them and ensure their safety and welfare in this regard.

One person's records stated that they had 'spates of poor diet and weight loss'. However,there was no information for staff about how they should support the person during these periods other than the person 'may require promoting with their meals'. Care plans for people's dietary needs were not always in place, those that were in place contained little detail. There were no care plans to show how people living with diabetes wished to be supported.

One person had developed a serious condition which was causing them significant discomfort and meant that they needed to elevate their legs as much as possible. There was no care plan in place to guide staff how they needed to change the way they supported this person and how to help promote their skin integrity. Several people had been identified as at risk of pressure areas. There were no plans in place to guide staff about the action that should be taken to reduce these risks. These issues put people at risk of receiving inappropriate care.

The outcomes from the visits or appointments with health professionals were not used to update people's care records when necessary. For example, a community jnurse told us that one person needed to elevate their legs. However, the person's care plan had not been updated accordingly. Another person's records showed that as a result of a visit from a physiotherapist they had been discharged from their care with a walking frame. This too, had not been updated in the person's records which indicated that they mobilised unaided.One relative told us that they had gone to visit their relative to find that they were freezing cold because their radiator was not working and this had not been identified by staff. A portable electric heater had then been supplied.

The amount of social engagement provided by the service was limited to the two or three mornings a week when an activities staff member was on duty. One person told us, "I like to spend time alone, but I played bingo this morning." One person said, "Staff can take me out if I pay their wages." Another person told us, "We have bingo and quizzes, but I'm often bored. There's the odd trip out, but not many." We observed the activities staff member supporting individuals as well as small groups at different times. However, given the limited time they had available there was little time to support people to any meaningful extent with their individual hobbies or interests.

The concerns constituted a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service advertised its complaints procedure in a leaflet in the lobby. This required substantial updating. This did not name the registered manager and referred to the manager being 'she' when the registered manager was male. It referred people to the Care Quality Commission although we do not investigate individual complaints. It did not refer people to other bodies that do, such as the local authority or the Local Government Ombudsman.

The service had received two written complaints, one of which had been dealt with appropriately. The other, which had been made on one of the service's complaints forms, had no record of any investigation or outcome. Both relatives we spoke with told us that they had raised concerns verbally with the manager in recent weeks, but they had not received any subsequent contact from them. One relative told us about a separate recent incident when they had raised a concern with a staff member about their family member's care. The staff member suggested that another carer was to blame. The deputy manager had heard the conversation, but they had not stepped in to resolve the situation.

One person living in the home told us, "I can't talk to the manager. I asked to make a complaint, but they never came back to me."

The concerns constituted a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The majority of people who lived at the home had lived there for some time. We observed that staff responded to people's requests for support on an individual basis and it was evident people were comfortable and relaxed in the company of staff.

Inadequate

Is the service well-led?

Our findings

Our last inspection in December 2015 had identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because of repeated breaches in relation to the management of people's medicines, ineffective audits and poor oversight of staff training.

At this inspection we found that improvements had been made in relation to the management of people's medicines. However, little progress had been made elsewhere despite the service having been put into special measures. We had met with the provider and the manager in September 2015 and January 2016 to discuss our concerns following previous inspections.

The manager had told us in December 2015 that they had not held any residents meetings to give people a chance to ask questions and provide feedback. During this inspection they told us that these meetings had not yet been implemented, but they intended to do so shortly. People's views had been sought via questionnaires. Thirteen questionnaires had been completed by people since the start of the year which identified areas where the service could improve. For example, some people had commented that meal portion sizes were either too large or too small. Other people had said that their food wasn't always hot enough. However, the questionnaires had not been analysed or any findings acted upon. Consequently, we were not confident that if people's views were obtained that they would be utilised to the improve the service that people received.

There was no system to audit the effectiveness of care plans. The manager was unable to tell us what determined the content and level of detail they would expect to see in a care plan or their expectations about how risks to people's welfare were identified or mitigated. The manager told us they were working on implementing a computerised care records system that would be rolled out across the provider's three homes. They felt that this would 'fill in the gaps' in their care records and advise them what needed to be done.

As well as managing this home and making the necessary improvements since our December 2015 inspection the manager was leading on implementation of the computerised care records system across the provider's three homes. They were also supporting the managers of the provider's other two homes in the area. These managers were new to home management and had been promoted internally as manager positions had become vacant.

Some audits were ineffective and had not been carried out with a high degree of scrutiny. An infection/environmental audit carried out in April 2016 asked whether a legionella assessment had been completed and the response had been that a document was displayed in the foyer. This legionella testing had last been carried out three years ago and was now overdue. The audit also asked whether staff had received training, the answer had been 'yes'. However, the training had expired. The same audit sampled the cleanliness in one bedroom. The manager said that they intended to sample one bedroom each month. However, they had not calculated that at this rate that people's rooms, based on the current occupancy level, would only be checked once every 19 months.

A monthly environmental health and safety audit was scant in detail. It did not consider the management of risks to people and staff relating to legionella, window safety, electrical, gas or lifting equipment servicing or risks associated with the outside areas to which people had access.

At this inspection the manager had been able to provide us with an overview of staff training. Staff training was considerably out of date. We had found the same issue at another of the provider's homes we had inspected a few weeks before this inspection. It was only since the inspection of the other home that actions had commenced to get staff training organised across the provider's three homes. This training issue had been known about, but had not been actioned for some time. Failure to ensure staff training was up to date could put the welfare of people living in the home at risk of receiving inappropriate or unsafe care.

Part of the Waterlow pressure area risk assessment assessment requires that a person's body mass index (BMI) is calculated. In order to calculate a person's BMI their height is usually required. The manager was not aware of this. We found that people's heights were not recorded. The manager told us that the calculation of people's BMI was an approximation. This meant that the assessments that were in place may not have been accurate.

The manager told us that the provider did not carry out any audits to assure themselves of the standard of care that people received in the home. The manager said they had not received any formal supervision from the provider, but said they were in regular contact and that they felt well supported by them.

The provider did not understand the importance of ensuring that risks to people's welfare were identified and reviewed and had no systems in place to do so. They had not identified the poor practices in place in the service.

The provider had not determined whether there were systemic failures in the way that their services operated and were managed. They were insufficiently involved in the day to day management of the organisation to ensure that suitable and effective systems were in place to meet people's needs and drive necessary improvements forward.

The manager told us that both they, and the provider, had considerable experience in care. However, we were concerned that our findings from this inspection were not commensurate with knowledgeable and effective leadership.

The provider was still in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The grounds needed some attention. The front of the premises was laid to paving slabs but weeds were quite tall. The rear areas, which were private, also required some care. The maintenance staff member we spoke with was aware of this but said that they didn't have the time to do much in the gardens as more pressing jobs were required to be carried out inside the home.

Staff held mixed views about the management of the home. Some felt the service managers were supportive and would assist with day to day tasks as necessary. One staff member told us that they had made suggestions in the past that had been taken up and implemented. Others felt the managers were not interested when they raised queries and that there was a divide between them. One staff member felt that meetings were management led and there was little opportunity for staff to make suggestions or give their views. The minutes we viewed from the last meeting showed little staff involvement.

Most people living in the home felt the home was well managed. One person told us, "Like everyone here, they're working hard and doing what they can." However, the relatives we spoke with felt that there was room for improvement.