Noblefield Limited

St Clements Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 19 July 2016 and was unannounced . At the last inspection on 28 May and 3 June 2015, we asked the provider to take action to make improvements in how they managed risks to people, how people were supported to be independent and systems to ensure the quality of care people received was monitored and improved upon. We found that the provider had failed to take effective action to address most of our concerns.

St Clements is a residential home which provides nursing care to older people most of whom are living with dementia. The service is registered with the Commission to provide accommodation and personal care with nursing for up to 37 people and at the time of our inspection there were 29 people using the service. There was a registered manager at this location. 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 and associated Regulations about how the service is run.

The registered manager had improved how they responded when they receive information of concern about a person's safety and the provider had made adjustments to the environment to make it safer for the people who used the service. However they had failed to take effective action to ensure there were enough staff to so people were supported to live independent lives and had not developed robust systems to monitor the quality of care people received. We found additional concerns with how people were protected against the specific risk presented by their conditions and medication. People continued to experience a lack of person centred care and meaningful interaction with staff and activities. You can see what action we told the provider to take at the back of the full version of the report.

Although the registered manager had reviewed the complaints process some people still did not receive a prompt or full response to their concerns.

The provider had taken action to improve the standard and safety of the environment. However some maintenance work was ineffective and was not always conducted in consideration of the needs of the people who used the service.

How staff protected people from risks did not always reflect recent advice from other health care providers. People were not always supported in line with their care plans.

Medication was not managed safely. Some medication was not stored at the correct temperature to maintain its effectiveness and there was a risk that some people's medication would run out before additional stocks were available.

Meal times continued to be a task orientated activity and did not promote people's independence or enjoyment. People receive sufficient nutrition to meet their needs although the provider had taken no

action to promote people's independence. Snacks and drinks were not freely available outside of set times.

People who used the service had mixed views about how good it was but relatives spoke positively about the care people received. People were able to comment on the care they received and were supported in line with the Mental Capacity Act 2005.

Activities continued to be group orientated and did not reflect the interests and abilities of people who used the service. Activities did not promote people's independence or consider how they might help with the management and improvement of some people's specific conditions.

Systems to monitor the quality of the service had failed to identify that effective action had not been taken to address known concerns about the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

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

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

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.

The registered manager hand not always taken effective action to improve the safety of the people who used the service.

People were at risk of receiving unsafe or inappropriate care because staff did not have time to give people the care they needed or to respond to emergencies.

People's medicines were not managed safely

Is the service effective?

Requires Improvement

The service was not effective.

Although staff had received training in the skills they required to meet people's care needs they did not always follow the advice of other health care professionals.

Meals times were not a pleasant and sociable experience as people had to wait for support. Not all people were involved in choosing what they liked to eat.

People were supported in line with the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always demonstrate compassion or treat people with dignity.

Staff did not spend time with people or promote their independence.

Although it was not the norm, there were several expressions of affection between the staff and people they supported.

Is the service responsive?

Requires Improvement

The service was not responsive.

The care and support provided to meet people's health care needs still did not consider their individual needs and preferences.

Complaints were not handled in line with the provider's policy. People did not always get a full response to their concerns.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to take effective action to improve the service.

The providers own systems for monitoring the quality of the service were still not effective to ensure people were being supported safely and appropriately.

People were happy with how the service was run.

St Clements Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We conducted a comprehensive unannounced inspection of this service on 19 July 2016. The inspection team consisted of one inspector and a specialist advisor who had clinical knowledge of the needs of the people who used this type of service. We were also accompanied by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we checked if the provider had sent us any notifications. 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 reviewed the information the provider had sent us after our last inspection about the action they would take to become complaint with the regulations. We used this information to plan what areas we were going to focus on during our inspection.

During our inspection we spoke with eight people who used the service. We spoke with three relatives and friends who were visiting people who lived at the home. We also spoke to the registered manager, two nurses, five members of care staff, an activities co-ordinator, the head cook, domestic supervisor and a domestic assistant. We looked at records including 11 people's care records and seven people's medication records. We looked at three staff recruitment records and staff training records. We looked at the provider's records for monitoring the quality of the service and how they responded to issues raised. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke to a pharmacist and quality monitoring officer from the local clinical commissioning group who had reviewed the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the provider had not taken effective action when they received information that people were being or at risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our latest inspection we found that the provider had addressed these concerns however we found the provider had not taken robust action to protect people from the risk of harm presented by their specific conditions or ensured the safe and effective management of medication.

The registered manager had not always taken effective action to improve the safety of the people who used the service. Although the provider had conducted assessments to identify if people were at risk of harm, staff we spoke with were not always knowledgeable about how they would manage these risks. During our inspection we received contradictory information from the registered manager and staff about how they reduced the risks associated with people's specific conditions. We observed that one person who was at risk of hurting themselves and others was not being supported in line with their care plan. Part of the person's risk assessment stated that staff were, "To support the person." The registered manager was unable to clarify what this meant.

Although care plans had been updated as people's conditions changed they did not always reflect guidance and advice received from health professionals who were involved in supporting people who used the service. One person's records contained detailed information from a specialist nurse about how to reduce the risk of them developing skin sores. This information had not been included in the person's skin integrity care plan and nursing staff we spoke with were unaware of this advice. People were at risk of receiving unsafe, unnecessary or inappropriate care.

Systems for ensuring people's medication would be available when needed were not robust. One person told us, "I am in pain and they don't give me pain killers." The registered manager could not confirm that new medication would be available when a person's existing supplies ran out. It was important to the person's wellbeing that this medication did not suddenly stop yet the registered manager had not sought further advice or guidance when the person's GP chose not to prescribe additional stocks or implement a programme to wean the person off this medication. Another person told us they had not received an injection they were due and the registered manager was unable to tell us when this would be administered.

Systems to ensure medicines were stored at the correct temperatures were not robust. Records showed that medication which required to be kept cold had not been stored at the correct temperature for several days before our visit. Staff had not taken effective action to address this issue or inform the registered manager. Other medication, including controlled drugs were stored appropriately. Failure to store medicines correctly could affect their effectiveness.

Medication records were not always completed. Staff did not always sign to indicate that people had received their medication however a count of two people's medication indicated that they had received their medication as prescribed. Records did not always provide enough information to support staff to

administer medication as required. Incomplete medication records and guidance did not enable staff to check if people's medication had been managed properly.

Staff we spoke with were confident that they supported people to take their medication appropriately however incomplete records did not enable us to verify this. A nurse who was employed by the service told us they received medication administration training and an agency nurse who was working at the service told us they had received a good introduction to each person's medication needs when they began working at the service. We observed nursing staff supported people appropriately when administering and prompting people to take their medication.

This failure to provide safe care and safely manage medication administration was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us that there were not always enough staff to support them when required. Comments included; "They are always short staffed," and "In the evening between six pm and seven pm it is very short staffed. You could go for hours without seeing a member of staff;" and, "I tell them that I need some help and then they don't come back. They say they forget." Staff we spoke with also raised concerns with staffing levels at the service. One member of staff said, "I feel stretched. There is not enough staff, especially in the morning and at mealtimes." Another member of staff said, "I don't think that residents are at risk but we need more staff."

People told us that staff did not always respond promptly to call bells or request for support with personal care. We observed one person in a lounge repeatedly shout out for staff to support them to use the toilet. At one point a member of staff told them they would have to wait until another member of staff could assist them and advised the person to, "Hold it." Later they told the person they were still unable to assist them because they were going to help feed another person. The person had to wait for 20 minutes before they were taken to the toilet and had become very distressed. The registered manager told us that it was policy that a member of staff should always be available in each lounge to promptly assist with personal care. Staff had not been deployed as required to meet people's care needs.

There were not enough staff to help people to have enough to eat and drink. One person told us, "I asked for more milk this morning as the Weetabix was dry. No one came back with the milk." Another person told us, "I am often hungry." Another person said, "They bring drinks and leave it on the table and I can't reach it. I have to wait for them to come and offer it to me." At lunch time we observed people waiting to be supported to eat and spillages were not cleaned up promptly. Staff were unable to spend time with people and prompt them to eat and we noted a lot of food was wasted.

The registered manager told us that they recognised staff were very busy but did not have a system to assess if staffing levels were sufficient to meet the needs of the people using the service. They told us they did not intend to admit any additional people to the service unless staffing levels were increased but did not have a process to identify how staffing levels might need to change when additional people started to use the service. Systems in place did not ensure there would be enough staff available to meet people's care needs.

Staff did not have time to give people the care they needed or to respond to emergencies. The lack of available staff and the impact this had on the provision of person centred care was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home and relatives we spoke with said staff were responsive and acted appropriately when they thought someone might be at risk of harm. A person who used the service

said, "I feel safe here. There's no trouble." A person's relative told us, They act on the littlest thing, and always call us if they are concerned." A member of staff said, "I have not witnessed any abuse and would not tolerate it. I would report it."

Staff we spoke with could recognise the signs of abuse and could explain the process they would take. The registered manager had improved the system for reporting information of concern and a review of incident records showed that they had notified the appropriate authorities when they were concerned about a person's safety. Staff told us they were encouraged to raise concerns about people's safety and said they felt their concerns would be taken seriously by the registered manager.

The registered manager had taken action after our last inspection to ensure the premises were managed appropriately to keep people safe. The registered manager told us the provider had improved their response to maintenance concerns. During our visit we saw several tradesmen working on site but maintenance work was not always effective. People told us the lift was often breaking down. During our inspection the registered manager had to take action when a visitor became stuck in the lift after it had been repaired earlier in the day. People told us that the lift frequently broke down and we noted that there was no clear and coordinated response by staff to this incident. Staff did not take action to reassure the person trapped in the left until prompted by the inspection team and one member of staff found the incident amusing. This lack of effective maintenance and emergency response presented a risk to the wellbeing of people who may use the lift without the support of staff.

We reviewed the recruitment records of three people who had recently started working at the service. They showed that the provider had conducted the appropriate checks to ensure people were supported by staff who were suitable to support the people who used the service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we reported that people were at risk of not receiving adequate support to receive sufficient nutrition to keep them well. Staff were unsure how to support people who required their food fortified or thickened. We found this had not improved.

We spoke with one member of staff told us they could not thicken a person's drink as directed by a nutritionist because, "If it was that thick, it wouldn't come out of the beaker." There was no evidence that staff had attempted to identify an alternative way of supporting the person to receive their drinks as required. Although records showed that staff had received training from a nutritionist about how to fortify people's foods, the practice of staff placed people at risk of choking or not receiving adequate nutrition to maintain their health.

At our last inspection we found that meal times were not a pleasant and positive experience. We continued to see that the quality of meal times had not improved and did not support people's independence and preferences. People told us they were not always offered a choice of meals although we saw there was a choice available to some people during our visit. Several people said the day was too warm to enjoy a hot meal at lunch time, but the menu had not been revised to address this. One person said, "I would have liked a salad." A member of staff said they had offered a salad to a person who they knew liked salad but had not asked other people. The dining room was noisy, plainly decorated and lacked homely furnishings. A television was on and staff were undertaking maintenance tasks including testing the fire alarms. This resulted in staff having to raise their voices to be heard and no one had consider the impact this would have on how people would enjoy their lunch. There were no menus or condiments available to help promote people's independence.

People were at risk of not receiving sufficient to eat and drink when they wanted. One person told us, "They bring drinks and leave it on the table and I can't reach it. I have to wait for them to come and offer it to me." The registered manager had not responded to concerns at our last inspection that fresh fruit, snacks or drinks were not generally available outside of designated meal times to ensure people would not become hungry or thirsty. At our latest inspection we saw that snacks and drinks were still not freely available around the home however during our visit staff had offered people cold drinks and ice cream to keep them hydrated and cool. Staff told us that this was not normal practice but was just undertaken as it was a hot day.

Records contained details how staff were to support people who were at risk of malnutrition however we noted that some people's weight had not been monitored in line with their care plan. This would prevent the early identification that a person was beginning to lose or gain weight. When necessary the registered manager had involved other health professionals such as dieticians to provide additional guidance and support to help people consume a diet which met their specific needs.

People who used the service gave us mixed views about how well it met their needs. Comments included: "I am not happy here. I feel very dehydrated and the nurse won't do anything;" "I just sit here and watch television; there is nothing else to do;" "They look after me OK. I don't have to wait." All the relatives we

spoke with made positive comments about the service. One relative said, "Dad has put on weight here, he eats well." However, two people we spoke to expressed concern that staff did not always know or adhere to their cultural and religious requirements to diet.

The service had failed to consistently ensure that people received sufficient food and drinks to keep them well and meet their preferences. This is breach of Regulation 14 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff received an induction when they first joined the service and regular training in the skills they needed to meet people's care needs. Staff we spoke with confirmed they had regular training and we saw evidence of future training events displayed around the home. One member of staff told us, "I understand residents' needs and their care plans." However we observed that staff did not always support people in line with their care plans. One person told us, "They tell me to roll over and they know I can't." Several members of staff we spoke to were unaware of people's latest support plans. Staff did not always follow directions when they had received expert advice from health care specialists. The registered manager had not ensured that information was effectively exchanged between all the services that supported people's care needs.

Staff told us that the registered manager was approachable for additional advice and guidance when necessary. We observed a handover between shifts which updated new staff coming on duty of people's latest care needs and how they were required to be supported.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. The registered manager had taken action to address concerns from our last inspection and had made appropriate referrals to the local authority when there was a risk that people were supported in a way which could restrict their freedom. The registered manager had a system in place to ensure approvals to restrict people's freedom were reviewed.

Most of the people we spoke with said that staff would seek their consent to provide care. We observed that staff asked people how they wanted to be supported. When a person was thought to lack mental capacity the registered manager had approached family members to support the person to express how they wanted their care provided. Staff we spoke with understood the principles of the MCA and one member of staff told us, "I would always work in the person's best interest." People's rights to receive care in line with their wishes and best interest were respected.

People told us they were supported to access additional health care services when they needed them. Care records sampled showed that staff accompanied people when necessary to attend health care appointments at other locations.

There were regular GP visits to the service to ensure people would be supported appropriately when their care needs changed.

Inadequate

Is the service caring?

Our findings

At our last inspection the provider was in breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 because they did not always support people's independence. We found this had not improved. People were not treated with dignity and respect. We found that the provider had not taken effective action to address this. We found additional concerns with the mismanagement of confidential information and on occasion observed staff leaving people in undignified situations. This meant that the provider was still in breach of this regulation.

Staff did not always demonstrate compassion or treat people with dignity. We had noted that failure of staff to respond to requests from a person to be supported to use the bathroom, led to the person shouting out for assistance and describing what would happen if they were not supported. The person shouted out for assistance for a considerable period of time before staff attended to them. Another member of staff who told us that there was going to be a party to celebrate a person's birthday wasn't aware that they had celebrated the previous day and could not confirm when the person's birthday was. Staff did not act promptly to support people to change their clothing when they had spilt food on themselves. We saw one person was left for a long period after lunch wearing a soiled and dirty apron. We observed one member of staff express amusement when a person visiting the service became trapped in a lift. Staff did not demonstrate that they were constantly considering the welfare of the people who used the service or their visitors. There were several occasions when the fire alarms were tested during our visit as part of maintenance checks and no one informed people living at the home that this would be happening. Staff did not take prompt action to reassure people about their safety or open people's bedroom doors which had shut automatically when the fire alarms were tested. Members of staff showed no consideration for how the maintenance work impacted on people's lunch time experience in the dining room. This work was noisy and startled several people who were trying to enjoy their lunch.

Some staff were wearing worn and soiled clothing that was not suited to the specific expectations of their role to prevent the spread of infection and maintain good food hygiene standards. This did not convey to the people who used the service that staff adequately protected them from risks arising from failing to adhere to good hygiene practice, or that they were important or valued sufficiently for staff to take an interest in how they appeared to people.

Staff did not demonstrate an understanding of the impact their routines had on the people who use the service. A seating area in the garden for use by people who used the service was also used by staff to take their breaks and to smoke. This could prevent people from accessing this area which had been created to help people enjoy and take part in gardening activities.

Staff did not respect people's right to confidentiality. We observed staff regularly calling out to each other about people's specific care needs which other people and visitors could hear. We observed people's care records were left unsecured in the lounges and details about peoples specific care needs were also on public display. A handover between staff was conducted in front of people who used the service and some relatives. They could hear the discussion about other people's specific conditions and care needs. An

agency nurse who was working at the service for the first time raised concerns about this practice with other members of staff who replied that this was normal practice. Whilst the registered manager told us this was not normal practice, the placement of the notice board and physical space for handovers of information about people indicated that this was usual practice.

Whilst people told us that staff generally respected their privacy we saw that some aspects of privacy were compromised. One person told us, "They wash me properly and treat me with respect when they do so." Another person said, "I am treated with respect when they administer personal care." We observed staff closing people's bedroom doors when providing personal care and staff we spoke with said it was important to support people's dignity and privacy. However we observed that some practices at the service did not always reflect good practice. It was usual to leave bedroom doors open so staff could monitor people being cared for in bed. People were not consulted on this practice and records did not indicate if this was their preferred choice. This resulted in visitors to the service being able to see some people lying in bed in their nightwear.

Systems to support people to express their views about the care they received were not effective. Although people were approached for their views not everyone felt listened to. One person told us, "The staff do come and speak to me but they don't ask my opinion." A relative told us, "There is a lack of communication especially handover information. They don't always tell you of the change in [Person's name] health." The registered manager held meetings for residents and relatives so they could express their opinions about the service but there were no communication aids to assist staff to communicate with people with complex needs. We saw they were no menus available or orientation boards to help people comprehend their surroundings or express their views. We observed that staff did not always act promptly when people raised concerns or requested support.

Most people who used the service and relatives told us they had developed positive relationships with most staff. One person said, "Some, not all, treat me with respect." "Some staff are okay and some nurses are no good." Relatives we spoke with were positive about the care people received. One person's relative told us, "Staff are very good, they are pleasant and very good at what they do." The relative of a person who had recently started to use the service told us, "The have settled in well. The staff have been very good." Staff spoke affectionately about the people they supported although some staff could not tell us about people's past histories and preferences. Relatives told us they could visit any time and were made to feel welcome. The activities co-ordinator had arranged for people to access a computer so they could communicate electronically with people who were important to them. However this was located in a public area so people were unable to have private discussions with people who were important to them. There were no suitable alternative arrangements so people who lived in their rooms could also enjoy this activity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we were concerned that activities did not reflect the interests, abilities or promote the independence of the people who used the service. At our latest visit we saw the support people received did not always reflect their preferences and care needs. People were not always at the centre of the care they received because staff sometimes focused on tasks rather than on the needs of people as individuals. We identified that this area needed improvement.

People told us that staff did not always respond promptly to their care needs. One person told us, "When I press the call bell they take a long time." Another person said, "I used to enjoy reading the paper but they no longer bring it in for me." A further person said, "I have never had to complain."

Staff did not always respond promptly when people required support. We noted that one person sat for an hour after finishing their lunch before staff removed their protective plastic apron and we did not see any members of staff support people in their bedrooms to engage in their personal interests and prevent them from becoming bored. It was a sunny day when we visited and the activities coordinator had supported some people to spend the morning in the garden. People were clearly enjoying this activity however they were not given the option of having lunch in the garden and had to return inside to have their meal. After lunch we observed that people were then left in the lounge and noted that staff did not ask people if they wanted to go back into the garden or engage in any specific activities. One member of care staff told us it was not their responsibility to support people to take part in activities. They told us, "The activities co-ordinator takes care of that sort of thing."

One person who was being supported in bed told us they wanted to sit out of bed but appropriate facilities were not available. One person told us, "I would like to get out of bed now and then but there is no relaxing chair in my room." A member of staff told us that another person had to be supported in bed because, "They slip out of their specialist chair so for safety is nursed in bed." Being supported in bed did not necessarily reflect the choice and wishes of some people who used the service and no request had been made for the person to be assessed for any specialist seating that would meet their needs.

Although the provider had taken some action to improve the choice and frequency of activities we found that further improvement was still required. There were links with local places of worship which helped some people pursue their chosen faiths. The registered manager told us the provider had refurbished the garden area and people had been supported to grow tomatoes. They told us that additional activities had been offered but were unable to clarify for us what these were. The provider's newsletter for the service stated that they intended to hold a barbecue during the summer but this had not been arranged at the time of the inspection. There were no plans to ensure that people who remained in their bedrooms would be included in events or activities.

Although the registered manager conducted assessments of people's care needs and preferences when they started using the service, these were not well known by staff. Records were not always updated as people's care needs changed or reflected the latest advice and guidance from health professionals. Although

people's care plans identified the gender of staff they wished to be supported by, staff we spoke with said there was not always the necessary staff on duty to accommodate these preferences.

There was an activities co coordinator at the service who was responsible for assisting people to engage in interests they enjoyed and to provide a stimulating and interesting environment. They told us they had helped some people to pursue their interests in knitting and sewing but did not have enough time to support people as much as they wanted. There was no other evidence that people received support with any other individual activity interest. We saw they had supported some people to sit outside and they told us that they had arranged for people to take part in, "Colouring in," during the afternoon. They told us care staff would take colouring sheets and pens around to people who wanted to engage in this activity. We noted that one person was sat at a table with pens but did not take part and no one else was encouraged to take part in this activity. Activities were not meaningful to people, and did not reflect the skills and abilities of all the people who used the service.

The failure to ensure that people received person centre care which reflected people's individual needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that people were supported to comment on the care they received at formal meetings and reviews. When people's rooms were decorated, they had been involved in choosing the colour schemes. People's care records were updated with new information as people's care needs and preferences changed but staff did not always have regard to the latest instructions and guidance.

The provider had a complaints process and we saw this displayed around the home. Relatives we spoke with were generally complimentary about the service and none felt they would have the need to formally complain. People told us they felt that any concerns would be handled appropriately.

However concerns from our last inspection about the complaints process had not been fully addressed. Complaints were not handled consistently or in line with the provider's policy. Complainants did still not always receive a prompt acknowledgment to their concerns. We saw that the registered manager took three weeks to acknowledge one complaint in April 2016 which was not in line with the two days required by the provider's complaints policy. They had also failed to send the complainant a final response even though they told us that action had been taken to address the concerns. After our last inspection the registered manager had introduced a check list to ensure complaints were handled appropriately but these were not always fully completed or indicated the action required to resolve issues or to reduce the risk of them happening again. One checklist was not dated so it was not possible to assess if the registered manager had taken timely action to address the person's complaint. The registered manager had not taken effective action to ensure a robust effective complaints process was in place.

Failure to operate an effective system to manage and respond to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

At our last inspection we identified a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes were not followed effectively to ensure proper assessment and monitoring of the quality and safety of the service people received. We found there continued to be a breach of this regulation.

We continued to identify concerns about the service and found progress had not been made in driving forward improvements to ensure that people were supported in a person-centred way that promoted their safety and ensured that they received good care and treatment. The registered provider and registered manager did not always maintain oversight of the service and did not always effectively resolve issues to keep people safe or ensure that their needs were met.

The registered manager had not taken effective action to ensure concerns were resolved in a timely manner. We found that requirements and improvements identified at the previous inspection to keep people safe, improve the meal time experience and to manage complaints had not been comprehensively addressed. The registered manager told us they had started to address these issues and felt their greatest improvement had been a refurbishment of some areas around the home. Some issues related to failures to address identified risks to people had not been prioritised and were still outstanding or only partially addressed.

Effective action had not been taken with regard to concerns that people did not receive prompt and appropriate support. People still had to endure delays before staff responded to requests for support and staff were not always present in communal areas to oversee people's safety and welfare.

People's care needs and wishes were not consistently known by staff or recorded in their care plans. The registered manager had introduced several systems to monitor the quality of the service including reviewing people's care records and increased staff supervisions. The reviews of people's care plans were not effective as they had failed to identify that people were not always supported in line with their current care needs or that records were not always fully completed. There was no system in place so the provider and registered manager could monitor and review if improvements to the service had occurred as planned or had been effective. This did not allow the provider to monitor if the quality of the service was improving. The registered manager conducted environmental audits to ensure the premises were clean and well maintained however frequent equipment breakdowns showed these had not been effective.

People we spoke with had mixed views about the leadership at the service. Most people were happy to be supported by the service but several people raised concerns about communication and that staff were not always managed appropriately. Comments included, "[Person] is less stressed here, it is a good home." "Some staff change shifts without informing management." Comments from staff included; "Some staff are not properly disciplined, there is room for improvement on the management front." "Things are addressed at staff meetings. We have supervisory meetings but not often." People said the registered manager was pleasant and approachable.

Systems in place failed to assess, monitor and manage risks to people using the service. The registered manager had not taken appropriate action to ensure staff provided care in line with people's care plans. Staff did not follow instructions from health professionals or guidance about how people were to be protected from the specific risks associated with their conditions. There was conflicting information between staff about how people were to be supported and on several occasions during our visit the registered manager was unable to confirm how people were to be supported. Medication continued to be managed inappropriately. People did not always receive their medicines as prescribed and medicine procedures were not always followed to ensure people's safety. This put people at continued risk of receiving unsafe or inappropriate care.

Systems used by the registered provider and registered manager had failed to identify and address the risk of people not having their nutritional needs met. Staff did not always provide care in line with people's nutritional plans and mealtimes were still operated as functional tasks instead of positive events which people could look forward to and enjoy.

The registered manager had taken action to improve how people were safeguarded from the risk of abuse and risks presented by the environment. Action to improve the environment had not always been effective as the lift frequently broke down trapping a person inside on at least one occasion. The registered manager had failed to identify that maintenance work was not always carried out sensitively or in consideration of the needs of the people who used the service.

The registered manager had not taken effective action to respond to our concerns about complaints handling at our last inspection. The provider had failed to recognise that the registered manager had not responded to complaints in line with their own policy.

The provider had failed to take sufficient action to ensure the care people received was based upon their individual needs and preferences. They had not established a culture which respected people's individuality and promoted their independence. Although staff spoke respectfully about the people they supported the registered manager had not developed systems or practices which respected people's confidentiality and dignity.

Staff told us there was a clear staffing structure and they could always seek guidance from the registered manager or senior staff when required. However staff continued not to be effectively deployed. A review of incidents at the service showed that the registered manager had notified us appropriately of events they were legally required to do so.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Providers must do everything reasonably practical to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users must be treated with dignity and respect. Regulation 10(1) A registered person should take all reasonable effort to make sure that discussions about care, treatment and support only take place where they cannot be overheard. Regulation 10(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Providers must do all that is reasonable practical to mitigate risk. Regulation 12(2)(b) Providers must do all that is practical to ensure the safe and proper management of medicine. Regulation 12(2)(g)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service had failed to consistently ensure that people received sufficient food and drinks to meet their needs and preferences. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons to the carrying on of the regulated activity. Regulation 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not followed effectively to assess, monitor and improve the quality and safety of the service provided. Regulation 17(2)(a) The provider must seek and act on feedback from other relevant persons on the service. Regulation 17 (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Regulation 18(1)