Longridge Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 11 October 2017. At our previous inspection we had found that the provider was in breach of six Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service as inadequate, served two warning notices and placed the service into special measures. At this inspection we found that minimal improvements had been made in some areas. However we found further concerns and breaches of Regulations as the service was not safe, effective, caring, responsive or well led. The overall rating for this service remains Inadequate which means it will remain 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.

Longridge Care Home is registered to provide accommodation and personal care for up to 32 people. At the time of the inspection 19 people were using the service.

There was a registered manager 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.

Risks of harm to people were not being assessed, managed or reduced to prevent further incidents which had resulted in harm.

People were not being safeguarded from the risk of abuse because the registered manager and staff did not recognise and report potential abuse.

Staff were not always safely deployed throughout the building to ensure adequate supervision and support

of people was available.

People's medication was stored and administered safely, however prompt action was not taken when people refused to take their medicines.

People were not always consenting to their care and support at the service. The principles of the Mental Capacity Act 2005 (MCA 2005) were not being consistently followed to ensure that people's mental capacity was assessed and support was gained to make decisions in their best interests if they lacked capacity.

Health care advice was not always sought in a timely manner when people showed signs of becoming unwell.

Staff were not always effective in their roles as they were not receiving support and guidance they required to improve the quality of care for people.

People were not always treated with dignity and respect and their right to privacy was not encouraged and upheld.

People were not always supported to be independent as they were able to be due to routines and restrictions.

People were not all receiving care that met their assessed needs and individual preferences due to a lack of effective reviews and assessment of needs.

There was a complaints procedure, however when people raised concerns these were not acted upon. People's views were not being taken into account to ensure their experiences at the service improved.

The systems the provider had in place to monitor and improve the quality of the service remained ineffective and prompt action was not being taken to address the concerns highlighted by other agencies.

There was a culture of institutionalised care that the registered manager had failed to recognise and respond to.

Hobbies and activities were available to people who chose to join in.

People were supported to eat and drink sufficient amounts to remain healthy.

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 consistently safe.

Risks of harm to people were not assessed, managed and action was not being taken to reduce the risks.

People were not being safeguarded from the risk of abuse as potential abuse was not being recognised and responded to.

There were sufficient numbers of staff however they were not always deployed appropriately and effectively in their roles.

People's medicines were stored and administered safely, however action was not taken when people refused their medicines.

Is the service effective?

Inadequate

The service was not effective.

People were not always consenting to their care and support.

The principles of the MCA and DoLS were not being consistently followed.

Health care advice was not always sought in a timely manner.

Staff were not always effective in their roles as they were not receiving support and guidance.

People were supported to eat and drink sufficient amounts to remain healthy.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity and respect.

People's right to privacy was not encouraged and upheld.

People were not always supported to be independent.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always receiving care that met their assessed needs and individual preferences.

There was a complaints procedure, however when people raised concerns these were not acted upon.

Hobbies and activities were available to people who chose to join in.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place to monitor and improve the quality of the service remained ineffective.

Prompt action was not being taken to address the concerns highlighted by other agencies.

People's views were not being taken into account to ensure their experiences at the service improved.

There was a culture of institutionalised care that the registered manager had failed to recognise and respond to.

Longridge Care Home Limited

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 11 October 2017 and was unannounced. It was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held on the service including notifications the provider is required to send us by law. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm.

During the inspection we spoke with nine people who used the service and two visiting relatives. We spoke with two care staff, the deputy manager and registered manager.

We looked at five people's care records, one new staff recruitment file, staff rosters and the systems the manager had in place to monitor the quality of service. We did this to check the management systems were effective in ensuring a continuous improvement of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the service was not safe and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that care was still not being delivered in a way that was safe and minimised the risk of harm and the provider remained in breach of these regulations.

We had previously been notified by the deputy manager of an accident to one person who had been found on their bedroom floor by the night staff. The person had sustained injuries to their face which required hospital treatment. We looked at this person's care plan and risk assessments and found that no action had been taken to reduce the risk of this occurring again. Their night risk assessment still recorded that they were at low risk during the night. We found that no precautions had been put in place to alert the night staff to the person mobilising in their room and no control measures had been put in place to reduce the risk of them falling again. The registered manager informed us that they had increased the night staff checks. However, the checks we saw showed that no extra checks had been put in place since the fall and the registered manager was not able to offer us an explanation as to why the records showed this. This meant that this person remained at high risk of falling and sustaining an injury.

We saw that another person had been admitted into the service following a fall in which they suffered a fracture. At the point of their admission this person had been assessed as being at medium risk of falls, however no control measures had been put in place to reduce the risk of them falling. We looked at this person's accident records and saw that they had fallen five times since being at the service. Their risk assessment had not been updated to reflect the falls and the risk of falling remained at medium. No precautions had been put in place to minimise the risk of this person falling again apart from a member of staff informing us that they removed their walking frame from them when they were in the lounge to stop them from attempting to mobilise alone. This meant that appropriate action had not been taken to mitigate this person's risk of falling.

We observed that in the lounge area there were times when a person who used the service was given the portable call bell to alert staff if anyone in the lounge required assistance. This happened at times when the lounge was left unsupervised by staff. We had seen this at a previous inspection and because we had seen that the person who had been given the responsibility to call the bell had fallen asleep we had alerted the registered manager to inform them. This was not an appropriate or safe action to take to give people who used the service the responsibility of calling for assistance for other people.

At our previous inspection we had found that several members' of staff had not been trained in the safe moving and handling of people. We had observed unsafe practice which had put people at risk. At this inspection we saw two members of staff supporting one person unsafely, however the senior member of staff intervened and corrected them. The registered manager showed us that some staff had received training and refresher training since the last inspection. However, they did not know that the health and safety executive guidelines state 'Manual handling training may be more effective if refresher courses are offered to employees on a regular basis to update and refresh their learning. These should be offered on a

yearly basis, or as a result of changes in equipment or working practices'. This meant that some staff's training was out of date by two years. This meant that these staff had not been deemed competent to fulfil moving and handling tasks safely.

These issues constitute a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we had found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was still in breach of this regulation as people were not being safeguarded from the risk of abuse.

We saw one person had a risk assessment in place for making false accusations against staff. The risk assessment stated '[Person's name] often accuses staff of harming them or causing injuries. Staff should reassure [Person's name] at these times'. Records confirmed that this person had made accusations that staff had not delivered care appropriately. However, no action had been taken to investigate the person's concerns and they had not been assessed as lacking mental capacity to understand the consequences of what they were saying. The risk assessment in place was not sufficient to protect the person from what could be potential abuse as no investigation into the allegations were being made and they were not being referred to the local safeguarding authority.

Care records for one person stated that the district nurses had received a call to visit the service due to a left arm trauma wound. An accident report recorded that staff had found the trauma wound whilst supporting the person with the use of the hoist. No investigation into this injury had taken place and no safeguarding referral had been made to the local authority to ascertain how the injury had occurred. The registered manager and staff had not recognised that this may be potential abuse and had not taken action.

We observed that a staff member removed one person's walking frame from them when they were sitting in the lounge. The staff member told us: "We do that so they won't get up and try and walk because they may fall". This action restricted the person from being able to mobilise independently and had not been assessed as the least restrictive measure to take to maintain the person's safety.

These issues constitute a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed views on whether there were sufficient numbers of staff available to them. One person told us: "I buzz when I wake at 5.30am and they usually come within 10 minutes. The staff may come and say we will be back in a few minutes, if they are dealing with someone else and they do. They get quite a lot of us up early I think". Another person told us: "They could do with more staff really but they do their best for you. Not noticed any real improvements in last few months although perhaps there are a few more regular staff". The registered manager told us that they had staff vacancies however they were having difficulty in recruiting so they were filling the vacancies with agency staff. They told us that they tried to maintain a consistency in the agency staff that they used. We observed that people did not appear to have to wait to have their needs met, however the lounge areas continued to be left unsupervised for short times during the day. A relative told us: "I think there is normally enough staff around when we come to visit now. There has been a positive change since the last inspection in that there is usually a member of staff in the main lounge at all times. What happened before was that if a relative came and was in the lounge, the care staff often took it on themselves to go out, for a break I suppose, knowing someone was there to get help if needed. They have now been told they are supposed to stay". However, we saw that there were still times when staff left the lounge area and they had been instructed to leave the call bell for one person who used the service

to call if other people required help. This meant that staff were not always deployed safely throughout the service.

At our previous inspection we found that people's external creams were not being managed safely as care staff did not have the instructions they needed to be able to apply them as prescribed. At this inspection we found that improvements had been made in this area and there were records in each person's room informing staff where each person required which cream applying and when. We found that people's medications were stored and administered safely by suitably trained staff.

New staff were employed using safe recruitment procedures to ensure that they were of good character and fit to work with people. Pre-employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that staff were of good character and fit to work with people.

Inadequate

Is the service effective?

Our findings

At our previous inspection we had concerns that people were not always consenting to their care and support at the service. At this inspection we had further concerns and found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some people were not consenting to being at the service or with the care they were receiving. One person told us: "I am not really happy here and I am confused about why I am here as I can do most things for myself". The registered manager told us that this person had told them they did not wish to be at the service and that the person's social worker was aware. The person had resided at the service for six years, however they were not consenting to their care and support and no action had been taken to support the person to find a more suitable placement.

Another person told us: "The senior staff won't let me stop upstairs in the day because I might tumble and even when I'm not feeling too well I have to sit in the lounge". We looked at this person's care plans. We saw it was recorded that when they were admitted in 2014 it stated '[Person's name] likes to spend time in their bedroom'. However, in 2017 this person's care plan stated '[Person's name] likes spends time in the lounge'. A member of staff told us that the person had signed and agreed to their care plan to spend time in the lounge during the day, yet this was not the case as the care plan was not signed and the person told us they wanted to remain in their room. This meant that this person was not consenting to their care and support.

Another person told us that staff had made them go to their room as they had vomited in the lounge. They told us: "The senior carer made me go to my room and stay there because I was a bit sick. I didn't have a bug, they just put too much custard on my pudding, they told my relative I had a bug and I didn't". We saw this person's daily records recorded that they had been verbally abusive when staff visited them in their bedroom as they did not want to be there. The deputy manager informed us that this was done to prevent the spread of infection; however there was no reason to believe this was a contagious illness and this was against this person's wishes. This meant that this person was not consenting to this care and support.

The deputy manager told us that two people were being restricted from being in their room alone. They told us this was because they were at high risk of falls and they felt it was unsafe. Neither of these people had their mental capacity assessed and as such had not been deemed to lack the capacity to consent to this decision. It was unclear whether these people were consenting to this action and as such was an infringement of their human rights.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

The registered manager lacked an understanding of the Mental Capacity Act 2005. 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. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We had previously found that the principles of the MCA and DoLS were not being was not appropriately applied. For example, we could not see that people's mental capacity had been assessed prior to DoLS applications being made.

At this inspection we found that no improvements had been made and people's mental capacity was still not being assessed and decisions were being made on behalf of people. For example, one person's walking frame being removed from them and other people not being able to access their bedrooms when they wished to. The principles of the MCA were not being followed and the action being taken was not being agreed in their best interests or as the least restrictive option to keep people safe.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At our previous inspection we had found that health care support was gained when people's health care needs changed. At this inspection we had concerns in this area.

We looked at one person's medication records and saw that on three occasions and on two consecutive days, they had refused their prescribed medication. This medication included anti-anxiety medication and pain relief. Staff at the service had not contacted the person's GP or alerted them when they visited the service to the fact they had been refusing their medication. This meant that this person was at risk of becoming unwell as they were not taking their medicines as prescribed.

We saw that one person's community psychiatric nurse had advised in July 2017 that the staff purchase a dementia friendly clock so as to help the person orientate to time and day. On the day of the inspection this had not been put in place for the person. The health advice had not been followed to aid the person in relation to their dementia.

We saw another person's care records and saw that they were diagnosed with diabetes. Staff took the person's blood readings on a daily basis. We saw there was a care plan for the treatment of diabetes; however it did not inform staff what the person's blood sugar readings should be to remain healthy and we saw that there had been three high readings of 16.7, 17.9 and 17.9 during August and September. The majority of this person's readings were around 8.0 and a normal person's blood sugar readings should be between 4.0 and 6.0. These high readings had not alerted staff to a potential problem with the management of this person's diabetes and no medical advice had been sought. This put this person at risk of becoming unwell due to high blood sugar levels.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At our previous inspection we had been concerned about the level of support staff received in being effective in their roles. At this inspection although we noted some improvements we still had concerns about the effectiveness of staff. A relative told us: "I have seen some changes since the last inspection and I now have more confidence that staff know what they are doing now or at least are more aware of what they should be doing, and if they are not sure or confident about this will get someone to help". However, we remained concerned that staff's effectiveness was not being monitored and managed to ensure they performed their roles as required. For example, we found that some staff's moving and handling training

was still not up to date. We found there were some institutional and undignified care practises which meant that staff were not following the principles of the MCA and ensuring that people were consenting to their care and support.

People told us they liked the food. One person told us: "The food is all very nice and just the right amount. There is never any problem with the food here". Another person told us: "The food here is very good and yes we have a choice. If I don't fancy what's on offer I tell them what I would like and it's never been a problem. Today I have had hard boiled eggs on toast as that is what I asked for". We saw if people required support and equipment to eat and drink then this was made available to them, such as lidded cups and plate guards to prevent the food from slipping off the plate. When people had lost weight, action was taken to refer people to their GP and some people were prescribed food supplements. However, we noted that at breakfast and lunchtime there were several people coughing whilst they were eating. We discussed this with the registered manager who told us that several people had chest infections. However, we only witnessed the coughing whilst people were eating in the dining room and not at any other times such as when they were sat in the lounge areas. The registered manager informed us that they would look into this and consider speech and language referrals for the people experiencing the coughing episodes.

Inadequate

Is the service caring?

Our findings

At our previous inspection we had concerns that people were not always treated with dignity and respect. We had found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had issued the provider with a warning notice to improve. At this inspection we still had concerns in this area and found that the provider was still in breach of this regulation.

We looked at the daily care records for all people who used the service and saw it was recorded that three people were being routinely washed, dressed and put back to bed by the night staff before 7.00am. One of these people lacked the mental capacity to agree to this and another person told us: "I wake at 6.30am and I am washed and dressed and then put back into bed by the night staff until 8.30am when the day staff come and take me to breakfast, this is not something I would have done at home". We spoke to the registered manager who told us that they had previously addressed this with the night staff and they told us that they were not aware that this was still happening. This did not demonstrate a caring attitude towards people who used the service.

Two people who used the service shared a room. We saw a commode in these people's bedroom with a large printed note above it which stated: '[Person's name] please use the commode not the toilet'. The registered manager informed us that this person had flushed their incontinence pads down the toilet when they used it so were being discouraged from doing this. This did not demonstrate an understanding for the need of privacy for this person, as they were being asked to use a commode in a shared room. Action had not been considered in relation to ensuring that staff could be present to support the person to use the toilet independently.

Two people told us they were not always treated with dignity and respect. One person told us: "The staff can be a bit brusque at shower time. It's not exactly come in here and take your clothes off but they tell me its shower time rather than asking me if I want to have a shower at that moment". Another person said: "We are not always treated with respect. I have to have two carers and some treat you like a bit of dirt at times. When there are two of them most of them talk to you and explain what they are doing but others talk across you to each other about anything and everything. It's just rude". These examples demonstrated that people were not always treated with dignity and respect.

One person we spoke with told us that they had asked to read their daily care notes. They told us: "I did read them and it's a load of rubbish, it states I refuse to do this, that and another. It really upset me and I cried all night". We looked at this person's daily records and saw that the language being used was negative and recorded that the person had been abusive and refused care intervention. This did not demonstrate respect for this person as their records were written in such a way that they caused the person to get upset.

We visited one person in their bedroom and noted a strong, overpowering smell of body odour or urine was evident. This person spent the majority of time in their bedroom and this would not have been conducive to being in comfortable surroundings. We saw that the local authority had also noted at their previous

inspection that they too noted the offensive smell in the person's bedroom, yet no action had been taken to remedy this. This did not demonstrate a caring approach to the quality of care for this person.

These issues constitute an on-going breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people we spoke with told us they were happy with the way in which staff treated them. One person told us: "The staff are very caring and understanding. They always ask, if you want anything else doing even if busy. They generally treat you right, had odd one who didn't but they didn't stay. Some have a bit of a joke and banter but they're always polite". Another person told us: "The staff are all very caring and always treat me very well. They talk to me properly, know what I like and don't like and I think they treat everyone the same. Some are better than others but that's normal. They can be rushed sometimes when they are short of staff but I am quite independent compared to some so it does not affect me as much".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that people were not always receiving care that met their individual needs and preferences. At this inspection we found further concerns and the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there were routines and restrictions on people's daily life which prevented care from being personalised and based on people's preferences. For example, daily records showed that staff were waking people up between the hours of 7.00am and 9.00am. One person told us: "On getting me up the staff knock, they don't ask, they just come in and say it's time. They help me wash and dress and then go off and my breakfast appears. Usually about 7.30am but can't remember ever been asked what time I wanted to get up". The registered manager told us that no one was made to get up but we saw that six people had stated in a recent quality survey that they were being woken up too early. The registered manager had not taken action to investigate these people's concerns and this did not demonstrate a personalised approach to the care people received as the routines staff followed meant that people's choices were not being respected.

Night staff were routinely supporting people to wash and dress and then putting them back to bed rather than allowing them to sit downstairs if they chose or wait for the day staff to receive the support they required. People had not been asked their preferences as part of their care planning process and routines had been developed to support the staff to deliver care and not based on people's individual preferences.

We found that people's preferences were not always being respected. For example, one person told us that they had expressed a preference to stay in their room during the day. They told us that they were not allowed to stay in their room. They said: "They won't let me stop upstairs in the day because I might tumble and even when I'm not feeling too well I have to sit in the lounge". Action had not been taken to make this person safe so they were able to their preferences met.

We found that people's needs were not being regularly assessed to ensure that their needs were able to met at the service. For example, one person had stated they did not wish to be at the service and the registered manager told us that they did not feel the service met this person's needs. However no support had been gained for an assessment of the person's needs to be carried out to find a more suitable placement for them.

These issues constitute a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

There was a complaints procedure and people we spoke with told us they knew who to complain to if they had any concerns. However, we saw that when people did have concerns, for example, being woken up too early, the registered manager did not take action to address this for people.

Since the last inspection people told us that there had been more activities available to them. A relative told us: "It has improved and the care staff do seem to try to do some activities with people every day now and

have asked residents and relatives for any ideas they may have. A few people went out last week in a social services ambulance, think it was to a garden centre and they have gone into the garden in good weather".

There was a weekly timetable of events displayed on the wall in reception which included group activities such as hoopla, bingo, bowls, movie night, golden memories karaoke, and arts/craft sessions. There had also been external in the service recently. The staff now produced a daily news sheet which also includes facts about what happened on that date in the past, which we saw carers using to stimulate conversation with people with variable success.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had concerns that the systems the provider had in place were not effective in ensuring continuous improvement of the quality of the service. We had found the provider in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had served a warning notice to improve. At this inspection we found minimal improvements. However, we found further concerns and more breaches of the regulations. The provider remained in breach of Regulation 17.

Since the last inspection the provider had asked people their views on the quality of the service through a survey. We saw that six people had recorded that they were being woken up too early. These surveys had been completed in July 2017 and no action had been taken to discuss these people's concerns and rectify this for them. The registered manager was not able to offer an explanation as to why these comments had not been acted upon. This meant that this survey was ineffective in improving the experience for people at the service.

Lessons were not being learned following incidents and accidents as they were not being investigated and action was not being taken to minimise the risks of harm to people. For example, two people had fallen and been injured at the service and no action had been taken to reduce the risk of this and improve the quality of care for these people.

People's care plans did not always reflect the change in people's needs. We saw that one person's risk of falls assessment had been reviewed monthly. We saw that it was recorded each month that there were no changes and no reported falls. However, we saw in the incident records that the person had fallen five times over five months. This showed that the review of this person's care was ineffective and did not improve the quality of care person received.

We saw that one person's medication reviews had not identified that they had refused their medication on three occasions. The reviews recorded no issues with medication this month. This meant that the review of this person's medication care plan was ineffective and did not ensure that action was taken in relation to their refusal to take their medication and in doing so improve the quality of care the person received.

There was a bathing and showering record in place and we saw that four people had appeared not to have had a bath or a shower offered to them over a period of ten days. We discussed this with the registered manager who was unable to offer us assurances that these people had been offered a bath or shower. This meant that this record was ineffective in ensuring that care was being delivered as required.

The fire service had undertaken a recent review at the service in August 2017 and left several requirements to carry out to ensure the safety of people using the service, staff and visitors. On the day of our inspection we found that only minor action had been taken to remedy their findings. One evacuation chair had been purchased, however the service required two. The registered manager informed us that the provider had said that people on the one side of the building would be able to use the stair lift, however electrical appliances such as lifts should not be used in the event of a fire. Staff had not been supplied with training in

the use of the evacuation chair so this would be ineffective in the event of a fire. We saw that fire doors were still obstructed with wheelchairs. The fire service report had asked the provider to implement weekly tests of the fire alarm system, however these had not been implemented and the system was being tested fortnightly. The registered manager told us that the provider had arranged for a fire risk assessment to be completed, however this risk assessment had not been seen by the registered manager who is the named person in relation to fire safety within the service. This meant that the provider was not responding quickly to ensure the safety of people who used the service.

The local authority had completed a quality monitoring visit to the service in September 2017 and had noted that the registered manager's name was not on the training matrix and advised for it to be put on. This had not been completed on the day of our inspection and the registered manager was unable to show us that their training was up date. At our previous inspection in May 2017 we had found that not all staff were trained in the safe moving and handling of people. The local authority had pointed out in September 2017 that staff's practical moving and handling training was required to be completed annually. We found at this inspection that some staff member's moving and handling training was still not up to date as the practical training is required to be completed annually. When we discussed these issues with the registered manager they said: "Yes, the commissioners did mention these issues". This meant that action to improve the service was not being taken based on the advice and requirements of other agencies.

The service had a culture of institutionalised care which meant that people's preferences were not being respected. The registered manager had failed to identify and address this through the reviewing of people's daily care records and listening to feedback from people who used the service.

These issues constitute an on-going breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the provider was in breach of Registration Regulations 2009 (Regulation 18) as they were not always notifying us of significant incidents. At this inspection we found that the provider was still in breach of this regulation as they had not notified us of an injury to one person who used the service.

At our previous inspection we found that the provider was in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they were failing to display their previous CQC rating. At this inspection we saw that the rating was on display and the provider was no longer in breach of this regulation.