Mrs Bimla Purmah

Angel Court Residential Care Home

Inspection report

Manor Road Precinct
Walsall
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Tel: 01922633219

Date of inspection visit:
20 June 2017

Date of publication:
14 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 20 and 21 June 2017. At the last inspection in February 2016, we found the provider was meeting regulations and we rated the service as 'good'.

Angel Court Residential Care Home is registered to provide accommodation for up to 25 older people, some of whom are living with dementia, who require personal care and support. On the day of the inspection there were 25 people living at the home. There was a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks were not consistently assessed or managed which meant some people were at risk from avoidable harm. Incidents and accidents had not always been reported which meant people's care had not been reviewed to reflect changes in their behaviours, which may put them at risk. People expressed concerns about night time staffing levels and recent incidents indicated that there were not always sufficient staff available at night to meet people's needs. People received their medicines as prescribed, but improvements were required to the systems used to manage medicines. People told us they felt safe and staff knew how to report and escalate concerns for people's safety.

The provider had not acted lawfully when seeking people's consent for care and support. People's capacity to make certain decisions had not been assessed or recorded and care records did not reflect how decisions had been made in people's interests. Staff did not always have the skills and knowledge to provide people with consistent care. People received sufficient amounts of food and drink and staff made referrals to relevant health care professionals to support people's health needs when required.

Some language used by staff was not dignified. However, people described staff as kind and caring and told us they were involved in day to day decisions about their care. People told us staff were respectful. Staff promoted people's independence where possible and visitors were made welcome by staff who knew them by name.

People were not supported to take part in activities or pastimes that interested them. There were minimal activities available to people which meant people did not receive person centred support. People and their relatives had been involved in the assessment, planning and review of their care. People and relatives knew who to contact if they were concerned about any aspect of their care and support.

Systems used to monitor the quality of the service had not been effective at driving improvement or identifying concerns. The provider had failed to notify us of events as required by law. People continued to be placed at risk of harm as the communication systems within the home had failed to ensure information about serious incidents was shared with the management team. As a result action had not been taken to

mitigate future risk to people's safety. People and relatives expressed mixed views about whether the provider had sought their feedback on their experiences of living at Angel Court. Improvements were required to the overall environment of the home and the provider had an improvement plan in place.

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.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks had not been assessed and managed to reduce the risk of avoidable harm.

Staffing levels at night were not always sufficient to meet people's support needs.

People received their medicines as prescribed, however systems used to ensure safe management of medicines required some improvement.

People felt safe and were supported by staff who knew how to report concerns for people's safety and well-being.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity to make decisions about their care and support had not always been assessed, which meant decisions made may not be in their best interests.

Staff received training relevant to their role but did not always act in way that recognised the needs of people living with dementia.

People received sufficient amounts of food and drinks were readily available.

People received support to manage their health care needs from staff who made appropriate referrals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Language used by some staff was not always age appropriate.

People described staff as caring and helpful. Staff knew people's cultural requirements and supported them respectfully.

Staff respected people's decisions. Visitors were welcomed by staff who knew them by name.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not supported to partake in activities or hobbies relevant to their individual needs and interests.

Where possible people and relatives had been involved in the assessment and planning of their care and support.

People knew how to raise concerns if they were unhappy about the care they received and there was a system in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Systems developed by the provider to monitor the quality of care people received were not effective in identifying the issues highlighted during the inspection.

People continued to be placed at risk because information about serious incidents had not been identified by the management team.

Although the provider had sought some feedback from people and relatives there was little evidence to suggest this had been used to drive improvements.

Angel Court 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 was prompted in part by notification of concerns raised by the local authority. The inspection took place on 20 and 21 June 2017 and was unannounced.

The inspection team consisted of 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 use this type of service. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. The provider had sent us a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give key information about the home, what the service does well and improvements they plan to make. We also contacted the local authority and commissioners for information they held about the service. This helped us to plan the inspection.

During the inspection we carried out observations of the care and support people received. We used the Short Observational Framework for Inspection (SOFI) to observe how care was provided for people who were unable to speak with us. We spoke with 16 people who lived at the home, two relatives, five staff members, the deputy manager and the registered manager who was also the provider. We looked at four records about people's care and support, three staff files, medicine records and systems used for monitoring the quality of care provided including accidents and incidents.

Inadequate

Is the service safe?

Our findings

We looked at how risks were managed in order to protect people from avoidable harm. We found that risks to people's safety and well-being had not always been consistently assessed or reviewed. This meant people were placed at potential risk of harm. We found that while there were risk assessments in place, these did not always contain up to date information, and some had not been reviewed following incidents. For example, records showed that one person, who was living with dementia, had on two occasions been able to leave the building at night and had been found by staff in the garden. The person's risk assessment, which offered guidance to staff about how to safely support the person, had not been reviewed following these incidents and no steps had been put in place to reduce the risk of a similar event happening again. As a result the person continued to be placed at risk.

We reviewed this person's care records and found that the guidance for staff stated that the person required supervision at all times as they were at high risk of falls. We observed staff at times prompting the person to use their walking aid and other's discreetly monitoring the person's whereabouts. However we observed a number of occasions throughout the inspection where the person was spending time in communal areas of the home and there was no staff supervision. This meant the person was placed at potential risk of harm because staff leaving the communal areas did not always check that one of their colleagues was available to support the person.

We discussed our concerns about the management of risk with the deputy manager who told us they were not aware of the incidents where the person had been found in the garden. Following the inspection we shared our concerns about this person's safety with the local authority.

We saw another person who was at risk from swollen legs. We observed the person sat for long periods of time throughout both days of the inspection. We reviewed the person's care records which indicated staff had noticed the person's legs were swelling and had contacted a healthcare professional for advice. Notes reflected the healthcare professional had advised staff to support the person to elevate their legs. The person was not able to share their views with us however; throughout the inspection we did not observe the person being supported to elevate their legs. We asked the deputy manager about this and they told us the person did not want to have their legs elevated, but there was no record of this in the person's care records and no evidence of a risk assessment around their refusal. Throughout the two days of the inspection we did not see staff ask the person if they would like their legs elevated and records did not reflect that the person had been asked and refused. We saw from the person's care records that the support they required with their mobility had increased recently and so this may have be impacted further by not receiving appropriate support. The person was placed at potential risk of harm by not having their legs elevated.

The provider had not ensured that risk assessments relating to the health, safety and welfare of people had been assessed or reviewed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Some of the people we spoke with expressed their concern about night time staffing levels. One person told

us that although they had not been personally adversely affected they were worried about other people who lived at the home, commenting, "It stands to reason that with the number of residents, the fact that some have dementia and wander and the chance of an emergency situation, that two staff are not enough." Another person told us they were concerned about someone trying to enter their room at night, and felt there were not enough staff to support people who did not sleep throughout the night. Other people told us they felt staff responded quickly to call bells during the night. However, staff members we spoke with also expressed concerns about staffing levels at night. One staff member told us, "There are only two staff at night and it is not enough. You need two people to support a lot of the residents and when they are upstairs who is looking after people downstairs." Other staff members expressed similar concerns. One told us, "It's difficult for staff if we need to call the paramedics at night, especially if one staff member needs to go with the person." A third staff member said, "We've told [the provider] about our concerns with staffing but they don't do anything." We reviewed night time records which reflected one person had been discovered by staff in the garden in the early hours of the morning and that this had occurred on two occasions. Although the person had not sustained injuries they were placed at potential risk of serious harm through a lack of consistent staff support.

Throughout the inspection people told us and we observed that there was very little support available from staff for people to take part in activities and hobbies. Although there were enough staff available in the day time to response to people's care needs, staffing was not sufficient to ensure people received support to take part in activities that interested them.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about night time staffing levels with the provider who told us they felt two staff were sufficient to meet people's needs, but did not have an assessment of peoples night time needs to demonstrate how they came to this conclusion. They said they were planning to install CCTV monitoring equipment on the first floor of the home, to enable staff to better monitor people's whereabouts and safety. The provider also told us that they had advised staff to carry out night time checks in pairs, for reasons of staff safety. However although there were plans for the installation of additional monitoring equipment this may not be sufficient to ensure people received staff support when they needed it. Staff we spoke with told us they operated an on call system during the night time, and several staff who lived locally to the home were available to respond in an emergency.

People told us staff were available to support them throughout the day and staff responded promptly to call bells. One person told us, "Staff are here when I buzz in a couple of minutes." We observed day time staffing levels throughout the two days of the inspection and found there were sufficient numbers of staff to respond to people and meet people's needs. Where people used their call bells to indicate they required assistance from staff, these were answered promptly.

We reviewed the management of medicines including the Medication Administration Records (MAR) for five people and found concerns. Although MAR sheets had been signed we were not able to check that all medicines had been given as prescribed because the total amount of medicines available did not match the records of receipt or administration. We asked senior staff about this and they were unable to verify what the total amount of medicines should be. They told us the deputy manager conducted monthly audits to ensure medicines had been administered as prescribed and that stocks of medicines stored on behalf of people were safe. However, when we asked to see evidence of these audits we were shown copies of audits that did not included checks on the amount of medicines kept in stock.

Some people told us they received medicines 'when required'. However, staff were not aware of protocols about how and when these medicines should be offered or administered. The provider told us guidance documents were available for staff to ensure people received their 'as required' medicines consistently; however staff we spoke with were not aware of these. This placed people at risk of either not being offered their medicines or not receiving them as prescribed.

Although we found concerns with the recording and management of medicines people told us they were happy with the way they were supported with their medicines. One person told us, "I get different medicines, but I'm not sure of the names." Another person shared with us how they received pain relieving medicines at regular intervals and told us staff had explained to them why they could not be given more frequently. We observed a member of staff supporting people to take their prescribed medicines and found people were given an explanation of their medicines and the time they needed to take them.

People told us they felt safe and comfortable at Angel Court. One person told us, "I feel safe because they look after us here." Another person said, "I know if I need help I can call on someone." We saw that people were relaxed when in the company of staff and felt confident to ask for help when needed. Staff understood their responsibilities in recognising and reporting suspected abuse and knew how to raise concerns with both the manager and other external agencies if necessary. One staff member told us, "If I had concerns I'd tell the senior or duty or go to the manager. I know I can go outside the home as well, to CQC." However, records we looked at showed that when safeguarding incidents had occurred, the registered manager had not always reported these to the relevant agencies for investigation, or notified us as required by law. This meant people may not be protected from future harm.

Staff told us that they were required to have pre-employment checks before they were permitted to start work at the home. We reviewed staff recruitment records and saw the provider had conducted appropriate recruitment checks prior to staff starting work at the service. Reference checks, identify verification and Disclosure and Barring Service (DBS) checks had also been completed. DBS checks help providers reduce the risk of employing unsuitable staff.

Requires Improvement

Is the service effective?

Our findings

People told us they were asked for their consent before care and treatment was provided. One person told us, "I had sore skin this morning and the carer asked before putting cream on for me." We saw staff asked people if they needed support and waited for their agreement before providing it. However, where people were unable to consent to care and treatment we found the provider had not always acted in a way that respected people's rights.

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.

Although staff we spoke with had some understanding of their responsibilities in relation to MCA we found the provider had not always carried out assessments of people's capacity to make certain decisions and care records did not reflect how decisions had been reached. For example, three people were given their medicines disguised in food or drinks. Records showed that although the person's GP had been consulted about this, there was not always evidence that the person or their family members had been involved in the decision or that the decision had been made in the person's best interests. Furthermore, an assessment of the person's capacity to indicate whether they had capacity to consent to this method of receiving their medicines had not been carried out. This meant staff may not receive accurate guidance about people's capacity to make certain decisions and the person may be placed at risk of being prevented from making their own decisions, should this be possible.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

We shared our concerns with the deputy manager who told us they were not aware that it was their responsibility to assess people's capacity; but following the inspection would ensure that in the future, decision specific assessments would be carried out.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed the care records of people living at the home who were currently deprived of their liberty and found there were no conditions applied to the authorisations. Staff we spoke with were aware of which people living at the home were subject to a DoLS and understood the reason authorisations had been granted. One staff member told us, "Some people want to go home, but unfortunately they can't so we are depriving them because it's not safe for them leave." We discussed DoLS with the deputy manager who advised there were a number of people who they had submitted applications for, but were awaiting a

response from the local authority. The deputy manager shared with us their system for the monitoring of DoLS, which ensured that where required, new applications, had been made prior to the expiry of current authorisations.

People told us they felt staff had the knowledge required to meet their care needs. However we found staff did not always have the skills to effectively communicate with people or to understand their behaviour. For example, we saw one person who was anxious and concerned about their family. A number of different staff tried to reassure the person, but did not use a consistent approach when responding to the person's concerns and each staff member gave a different response. This resulted in the person becoming confused and more anxious. Staff did not recognise how their approach was affecting the person, which meant that although they were well meaning, their actions had a negative effect on the person.

Staff we spoke with told us they received training relevant to their role which they felt gave them the skills and knowledge required to support people. One staff member told us, "The training is very good, we have lots of hands-on training like moving and handling." Another staff member told us, "I think we can meet people's needs." A third staff member shared with us how they had been supported to obtain a nationally recognised qualification, "The training is good. I've done an NVQ3 and hopefully will do more. It's good to develop." Although staff were happy with the training they received improvements were required to ensure staff were able to support people in a consistently effective and safe way.

People expressed mixed views about the food and drink provided. One person told us, "Sometimes it's tasty, sometimes it's not." However a relative told us, "[Person's name] has never complained about the food." We observed breakfast and lunchtime and saw different options were available, including an option for those who required halal meat. One person did not like their meal and complained to staff, who responding by offering alternatives, one of which the person accepted and happily ate. We saw that drinks were offered throughout the day and people confirmed this was usually the case. One person said, "When I am thirsty I have a cup of tea. You can always get one." We saw one person was pleased that Caribbean dish was on the menu, because they liked the cook's Caribbean cooking.

Staff told us and records confirmed that fluid and food intake was monitored and recorded to ensure people who were at risk of dehydration and malnutrition received enough to eat and drink. Staff recorded people's daily intake and these records were then reviewed by senior staff to ensure people received sufficient amounts to maintain their health. People weights were also monitored and we saw referrals had been made to the dietician where concerns had been identified.

Most people we spoke with were not able to share their experiences of staff assisting them with their day to day health needs or helping them to access healthcare professionals when required. However, we saw from records that there was regular intervention with healthcare professionals such as GPs, dieticians and community psychiatric nurses. During the inspection we saw two visiting healthcare professionals reviewing the needs of people living at the home. One person's care records reflected that they required a visit from an optician to review their vision; we saw that this had been arranged and glasses had been prescribed. Staff told us they had received training from local nurses to support them to assess when to contact a GP for advice about a person's health. One staff member said, "The training from the nurses was really helpful, but of course if the person did not get any better we would contact the GP if necessary."

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the way staff supported them and felt staff were caring towards them. One person said, "The carers are quite alright. I can't find fault." Another person shared, "Everyone [staff] is nice to me." We observed some positive and caring interactions between staff and people. For example, we saw one staff member take the hands of a person and guide them towards the table to encourage them to eat. The person responded by smiling and then eating their meal. While we saw that individual staff were kind and caring towards people, the provider's systems and processes did not always ensure that people were cared for safely. For example the night time staffing arrangements in place placed people at risk of harm. In addition staff did not consistently follow instructions from health care professionals in respect of meeting people's needs.

During the inspection we saw examples where people were not treated with dignity and respect. On two occasions we observed staff use language that was not age appropriate towards a person. For example, by saying, "Good girl" to a person when they finished their meal. Although the people involved did not raised concerns about the way in which they were spoken with, the staff member's use of language meant that people's dignity was not always considered. We shared our observations with the deputy manager who advised action would be taken to address this.

Despite these concerns we saw other examples of staff maintaining people's dignity in the way they supported them with their care needs. For example ensuring bedroom and bathroom doors were closed when in use, and being discreet when asking people about personal care. We also saw staff knocked on people's doors before entering their rooms and allowed people their own time and space. One person told us, "Staff always knock before entering my bedroom." Another person shared with us how staff were respectful when supporting them with personal care. They said, "I wear a continence aid and staff are respectful."

People's cultural needs were met by staff who were aware of their religious and cultural preferences and requirements. A variety of foods were available which reflected people's dietary preferences. Where people had specific requirements in relation to their person care we saw these had been identified and people received appropriate support from staff who were aware of their needs. Staff told us that where people identified with a specific faith, people from their congregations visited regularly. Staff were aware of people's preferences and knew their relatives by name.

We observed staff encouraging people to maintain their independence with their mobility. For example, one staff member encouraged a person to walk by themselves around the communal area, while discreetly offering verbal support and positioning themselves near to the person. People told us staff involved them in day to day decisions about their care. One person said, "Staff always explain things clearly." Other people we spoke with told us they were pleased staff gave them the freedom to keep their bedroom as they wished.

We observed visitors were present at the home throughout the day and were welcomed by staff who knew them by name. We saw that visitors were offered drinks and one relative was invited to stay for lunch so they

could enjoy a meal with their family member. The visitor told us, "We are very happy with Angel Court, I am always made welcome."

Requires Improvement

Is the service responsive?

Our findings

We found that people living at Angel Court were not always supported to take part in activities that interested them. Throughout the two days of inspection we saw people were offered very little stimulation and most people spent their time sitting in the lounge without anything to engage them. One person told us, "It's very dull" and another person said, "What it wants is something to do." A number of people living at the home were reliant on staff support to take part in activities that interested them. However there were very few occasions throughout the inspection where staff offered people activities to take part in. For example, some people occupied themselves by walking around the home, or spending time in the garden or their bedrooms, other simply sat and passively watched people around them. There was an activity schedule on display which indicated the activity on the first morning of the inspection was 'exercise'; however we saw no evidence of this taking place. We observed one staff member who tried to engage people in singing and dancing, however this was well received by only one person in the lounge at the time and other covered their ears and did not wish to participate as the activity was not something that interested them. Later on in the day staff played dominoes with two people, whose facial expressions showed they enjoyed the game. On the second day of the inspection we saw staff encouraging a small number of people to take part in card making. However, the majority of people were not engaged in activities or pastimes that interested them. We asked one person about life at the home and they told us, "I get bored." Another person said, "I'd like to go out and sit in the park, I need a carer with me and I know there isn't one to take me."

We discussed our concerns about the lack of activities or stimulation with the registered manager who told us activities were usually led by a member of staff who was not currently working in this role. However, they were making arrangements for another staff member to take the lead with activities in the interim period.

We found there were some people living at Angel Court whose needs could not be consistently met by the skills, knowledge and experience of the staff team. For example, some people's primary need was such that staff had not received training to enable them to effectively support the person. The provider had carried out assessments of these people's needs and offered them a place at Angel Court; however their needs were now such that staff were not skilled to support them effectively. At the time of the inspection reviews were underway by local authorities to ensure people whose needs could not be met by staff at Angel Court were offered more appropriate accommodation. These reviews were being conducted in response to recent concerns raised by one of the local authorities.

Most of the people we spoke with were not able to tell us if they had been involved in the assessment and development of their care plan, because of their needs. However relatives told us they had been asked to contribute to their family member's assessment before they moved in to the home. One relative said, "I was involved in [person's name] assessment, the manager talked to me about them and asked about their behaviours." Other relatives told us they had been asked by the registered manager to participate in reviews of their family member's care and support. One relative said, "Staff are quick to call me if there any changes to [person's name]'s health. We are invited to reviews, as [person's name] cannot always remember." Another relative said, "If there are any concerns staff give me a call. I feel I am kept updated." We reviewed people's care records and found they contained minimal amounts of information about people's individual

life histories. The deputy manager told us people's care plans were being reviewed and a new style of care plan was being developed, which would ensure more detailed information would be recorded to enable staff to deliver improved person centred care and support.

People told us they knew how to make a complaint if they were unhappy about the care and support they received. One person said, "I have never had cause to complain, but the provider will pop in to see me." In their PIR the provider told us they had not received any formal complaints but had worked to resolved concerns raised by relatives about people's laundry getting misplaced. The provider had a system in place for the management of complaints and we saw complaints forms were easily accessible to relatives and visitors in the entrance hall of the home.

Inadequate

Is the service well-led?

Our findings

We reviewed systems the provider used to ensure the service was safe and to monitor the quality of care provided. We saw that a range of checks were completed including health and safety audits, fire checks, gas safety checks and medicines audits. Although quality assurance systems were in place to identify areas for improvement; these systems were not robust enough to identify the issues that we found during the inspection. We saw the deputy manager maintained a log of serious incidents, accidents and near misses. However some of the events we identified during the inspection were not included in the management oversight records. The provider's communication systems had not been effective in ensuring all information about people health, welfare and safety had been shared with staff or the management team. This meant that some serious incidents had not been reviewed and as a result no action had been taken to mitigate future risk. This potentially placed people at risk of avoidable harm.

The provider had not established systems to ensure risks to people were effectively assessed and reviewed. We found the risk assessments were not always current, which meant staff knowledge of the risks people faced was not consistent. For example, when supporting people with their mobility or night time routines.

We found audits conducted by people instructed by the provider were ineffective at identifying concerns. For example, we reviewed a medication systems audit from April 2017 which indicated a check of received and administered medicines had been carried out. However when we looked at MAR sheets for the same period we saw that balances of medicines had not been carried forward and as a result medicines stock had not been checked.

The provider told us they had reviewed staffing levels at night and were satisfied that staffing numbers were sufficient to meet people's needs and maintain people's safety. However, following our review of night time records we identified incidents that had occurred during the night where people were at risk of harm. The provider's system of assessing the numbers of staff required had not been effective in identifying recent events, or given due consideration to people's changing needs and behaviours. This meant people had been placed at risk of harm.

The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to and following the inspection we reviewed the information we held about safeguarding and serious incidents within the home. We found that the provider had not always completed appropriate notifications about incidents that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law. During the inspection we became aware of incidents of potential abuse that had not been reported to CQC as required by law.

This was a breach of Regulation 18 Care Quality Commission (Registration) 2009.

People expressed mixed views about whether they felt the service was well led. One person told us, "The provider's priorities are not the same as my priorities." Another person expressed a more positive view telling us they felt the management of the home was 'fine' and that they felt the home was well organised. Relatives told us they did not always feel able to approach the management team and that they were not aware of whether there had been any formal consultation with relatives or residents to gather their views on how the home was run. We spoke with one person who told us they had been asked to complete a questionnaire about their experiences, but had not received any feedback or seen any changes in response to the issues they raised. Although the provider had sought the views of some people and their relatives there was no evidence to suggest that this feedback had been used to drive improvements or to develop the home for the benefit of people who lived at Angel Court.

Staff told us they felt the home was well managed and they had the support they needed from both the provider and deputy manager. One staff member told us, "I am comfortable and happy here, both managers are very friendly and I can approach them at any time." Staff told us they had regular handover meetings which were used to share information about people's care needs. Team meetings also took place which were used by the management team to give guidance and direction to staff about any training requirements or share learning as well as planning people's support and care.

During the inspection we identified a number of improvements were required to the general fabric and environment of the home. For example there was a strong smell of urine in some parts of the home and improvements to ventilation on the first floor were required. A high number of people residing at Angel Court were living with dementia; however there was limited dementia friendly signage throughout the home, which could mean that people struggle to find their way around. In the PIR the provider told us, "We are planning new floors in the lounge and dining room. This will create a space which is easy to clean and provide a lift to the new decor. We are planning to continue the redecoration work to create a dementia friendly environment. We have already purchased brick effect wall paper to create themed walkways and paint the doors different colours to assist with recognition and to look like the front door of their own 'house'." The provider and deputy manager told us they planned to replace the carpets in the weeks following the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found that the provider had not always completed appropriate notifications about incidents that had taken place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was only provided with the consent of the relevant persons.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risk assessments relating to the health, safety and welfare of people had been assessed or reviewed.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided.

The enforcement action we took:

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