Abbey Health Care Limited

Abbey Court Nursing Home - West Kingsdown

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Abbey Court Nursing Home on 16 and 17 March 2017. The inspection was unannounced. Abbey Court Nursing Home is a nursing home providing support and accommodation for up to 22 people. At the time of our inspection there were 20 people living at the service. Abbey Court is one large converted building with a purpose built extension. Support was provided over two floors.

There was a registered manager in post who was registered with the CQC. 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.

At our last inspection on 7 and 8 April 2016, we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relations to people's records not being effectively updated to accurately reflect their current need. At this inspection, we found that the provider had not acted on this previous breach of regulation and this was a continuing breach of the Regulations.

There were not enough competently trained staff to fully support people at the service. People, relatives and staff told us there was not enough staff at the service.

The registered provider had not ensured effective medicine management systems were in place at the service. There were no protocols in place for medicines that are prescribed as and when needed. We found discrepancies in stock levels of medicines and staff were not double signing for medicines where needed.

The registered manager had not done all that was required to reduce risk. Cleaning equipment was left unattended and staff were not recording all accidents and incidents appropriately. Moving and handling risk assessments were not being updated when required.

The registered manager had not ensured that the building was well maintained. We found that an exit door required an emergency repair to make it safe and the carpets in communal areas were, in places, ripped and lifting from the floor.

The registered manager had not ensured the cleanliness of the service. There were bad odours in areas of the home, pieces of food left on the floor and the carpets required a deep clean.

The registered manager had ensured that people were safe to work with vulnerable adults. Staff files showed that people had relevant safety checks along with two references and photographic identification.

Staff could identify the forms of abuse and how they should report any suspected abuse. Staff could identify that they could contact the local authority or Care Quality Commission with any concerns.

The principles of the Mental Capacity Act 2005 (MCA) were adhered to. People were being assessed appropriately and best interests meetings took place to identify the least restrictive methods of keeping people safe. Staff had training on MCA and had good knowledge.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005.

The training provided was not completely robust as staff received moving and handling training, but we saw poor moving and handling techniques during inspection.

The registered provider took into account people's nutritional and hydration needs. However, the registered manager had not identified all risk regarding those living with diabetes. We have made a recommendation about this in our report.

People's records showed that there were appropriate referrals being made to health professionals. Staff were effectively managing people's wound and pressure areas.

People and their relatives were not being consulted with the reviews of their care. People and relatives told us they were not involved with the reviews and their records confirmed this.

Staff were seen to be kind and compassionate to people during our inspection. Staff understood the importance of people's privacy and independence. People's confidential information was kept safe and never left unattended in public areas. We have made a recommendation about this.

The registered provider had not ensured that there were meaningful and stimulating activities for people at the service. People and relatives told us there were no organised activities at the service. During inspection, we saw a quiz and hand massages take place.

The registered manager did not have effective systems in place to record complaints. There was a complaints file and we found that the most recent recorded complaint finished mid-way through a sentence. People also told us of situations where they took concerns to the manager and these had not been recorded in the complaint log.

The registered manager had a sign in the entrance hall that restricted visiting times. Some relatives confirmed that at times they had trouble visiting outside of these times. However, others told us they had visited during the advertised restrictions without hindrance. We have made a recommendation about this in our report.

People were given choices on how they decorated their rooms, food and if they wanted to take part in the activity that was seen during inspection. People were also invited to meetings regarding the service.

People's records were not organised in a way that it was easy to read and follow. The registered manager had not ensured that people's records were being updated when required by staff. Auditing systems had not been effective in finding shortfalls within the service. The registered provider did not ensure that people, relatives and staff were consulted through feedback to identify shortfalls and good practice at the service.

The registered manager had not informed the Care Quality Commission of all notifiable events such as DoLS authorisations, safeguarding referrals and events that cause a disturbance to the service.

We found breaches in the regulations. You can see what action we took at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough competently trained staff to provide full support to people living at the service.

Staff were not reporting maintenance issues and repairs.

Medicines were not being effectively managed.

Risks were not being clearly identified throughout the service.

The standard of cleanliness in communal areas of the service was poor.

Staff were not appropriately reporting accidents and incidents.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager had not identified all risks regarding those who required a diabetic diet.

Wound and pressure care management was effective. People were referred to healthcare professionals when required.

Staff had regular one to one supervisions and annual appraisal.

Is the service caring?

Good

The service was caring.

People and their relatives were not always involved with the reviews of their care. We have made a recommendation about this.

Staff understood the importance of people's privacy and were seen to be kind and compassionate during inspection.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of stimulating activities that were not related to people's hobbies and interests.

There was no robust system in place for recording and acting on complaints.

People attended regular meetings to discuss certain parts of the service such as upcoming menus and events.

Pre-admission assessments gave staff the information required to start to provide care when a person arrived at the service.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager was not open, honest and transparent during inspection.

People's records were not updated when required by staff.

The registered manager was not using auditing systems effectively to identify shortfalls within the service.

The registered manager was not notifying the Care Quality Commission of all notifiable events as required by the regulations.

The registered provider had not ensured that there were appropriate avenues for people, relatives and staff to feedback on the service.

Abbey Court Nursing Home - West Kingsdown

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.

The inspection took place on 16 and 17 March 2017. The inspection team consisted of three 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. At our last inspection on 7 and 8 April 2016, we rated the service as Requires Improvement.

Prior to the inspection, we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the local authority. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection, we spoke with nine people living at the service, five relatives, three nurses, four care staff, one cook and the registered manager. As some people who lived at Abbey Court Nursing Home were not consistently able to tell us about their experiences, we observed the care and support being provided. We looked at nine care plans, medication administration records, risk assessments, accident and incident records, complaints records, health and safety checks, fire safety documentation, menus, cleaning schedules, activities programme and quality audits.

Requires Improvement

Is the service safe?

Our findings

People, relatives and staff told us there were not enough competently trained staff at the service. One person told us there were not enough staff because, "The girls are so rushed off their feet." A relative told us, "Staff do their best, but there is just not enough staff to meet every resident's needs. One member of staff told us, "There is not enough nursing staff."

People were not supported by sufficient staff with the right skills and knowledge to meet their individual needs. The registered manager said, "We have three care staff during the day and two at night and there is one nurse on every shift." People at the service required two people to support them with personal care and moving around the home. However, we saw that people in the communal room had to wait up to 15 minutes before two carers were available to support them into a comfortable position or to go the toilet. One person was cared for in their room and required full support from staff for their daily needs. On the day of inspection the person told us, "I have had to wait an hour to get my lunch." Another person told us, "I do have to wait to go to the toilet." We observed that one person used their call button to assist to go to the toilet. A member of staff responded to the call quickly but it took a further 17 minutes for a second member of staff to be available to support the person to the person to the toilet. The person's care plan identified that they required two to support with transfers.

Registered nurses are required to revalidate their registration with the National Midwifery Council every three years to demonstrate continuing learning and experience. While all nurses employed by the registered provider had their validation certificates kept on site, the registered manager had not completed her own revalidation on the due date of 28 February 2017. The rota showed that from 28 February 2017 the registered manager was on their own covering nursing shifts on at least five occasions. People at the home were therefore at risk that their nursing care was being provided by someone who was not correctly registered with the relevant professional body. We discussed staffing levels and nursing cover with the registered manager who revised the rota to ensure that there would always be a validated registered nurse on site. The registered manager also showed us evidence of new staff to be employed at the service, which included a new nurse, new care assistants and a senior care assistant. On the second day of inspection, we met a new nurse who was shadowing a trained nurse for the day.

The failure to ensure that there was enough competently trained staff on duty is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Competently trained staff were managing medicines. All staff that managed medicines were tested for their competencies. However, people were at risk of errors when being given medication due to shortfalls in the systems for the management and administration of medicines. At our last inspection on 7th & 8th April 2016, we identified areas for improvement in medicines management, including that 'as required' (PRN) protocols were not being used which could increase the risk of people not receiving PRN medication safely or in line with their individual guidelines. At this inspection, we also found that there were no PRN protocols available. The absence of PRN protocols meant the provider was unable to embed a consistent approach to the management and administration of PRN medicines.

Medicines were kept in locked cabinets in a designated room by the nurse's station. When we checked the stock levels of medicines we found a discrepancy with the numbers of one person's medicine. The nurse on shift was not sure why the medicine was missing. Medicines which required safer storage by law were kept separately in their own locked cabinet. We checked the stock levels of these medicines being stored at the service and found no errors. However, medicines requiring safer storage should be signed for by two people to ensure safe management. We found only one person had signed the daily check, and the last record of it being doubled signed was 18th September 2016.

During the inspection, one person told us, "I did not get my medicine until 10:30 this morning when it should be at 8am." Medicines should be administered at the time prescribed to ensure that their effectiveness is not undermined and sufficient time between doses.

The failure to ensure the proper and safe management of medicines is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were no being protected against potential harm as the registered manager had not ensured that all risks were mitigated. We saw evidence to show that staff were acting in a safe manner when dealing with accident and incidents and staff demonstrated a good knowledge of how to support people and what they should do, but they were not appropriately reporting accidents and incidents. We noticed that one person had a wound dressing on their arm. The person told us, "I recently caught my arm on a door frame." We could not see any evidence to show that this was reported in the accident and incident book. Whilst staff acted accordingly to dress the wound no efforts were made to discover if there was any reason as to how the person caught themselves on the doorframe.

During the inspection, cleaning equipment was left unattended, with cleaning products blocking a fire door. It was observed during inspection that the cleaner was plugging in a vacuum cleaner in the hallway and entering rooms leaving the chord unattended. People's records showed that some people were independently mobile with walking aids and this created a trip hazard.

Emergency lighting was recorded as last being tested 25/1/2017. According to the maintenance book, testing should be completed every week. Fire alarm testing was happening on a weekly basis. The last fire risk assessment carried out by a competently trained person was 16 November 2015 and suggested another inspection take place 16 November 2016, this had not been done. Records showed that actions required from the 2015 fire risk assessment had been completed. Personal evacuation plans were in place for each person and identified any concerns that a person may have in the event of a fire and what level of support was required. For example, one showed us that a person may shout and be abusive during an evacuation and requires support of two staff. Another identified that the person wears glasses and a hearing aid.

Safety checks were carried out for the environment but these were not effective to ensure that the service was completely safe. The registered manager carried out a bi-yearly environmental risk assessment for every room in the home. The registered provider had ensured electrical and gas testing was carried out yearly. Competent persons were testing fire equipment, there was a fire drill carried out 12/12/2016, and records showed that fire alarms were being tested on a weekly basis. However, staff were not effectively recording maintenance tasks for repairs to be completed. On the second day of inspection, some skirting on the second floor had fallen away from the wall. This was not reported in the maintenance file. We noticed during the inspection that an exit door was being kept closed by a scarf being wrapped around the door handles. We asked a member of staff if they knew about this and they confirmed that they knew the door was not working. We checked the maintenance logbook and there was no record of this. We reported this to the registered manager who contacted a contractor to attend site to fix the repair but they would not be able to

attend until the following day. The handy man on site along with another member of staff made the exit door safe and a competent contractor was contacted to inspect and repair for safe functioning. It was also observed that areas of carpets were ripped and lifting in areas.

The general cleanliness of the service was poor and this undermined good hygiene and infection control. We found the remains of a sandwich on the floor in the morning of the first day of inspection. This remained until we informed the registered manager at the end of the first day of inspection. There were foul smells throughout the home during inspection. One relative told us, "I think it really smells." Another relative told us, "It always appears to be dirty; the floors always look filthy, there is always food debris on the floor and nasty odours when I come, no matter what time of the day I visit." We also observed that some of the equipment used had not been cleaned, as there were some dried food stains on the surface. The registered manager told us, "The regular cleaner is currently on leave and there is someone else here on a temporary measure." It was observed that people living at the service were clean in their appearance and that their rooms were clean.

The registered manager had not done all that is reasonably practicable to assess and mitigate risks. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had ensured that staff employed were safe to work with vulnerable adults. We looked at the staff files of six members of staff and the validation certificates of all registered nurses on site. All staff files had appropriate references, safety certificates and proof of identity on file.

Staff we spoke with understood indicators of abuse and the process to report any concerns. They were aware of the whistle blowing procedure if they were not satisfied that issues were dealt with appropriately in the home. Staff we spoke to could identify that they could report concerns to the local authority safeguarding team and the Care Quality Commission. There was a safeguarding file kept on site at the service that included guidance to staff to spot the signs of abuse.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke to told us that the staff were effective in providing care. One person told us, "The matron is extremely good and the girls are very kind." One relative told us, "There is always someone knowledgeable on site." However, we found some areas of the service that were not effective.

Training was relevant to people's needs and included safeguarding, mental capacity, and dementia awareness. We spoke with care staff who demonstrated the knowledge they had acquired during their training in these areas and who were confident to apply it in practice. They were able to identify types of abuse and knew who to contact should they suspected abuse taking place. They were aware of the principles of the Mental Capacity Act 2005; and appeared to understand the particular needs of people living with dementia or confusion. A member of staff told us, "I know about the whistle blowing policy and would not hesitate to use it, although all the staff here are very nice and efficient." However, although staff had had training in manual handling, we observed that there were some poor moving and handling techniques that included transferring people in wheelchairs without footplates. The registered manager carried out spot checks of the night staff. The last spot check was carried out 20 December 2016 at 3am. It identified that staff needed to offer fluids to people who are awake. No other concerns were identified and the registered manager commented that the service was clean, tidy and no smells.

We recommend that the registered provider ensures that there are processes in place to ensure that all training is effective.
A member of staff told us they received regular one to one supervision and were able to obtain informal supervision and support whenever they needed it. They were considering enrolling on a study programme to obtain a qualification in social care and told us they had been encouraged to do so by the registered manager. During inspection, we saw records to show that people were having their supervisions on a regular basis and an annual appraisal.

People's mental capacity was appropriately assessed and documented about specific decisions relevant to their care, the use of equipment and routines. The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards, which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005 (MCA). People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

People's mental capacity had been assessed to check they could agree to have an airflow mattress in place, bed rails, were able to use their call bells or manage their medicines. When the assessments indicated a lack of relevant mental capacity, meetings had been held with appropriate parties to reach a decision in their best interests. The registered manager showed us how they had applied for authorisation from the DoLS office about depriving people of their liberty, as most people were unable to come and go out of the premises unaccompanied or be without constant supervision. They had considered the least restrictive options for people, as per legal requirements.

Consent was sought from people by staff before any interventions. We observed staff asking whether a person consented to having their hand massaged, or to being assisted with equipment to help them move around. A person told us, "They [staff] are always polite, they always ask before they do anything for me." A person who was leaning on one side in their armchair had declined assistance from a member of staff who respected their decision and revisited a few minutes later to check whether they had changed their mind.

The provider ensured that people's nutritional and hydration needs were being met and care plans contained nutritional assessments. People's care plans had nutritional screening record, eating, and drinking risk assessments. The kitchen area was clean and tidy. Staff were labelling food when it was opened. There was a cleaning schedule in place that was carried out by kitchen staff. Temperatures were taken of food to ensure that they were cooked to safe temperature.
The kitchen had information available of resident's specific needs. This included information of those who were living with diabetes and any preferences such as likes and dislikes and potion size preference. One member of the kitchen staff told us, "I make two puddings one with normal sugar and the other with sweeteners. This is so everyone can enjoy the same thing." It was seen on inspection that there were ample supplies of sweeteners available for the kitchen staff to use. Those who required support with eating were given it and staff did this in an appropriate way. However, records did not show a risk assessment to guide staff on the risks of supporting someone living with diabetes. For example what staff should do if a person start to feel faint during periods of high and low blood sugar levels.

We recommend the registered provider seeks guidance from a reputable source to ensure that risks specific to individual people's diabetes is recorded and available to staff.

People were appropriately referred to health care or social care professionals when needed. People had been referred to the GP and dietician when their weight had decreased; to a specialist nurse when wounds did not heal as expected; to a diabetic clinic; to a podiatrist; and to a local authority case manager when a person's behaviour had changed.

People's wound care plans were appropriately documented and monitored by the matron until wounds had healed satisfactorily. A Wound care audit was carried out by nursing staff on 2 February 2017. It identified if wounds were getting better and what support is in place and if further support was required. One identified that an ulcer was getting worse. As a result, this was referred to healthcare professionals for further support. Body maps and photographs were used to monitor healing and specialist nurses' recommendations were followed.

A person was having their dressing replaced and their wound treated in a certain way every three days in line with their care plan. The matron was aware of a person's bruises that they had acquired in the home. They had completed a body map, taken a photograph, and monitored skin healing through daily observations, reading staff daily logs and the completion of 'nursing care daily evaluation sheets'.

People had individual slings for staff to use, that took account of their body weight and size. People's catheters were checked in line with their continence and catheter care plan. Charts were kept in people's bedrooms for staff to complete when people had been washed and dressed for the night; their catheters checked; had their call bells, glasses and TV remotes within reach; the pressure level of their mattress checked; and that they were left comfortable.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the care staff. One person told us, "I appreciate what the care staff do for me." Another person told us, "The carers are nice. They will do anything they can for you." A third person told us, "I get on well with the staff." A relative told us, "Care staff are very pleasant and helpful." Another relative told us, "The staff are very good. The staff are helpful and you can talk to them if you have a problem."

Staff treated people in a kind and compassionate way. They enquired respectfully if they wished to be helped and get out for a 'bit of fresh air' or maybe would they like something to be brought to them. They used an appropriate cheerful tone and called people by their preferred name. Staff took time to explain to people what they were doing and if people were sitting down made sure they were at the person's level whilst speaking with them. Staff spoke clearly and slowly with people who could not hear very well or immediately understand what was said to them. When a person asked to be 'pulled up' from their armchair, the registered manager provided them with a pillow to check they were made more comfortable. A member of staff sat down to talk to a person about the country they were brought up in. We observed good interactions between nursing staff and people. Medicines were administered in a kind and caring way and nurses told people why they were here and what medicines they were taking.

Staff understood the importance of maintaining people's privacy. Staff were seen to be knocking on doors before entering people's rooms and explaining to people why they were there and who they were. No conversations regarding people's private matters were discussed by staff in communal areas. People's private information was kept in a secure location and was never seen in communal areas left unattended.

People were encouraged to be as independent as possible. Staff demonstrated good knowledge of people and how they like to be independent. One member of staff told us, "One person likes to take themselves outside to smoke." This was confirmed by the person who told us, "I go outside no more than six times a day whenever I need to smoke. I do not have to ask as staff are aware. They gave me a ramp so that I could get out by myself more easily." We also saw staff encourage people that were independently mobile to move around the home with limited staff involvement. Staff were talking to people in an encouraging tone when supporting people throughout the home and those that could mobilise independently were left to do so and staff were aware of those that could. People's records identified if people followed a religion. People and staff told us there was a church service held at the home every three weeks. The religious service was also documented in the activities folder.
Relatives told us that they were contacted by staff for updates on care. For example, one relative told us, "Staff call me when they need to alert me of something." Another relative told us, "They called us when she was admitted to hospital." However, people and relatives told us that they were not always involved in reviews, and we saw that care plans only had staff signatures could be seen to identify a review took place. People and relatives were not signing to identify that they were involved with reviews.

We recommend that the registered manager establish systems to ensure that people and their relatives are engaged in care reviews and sign care plans to show this.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us there were very few organised activities at the service. One person told us, "We used to have activities and would play games and do other things but this is no longer the case." Another relative told us, "I am fed up as there is nothing to do." One relative told us, "They used to do activities but that does not happen anymore. They sit there and watch TV."

We observed two activities that included a pampering session and a quiz. However, the timetable for activities indicated that armchair exercises should have taken place on the day. The quiz was not a long session and staff did not take time to encourage people to take part. Staff did not engage with people during the activities to encourage participation. During the quiz a member of staff was reading a set of questions from a quiz book to people sitting in the lounge. We observed that people were supported to spend time outside, as the weather was nice. However, one relative told us, "They never go outside." Between these short sessions people were seen sitting in the lounge for long periods of time watching television. On two occasions, the inspection team sat with one person in their room when they kept calling out. We asked a member of staff about the person and was told, "She normally calls out." During inspection, this person was never seen out of their room. We did see staff on occasion check the person was safe but very little interaction was seen. On one occasion, there was a member of staff sitting in the room with the person but there was there was no conversation happening between staff and the person. One member of staff told us, "If we had more staff then we could spend more time with the residents." We reported our concerns to the registered manager who told us, "The activities person is off on long term leave but we have successfully recruited a replacement activity coordinator." The successful candidate's application was seen. People, staff and relatives also told us that they were aware of the current situation regarding the activities at the service.

The registered provider had not ensured that people received meaningful activities that were personalised to their needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not have effective systems in place to record complaints. There was a complaint record book available. The last recorded complaint was 8 July 2016 and the record was not completed and finished mid-sentence. One person told us that a boiler was not working for up to three weeks last year and that they were not happy and told the manager. Another person told us, "We complained to the manager as our Nan is rarely ready for when we take her out, and nothing seems to get done." Another person told us, "My mum complained a month ago about the state of the room. This was sorted out." There was no log of any of these in the complaints book.

The registered manager had not established and operated effectively an accessible system for recording and responding to complaints. This is a breach of regulation 16 of the Health and Social Care Act 2014.

People were not completely supported to maintain relationships with people important to them. In the entrance hall there was a sign restricting visiting times to after 10:30am and that people should not visit during lunch times. One relative told us, "We were told we could not visit as it was too late by a member of

staff it was after 6pm." However, other relatives told us that they had no problems with visiting. One relative told us, "I can visit when I like". Another relative told us about visiting restrictions, "There are none." We reported our concerns to the registered manager who told us, "The sign was advisory but we will remove it."

We recommend that the registered manager ensure that people friends and relatives are free to visit the service at any time.

Pre-admission assessments gave staff the information required to start providing care to people when they arrived. The information included reason for admission, background information, health and nutritional needs. The information provided was detailed and was personalised to people's needs and was carried through into the care plans. For example if people had changes in medicine or if a wound was improving or required further assistance from other medical professionals. Information from medical professionals such as GP's, tissue viability nurses, occupational therapy and speech and language therapists was documented in the care plan and the information was put into the care plan at the next review.

People were encouraged to make their own choices at the service. People's rooms were decorated to their own choosing and included their choice of furniture and personal items. People were always given choice at each meal by staff. Each day people could choose from a selection of food choices and drinks. One person told us, "I can always choose what I want to eat, they show us a menu and we pick from that." Another person told us, "This morning I got a choice of porridge, cornflakes and toast but I decided to have a bacon sandwich instead." We saw that each day people were shown the menu and could pick what they wanted from it. The menu also included pictures to help to communicate to people what they could have. If people wanted something else, there were alternatives available for people to choose from.

Records showed that there were resident and family meetings. The last recorded meeting was 27 January 2017 and 9 people attended and no concerns were identified. There were recorded discussions regarding the new upcoming menus. A previous meeting 21/11/2016 discussed upcoming plans for Christmas and people said there were enough activities. People were also consulted about the Christmas menu.

Inadequate

Is the service well-led?

Our findings

People and relatives told us that there was a lack of visibility and ability of the registered manager. When asked about the registered manager, one person replied, "What manager?" Another person told us, "Never really see the manager, the matron is normally around." One relative told us, "I only really see the manager when bills have to be paid". Another relative told us, "The service is not managed very well, it's just bums on seats." A third relative told us, "Very approachable when here."

At our previous inspection on 7 and 8 April 2016, the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered manager had not kept people's records up to date. At this inspection, we found that the registered manager was still not compliant with this regulation.

People's records were not organised to ensure staff could access information quickly. People's care files were kept in folders that were stored on top of each other in one drawer, some were worn and unkempt with dividers and pages that came away and as a result, information was not easy to find. The matron was able to locate a particular care plan that we requested to see only after a thorough search. The provider was aware of the need to improve the way information was stored and accessed in the nurses' station. They had commissioned a person responsible for restructuring the service's filing system. One person's records clearly stated that a person did not want to be resuscitated after the date of this a do not attempt cardiopulmonary resuscitation (DNACPR) was put in place by medical professionals in consultation with the person and their family. The DNACPR was easily seen in the care plan but the person's records had not been updated to reflect this. In another person's records, it showed in their moving and handling assessment that the person was able to stand independently, however a care assistant advised that the person was unsteady on their feet. This person's care plan was last reviewed 28 December 2016.

The failure to ensure that people's records were kept up to date is a continuing breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had failed to ensure that effective auditing was taking place to identify shortfalls within the service. There were audits in place for cleaning, care plans, catering, maintenance and care planning. The care planning audit was completed 17 December 2016 and an individual care planning documentation audit on 31 January 2017. These did not identify the concerns we raised regarding ensuring that people's records were up to date.

Medicine audits were carried out every two months and the last one recorded 18 January 2017. It identified that some medicines were missed, some people were refusing medicines and these needed to be disposed of correctly. The medicine audit failed to identify the concerns we found regarding the management of medicines. General maintenance checks were not being completed. A room safety check was supposed to be completed weekly this had been done until 11 January 2017 no further records were available. The last maintenance audit was carried out 29 December 2016. The only concern identified was that staff were not wearing protective clothing when required. Staff were seen to wear protective clothing during inspection.

There was no accident or incident audit being carried out by the registered manager. This means that any patterns relating to accident and injuries would go unnoticed.

The failure to ensure effective monitoring systems is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not informed the Care Quality Commission (CQC) of notifiable events, such as allegations, injuries and incidents, as set out in the CQC (Registration) Regulations 2009. These include safeguarding referrals to the local authority, outcomes of deprivation of liberty safeguards (DoLS), death of service users and any events that cause a service to run efficiently. Records showed that the registered manager had failed to notify the CQC of a safeguarding incident that was identified in a complaint. The registered manager had also failed to notify the CQC of outcomes of Deprivation of Liberty Safeguards, and had failed to notify the CQC of a boiler failure that prevented the service running properly for over a 24-hour period. One relative told us, "The home was not running effectively for around 3 weeks."

The failure of the registered manager to notify the CQC of the above incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider did not ensure that people, relatives and staff were consulted through feedback to identify shortfalls and good practice at the service. Meetings did take place with residents and these were advertised in the entrance hall for family to attend. However, there were no surveys completed by people, relatives and staff in 2016. The last questionnaire completed was a relative questionnaire in October 2015 to which eight relatives replied. There were no concerns identified. There have been no other surveys completed by people, relatives or staff since this date.

The failure to ensure that the registered provider seek and act on feedback from relevant persons and other persons on the service provided is a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 The registered manager failed to notify the Care Quality Commission of notifiable incidents. Regulation 18(c)(g)(4A)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager had not ensured that people and their relatives were actively in encouraged to participate in their care. Regulation 9(3)(a) The registered provider had not ensured that people received meaningful activities that were personalised to their needs. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered manager had not ensured that the service was properly maintained. Regulation 15(1)(e) The registered manager had not ensured that all areas of the service was clean.

Regulation 15(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager had not established and operated effectively an accessible system for recording and responding to complaints. Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed at the service. Regulation 18(1)

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 registered provider had not ensured the proper and safe management of medicines. Regulation 12(2)(g) The registered manager had not done all that is reasonably practicable to mitigate risks. Regulation 12(2)(b)

The enforcement action we took:

Conditions on registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to ensure that people's records were kept up to date. Regulation 17(2)(c) The registered manager had failed to ensure effective monitoring systems to identify shortfalls within the service. Regulation 17(2)(a) The registered provider had failed to seek feedback from relevant persons and other persons on the service provided. Regulation 17(2)(e)

The enforcement action we took:

Conditions on registration