Care Quality Commission

Prime Healthcare UK Limited

Ranelagh Grange Care Home

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?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We visited this service on the 30 April and 5 May 2015. Both these visits were unannounced.

Ranelagh Grange Care Home is registered to provide accommodation for persons who require personal care. The home accommodates up to 35 people and bedrooms are located on the ground and first floor of the building. There were 34 people living at the home at the time of this inspection.

The registered manager has been in post since August 2014. 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.

During our previous inspection of the home in December 2014 we found that improvements were needed in relation to how records were managed; people's rights in relation to decision making; the premises; the

Summary of findings

identification and management of risks; planning people's care and support and the monitoring systems in place to measure the quality of the service people received.

At this inspection we found a number of breaches and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We found that the registered provider did not always provide a safe environment for people to live. Potential risks to people had not been considered or planned for in relation to equipment in use. We found that bedrails were in use but risks to people using them had not been documented. Equipment was found in a person's bedroom that was known to create a risk to the individual. These risks had not been considered or their care planned for.

Improvements were needed in relation to planning people's care and support. Not all of the people living at the home had care plans in place detailing how their needs and wishes were to be met.

We found that people's needs were not being met in relation to the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. This meant that the rights of people who were not always able to make or communicate their own decisions or needed their liberty restricting for their safety were not protected.

Records were not always in place or information was not recorded in relation to staff recruitment and people's care needs.

Insufficient systems were in place for the provider to monitor the quality of the service that people received at the home. This meant that failing areas of improvement were not identified and planned for.

The provider had failed to notify us, as they are required to do, of events that had occurred in the home. For example, the death of a person who lived at the home.

Sufficient staff were on duty to meet people's needs. Staff knew how to keep people safe from abuse and knew who to contact if they had concerns about people.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

The registered provider and the registered manager had not made the improvements required at the last inspection to make people safe.

We found that some areas of the home did not always promote the safety and wellbeing of people. Risks to people had not been identified and planned for and plans were not in place to support people safely in the event of an emergency.

People told us they felt safe in the home. Staffing levels were sufficient to meet people's needs.

Is the service effective?

Inadequate 

The service was not effective.

The registered provider and the registered manager had not made the improvements required at the last inspection to provide an effective service for people.

We found that no action had taken place to ensure that when required, people's rights in relation to decision making was maintained.

Not all of the people living at the home had a plan of care and on occasions people's needs in relation to nutrition were not planned for. The lack of planning available in relation to people's dietary needs could put people's health and wellbeing at risk.

Is the service caring?

Requires improvement 

The service was not always caring.

Systems were not in place to promote people's dignity and independence in relation to personal hygiene as soap was not available in people's bedrooms.

We observed staff treating people in a manner that respected their privacy. People and their relatives told us that staff were caring and friendly.

Is the service responsive?

Inadequate 

The service was not responsive.

The registered provider and the registered manager had not made the improvements required at the last inspection to make this a responsive service for people.

People's needs and wishes were not assessed and planned for and therefore people were at risk of not receiving the care and support they needed.

Summary of findings

Care planning documents were not available to people or the staff team delivering care and support to people. This meant that staff were not aware of all of people's needs.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager in post.

The registered provider and the registered manager had not made the improvements required at the last inspection to ensure that this is a well led service.

The registered provider did not have effective systems in place to monitor the quality of the care and service people received whilst living at the home. This meant that people's changing needs in relation to their care and support and their living environment were not identified and acted upon.

Ranelagh Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 30 April and 5 May 2015. Both of these visits were unannounced.

The inspection team on the 30 April 2015 consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal or professional experience of using this type of service. The inspection team on the 5 May 2015 consisted of two adult social care inspectors.

We spent time observing the support and interactions people received whilst in communal areas. We spoke with 13 people living at the home and five of their visiting relatives. In addition we spoke with the registered manager and six members off staff.

We looked at areas throughout the building and the immediate outside grounds. We spent time looking at records relating to people's care needs and the records of nine people in detail. We also looked at records relating to the management of the home which included duty rotas; policies and procedures in place and the recruitment information for four staff members.

Before our inspection we reviewed all the information we held about the service. This included any notifications received from the registered manager, safeguarding referrals, concerns about the service and any other information from members of the public. We contacted the local authority intelligence and outcomes unit who told us that they were currently monitoring the service. We also contact the local fire and rescue service for information relating to their most recent report on the home.

Inadequate

Is the service safe?

Our findings

At our inspection in December 2014 we asked the provider to take action to make improvements to people's living environment; identifying and assessing risks to people. We asked the provider send us an action plan telling us what action they had taken. No action plan was received from the provider.

People and their relatives told us that they felt the home offered a safe environment. However we found that areas of people's living environment needed improvement. In five of bedrooms we visited, we found there was a very unpleasant odour and in two of the rooms, and communal lounge areas we found the carpets were sticky. The registered manager said that the unpleasant odour was coming from the carpets, however, we lifted the bed clothes on one person's bed and found that the mattress also omitted an unpleasant odour. We spent time in the communal lounge and conservatory. We found that these areas also had a very unpleasant odour. Staff told us that the source of the odour was the chairs that people were sat in. Relatives commented that the home was in need of some refurbishment and that was taking some time.

We saw that designated fire doors were wedged open. One door, for example, leading from the dining room to the stairs and designated fire exit was held open by two wheelchairs being stored in the area.

We saw that one person's bed had a mattress that failed to fit the bed appropriately. This resulted in a large gap between the end of the mattress and the metal base and headboard of the bed. The gap was sufficient to cause an injury to the person. We brought this to the attention of the registered manager during the inspection.

Few bedroom doors had working privacy locks. The registered manager told us that five bedrooms had locks that automatically engaged when the doors were closed and staff were required to open these door with a key. This meant that people were not always ensured privacy or were able to access their bedrooms independently.

The provider was not ensuring people were protected against unsafe or unsuitable premises and equipment.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people who used the service were not protected against the risks associated with unsafe or unsuitable premises and equipment.

We found that potential risks to people were not always assessed and planned for. We saw that bed rails were in use and no risk assessment had been developed to consider any potential risk that this equipment could present to people. In addition, we saw information relating to another person that clearly identified a potential risk from certain pieces of equipment. On visiting this person's bedroom we saw two pieces of equipment that could cause potential harm within the room. No risk assessment had been developed to consider the potential risks that this equipment could present to the individual.

The registered manager told us that there were no personal evacuation plans for people living at the home. He told us that he was working on these documents. This meant that the risks faced by people when evacuating the building in an emergency had not been planned for. The lack of this information meant that staff were not able to ensure people's safety if emergency situations arose. During our second visit the passenger lift had broken down. This resulted in people not able to use the stairs could not access their bedrooms for the period of time the lift was out of order. The lift had also broken down the previous week. The registered manager told us that there was no risk assessment completed to consider people's safety or access around the building in the event of the passenger lift not working.

The registered manager said that he was not aware of any contingency plans in place within the home for use in the event of an emergency.

The registered provider and registered manager did not ensure that people were protected against receiving inappropriate or unsafe care and support.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected against the risk of receiving care that is inappropriate or unsafe.

Medicines were not always safely managed. For example, we saw that a cabinet used for the safe keeping of specific

Inadequate

Is the service safe?

medicines was not secured to the wall. In addition the cabinet was too small to store the amount of these medicines in use. We found that the medicine cabinet was also being inappropriately used to store people's jewellery, staff wage slips, perfume and other personal items.

On the second day of our visit medicines no longer in use had been collected to be returned to the pharmacy to be disposed of. However, we saw that medicines that had not been required for four months were still stored in the home in a large plastic container. This demonstrated that people's medicines were not always managed, stored or disposed of in relation to current best practice guidance. The National Institute for Health and Care Excellence (NICE) guidance dated 2014 provides recommendations for good practice on the systems and processes for managing medicines safely in care homes. This includes clear guidance on the storage of medicines within a care home.

We asked the registered manager for a copy of the medicines management policy and procedures. He told us that he was in the process of producing these documents. No further information was made available to us in relation to the safe management of medicines.

The registered provider and registered manager was not ensuring the proper and safe management of medicines.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from the proper and safe management of medicines.

The registered manager demonstrated a clear understanding of what was required to ensure that new staff were recruited appropriately and safely. However, we saw that records relating to staff recruitment were not available for each individual member of staff. The registered manager told us that out of the 35 staff employed at the home only 27 had a complete recruitment file. Evidence made available to us failed to demonstrate that only people suitable for the role were employed within the service.

The registered provider and registered manager did not ensure the proper and safe recruitment of staff.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected as effective recruitment procedures were not in operation

A copy of the local authority's safeguarding procedures were available within the home. The registered manager and staff were able to tell us what action they would take if they felt that a person had been abused or where at risk from abuse.

Sufficient staff were on duty at the time our visits. We did not observe people having to wait for care. Three care staff, a senior carer and the head of care where on duty to meet the needs of people. In addition, a number of catering and ancillary staff were on duty. Visiting relatives commented on the number of staff on duty. They told us that they had noticed an increase in staffing in recent weeks. In addition, other relatives told us that the cleanliness of the lounge floors had improved since an afternoon ancillary worker had been employed to work in the afternoons.

Inadequate

Is the service effective?

Our findings

People told us that they were able to move around the downstairs of the building freely.

People described the food served at the home as "good" and "alright" and that the soup was particularly good. They told us that drinks were available all day long.

At our inspection in December 2014 we asked the provider to take action to make improvements to how people's rights were protected in relation to decision-making and staff training. We asked the provider send us an action plan telling us what action they had taken. No action plan was received from the provider.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager demonstrated a good awareness of identifying the appropriate times in which to and how to apply for a DoLS on behalf of individuals and had access to the local authority's policy and procedure on DoLS. We saw that these procedures had not been adhered to. The registered manager told us that he estimated that 29 people living at the home required a DoLS application to be completed, however, the registered manager told us that none of these applications had been made.

No records were available to demonstrate that the principles of the Mental Capacity Act 2005 had been used to assess an individual's ability to make a particular decision. The registered manager confirmed that there were no procedures in place to record people's consent or to inform or support best interest decisions made on behalf of people.

The lack of DoLS applications and lack of implementation of the Mental Capacity Act 2005 failed to ensure that the rights of people, who were not able to make or communicate their own decisions were protected or that people were being deprived of their liberty within the legal framework.

The registered provider and registered manager did not ensure that systems were in place to ensure that people's rights were protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards..

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from inappropriate deprivation of their liberty.

We requested an up to date record of what training staff had received for their role. The registered manager supplied us with a document that had last been updated in March 2015 and told us it did not reflect the training that staff had attended. We requested that an updated training matrix be sent to us following the inspection. This information was not made available to us. The information that was made available demonstrated that out of the 20 care staff employed three staff had completed training in death, dying and bereavement, 14 staff had completed training in the role of the care worker and hand hygiene and five staff had completed moving and handling training. Staff we spoke with told us that they had not all received training in moving and handling which they thought was important to their role. Two staff who had undertaken training in moving and handling said they felt that the training could be improved as they thought there was a lack of understanding with regard to current methods of moving and handling people safely. Training records made available and information from staff spoken with demonstrated that staff had not undertaken all of the training required for their role.

An induction policy and procedure was in place. The procedure stated that all new members of staff will successfully complete an induction programme to the standard of the Skills for Care Common Induction Standards within 12 week of their appointment. The training matrix failed to demonstrate that staff had completed any of this induction training. In addition, staff told us that they had not received an induction into their role.

Staff spoken with told us that they did not receive regular supervision or have the opportunity to discuss their role with their line manager. Three staff spoken with told us that they had not received any formal supervision. The registered manager told us that he had completed a number of staff supervisions but records were not available for these meetings. The registered manager was able to demonstrate that four staff had received supervision for their role.

Inadequate

Is the service effective?

The registered provider and registered manager did not ensure that people were protected by ensuring they received care and support from an appropriately trained and supported staff team.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not supported by staff who had always received appropriate training and support for their role.

There was a lack of care planning documents available to in relation to people's dietary needs and wishes. Staff spoken with told us that they were verbally informed by senior staff of people who had diabetes and therefore staff knew that the sugar intake for these people should be limited. No further information relating to people dietary needs and prefences were available to staff supporting people.

We saw that people's needs in relation to nutrition were not planned for. For example, records demonstrated that one person had lost approximately 6.5kg in weight over a period of five months. We saw no evidence of monitoring of this person's diet, and staff were unable to produce evidence that the person's food intake was being monitored other than size of meal that the person had been served. There were no records to demonstrate what actual food the person had eaten. Staff told us that advice had been sought from a speech and language therapist as well as a dietician in relation to this weight loss. There was no evidence that advice received by professionals had been recorded. An eating and drinking care plan had been developed and stored on a laptop computer. The plan stated "diet and fluid intake is to be monitored and documented throughout the day and night as she only eats and drinks a very small amount." This information was not printed or available to staff delivering care and support to the person.

The registered provider and registered manager did not ensure that people's nutritional needs were assessed and planned for.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the nutritional needs and wishes of people were not always planned and monitored.

People were seen to take their meals in the communal dining room and the lounge areas. We observed people being offered and given support with their meal, for example, with the cutting out of foods when required. People were given a choice of two cooked meals for lunch. Plate guards were available to assist people to eat their meals. A plate guard attaches to a plate to help prevent people's food falling off their plate whilst eating. We saw that the menus had recently been changed. The registered manager explained these changes were following a survey completed by people in relation to their preferences. The menu for the day was displayed in the dining room.

We saw that there was insufficient seating available in the dining room and the lounge areas in the event of all people wishing to use these rooms. A visitor commented that there was a lack of quiet space for people to spend time in. In addition, they told us that the lounge areas could get crowded when people were visiting. Another relative commented that people sitting in the lounge for meals needed proper tables or trays to rest their food on instead of the small side table that were around the room. The lack of appropriate seating and tables available may fail to give people the freedom to sit when and where they wish or to eat their meals comfortably.

Requires improvement

Is the service caring?

Our findings

The majority of people and their relatives told us that staff were caring and friendly. Two relatives told us that some staff were better and more friendly than others but had no complaints. Other relatives told us that they had been "Quite impressed" with some of the newer staff.

People told us that staff were respectful and treated them with kindness. One person told us that staff always knocked before entering her bedroom.

We saw that improvements could be made in promoting people's dignity and independence. For example, soap was not available in people's bedroom en-suite toilets. The registered manager told us that soap for these en-suite toilets was not supplied by the service. This meant that a number of people had to leave their own bedroom to wash. Staff told us that a supply of toiletries were available for people to purchase, however, these toiletries were products designed for men. This demonstrated that people were not supported to access soap and toiletries of their choice.

We saw staff supported people in a caring manner. For example, people were supported to mobilise around the building in an unrushed manner with staff giving assurances when people needed it. Staff were able to tell us about how they cared for people and they demonstrated an awareness of people's choices, likes and dislikes in relation to what time they got up in a morning and went to bed, how and where they liked to eat their meals and their personal care preferences. Staff told us they gained this information from talking to people and requesting the information from other staff.

Staff offered reassurance and support to people to maintain their independence. For example, one person appeared agitated whilst waiting for their lunchtime meal to be served. Staff reassured them that their meal was on its way which calmed the person. Another person who liked to walk in and out of the dining room was gently supported by staff to sit and have their meal. Staff accompanied the person when they wanted to leave the dining room to the lounge where they wished to go.

We saw that staff supported people in a caring manner. For example, we saw a member of staff asked one person sat by the front door if they were cold and if they wanted to put some extra clothing on.

Throughout our visit we saw staff treated people with respect. For example, staff spoke with people in a respectful manner and it was evident that evident that positive relationships between people and staff had been made.

Information was made available to people in the form of a service user guide. Since our last inspection the registered manager had updated the document and told us that a copy of the service user guide was available in each bedroom. The document made reference to the homes philosophy of care, medicines, complaints, confidentiality and the admission process.

Inadequate

Is the service responsive?

Our findings

At our inspection in December 2014 we asked the provider to take action to make improvements to how people's care was assessed, planned and recorded. We asked the provider send us an action plan telling us what action they had taken. No action plan was received from the provider.

A choir visited the home during our inspection. However, we found that otherwise there was a lack of activities and stimulation for people. Relatives commented and we saw that there were no planned or organised activities available. People told us that they had a weekly keep fit session which was enjoyable and good exercise. We observed people sat mainly in communal lounge areas watching television and on one occasion staff were seen to demonstrate exercises to people along with music playing in the same area in which others were watching television. This resulted in people being unable to hear the television. The registered manager told us that they were currently advertising for an activities worker. Staff spoken with told us they felt people did not receive sufficient mental and physical stimulation.

During this visit we saw that no improvements had been made as to how people's care needs and wishes were assessed, planned for and recorded. The registered manager told us that new care plans were in the process of being developed for people and the documents were stored on a computer. We looked at the computer and saw that an electronic file was available for 17 of the 35 people in residence. Three out of the 17 electronic files contained completed care plans for people. The completed care plans were not person centred and there was no evidence that the three people had been included in the care planning process. Care staff told us that they, and the people who used the service had no access to the information stored on the computer.

Written care plans that had been in place at our previous inspection had not been reviewed or updated since our last visit. The registered manager told us that this was because new care plans were being developed.

A number of people were living at the home for a short period of time. We saw that a needs assessment had been completed prior to them moving into the home. However, no care plans had been devised for them which meant that staff could not meet their needs. For example, one person's pre-admission assessment stated they had mental and physical health needs however, there was no information available to staff as to how to assist the person with these identified needs. Another person's pre-admission assessment stated that they had mental health needs, physical and medical needs. There was no information available to staff as to what care and support the person required. This put people at risk of not receiving the care and support they required.

The registered provider and registered manager did not ensure that people received the appropriate care and support as their needs and wishes were not planned for.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people the needs of people who use the service were not planned for.

People told us that they knew who to speak to if they had a concern. The registered manager told us that no complaints or concerns had been raised by people since we last visited. The Care Quality Commission had received four concerns relating to the service since January 2015. These concerns had been passed to the local authority for investigation.

A copy of the newly devised service user guide was available in each person's bedroom which stated that each person would be provided with a copy of the complaints procedure. We saw no evidence of this procedure during our visits and no complaints procedure was visible around the building informing people of how to make a complaint , how it would be handled, investigated and responded to. The information available to people failed to demonstrate that an effective system was in place for the management of complaints.

The registered provider and the registered manager did not ensure that effective systems were in place for complaints to be managed.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was no system in place for people's complaints to be managed.

Inadequate

Is the service well-led?

Our findings

At our inspection in December 2014 we asked the provider to take action on how the service people received was assessed and monitored. We asked the provider to send us an action plan telling us what action they had taken. No action plan was received from the provider.

There was a registered manager in post who registered with the Care Quality Commission in August 2014. People who used the service were aware of who the registered manager was. Relatives told us positive things about the registered manager. Their comments included "Seems a caring sort", "Doesn't expect staff to do anything he wouldn't do himself" and "Approachable and hands on."

There were no systems in place for the provider to monitor the amount of hours staff were working within the home. For example, we saw records that demonstrated that the registered manager had worked in excess of 100 hours a week on a number of occasions since we last visited.

We saw that there were no effective systems in place for the monitoring of the service that people received. For example, we saw that people's care planning documents, when in place, had not been reviewed, identified risks for individuals had not been assessed and planned for and the lack of the review of records had failed to identify when information was not available, missing or required updating.

Accurate records in relation to people who used the service and staff were not maintained which put the health and safety of people at risk of not receiving the care and support they required. In addition, a lack of information for staff as to how they needed to support individual's put both people and the staff at unnecessary risk of harm.

Identified environment risks had not been addressed which could put people at risk from unnecessary harm. Records relating to the monitoring of the environment were not available. For example, the registered manager told us that the records maintained of water temperature checks and fire detection equipment had been lost. Other records relating to staff supervision, staff meeting minutes and recruitment were not available. The home manager demonstrated a new auditing system that had been purchased by the registered provider to monitor the service. However, only one of these audits in relation to maintenance had been completed.

Monitoring records that were in place in relation to people's care and support were not always completed. A record used to outline what people had eaten and what personal care they had received were to be completed daily by staff. We saw that these records were not always completed. For example, there was no record of one person receiving food or personal care for a period of three days. Due to the lack of monitoring systems in place this information had not been seen or addressed.

Daily checks of the cleanliness of people's bedrooms were recorded. However, we saw that these checks were not effective. For example, people's bedrooms had been recorded as being thoroughly cleaned but we saw that the carpets were sticky and omitted a strong, unpleasant odour. This demonstrated that there were no effective monitoring systems in place for the environment.

We saw, and the registered manager confirmed that there were no systems in place to record and monitor accidents and incidents that occurred. The registered manager told us that he was in the process of implementing a new monitoring system, however, this was not as yet in use.

An analysis of use of the call bell system was made available. We saw that one person had activated their call bell in their bedroom 153 times during a six day period. We reviewed the daily notes of the person and saw that there was no reference that the person had used their call bell, nor was there any information which explained why the nurse call had been used for that amount of times. The registered manager told us that he was aware that the person used the call bell frequently as they were particularly anxious over a number of issues. There was no evidence that this information had been recorded or the person's needs had been planned for in a manner that alleviated their anxiety. This demonstrated that effective systems were not in place to ensure that health, safety and wellbeing of people who used the service.

The registered provider and registered manager did not ensure that proper systems were in place to assess, monitor and plan for the service people received.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.

Inadequate

Is the service well-led?

Information gained during the inspector from the registered manager demonstrated that they had failed to notify the Care Quality Commission of the deaths of three people who lived at the home.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Since the previous inspection meetings for the relatives of people living at the home had been arranged and taken place. Relatives told us that they had attended these meetings which had been chaired by the registered manager. They told us that issues raised at the meeting included the poor state of some of the lounge chairs.

Relatives were pleased that these chairs had been removed but there was slight frustration that the chairs had not been replaced. One relative told us that as a result of telling the registered manger that there was a need for more cleaning in the lounge areas during the afternoon staff had been employed to do this.

The registered manager demonstrated that he had developed questionnaire to be sent to people, their relatives and staff to gather their views on the service provided at the home. He told us that these surveys were scheduled to be sent throughout the year. None of these surveys had been sent at the time of the inspection.