Tudor Care Limited

Beechfields Nursing Home Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 and 19 June 2017 and was unannounced. At our previous inspection on 4 October 2016, the service was rated as requires improvement overall. Improvements were needed to ensure people were supported with decision making, and that quality assurance systems were effective in bringing about improvements.

At this inspection we found that the improvements seen at the last inspection had not been sustained and we identified further concerns with the management of risks associated with people's care and medicines. Failure to sustain past improvements meant that breaches of the regulations identified at our inspection in November 2015 had reoccurred, giving us little confidence in the provider's ability to deliver improvements for people living at the home. We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive or well led. The overall rating for this service is Inadequate which means it will be placed into 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.

Beechfields Nursing Home is registered to provide accommodation and or nursing care for up to 35 people. At the time of the inspection 29 people were using the service, all of whom required nursing care.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found staff did not always follow people's care plans to reduce the risk of avoidable harm and when

people's needs changed, staff did not always act on specialist advice to ensure identified risks were minimised as far as possible. People's nutritional and hydration needs were not effectively recorded and monitored to ensure their individual needs were met. People's medicines were not administered, stored and recorded safely.

People were not always protected from the risk of abuse because systems were not in place to ensure concerns would be escalated for investigation by the local safeguarding team if needed. Accidents and incidents were not always recorded and monitored to ensure that investigations could take place to minimise the risk of reoccurrence.

Staff were caring in their approach but people were not always treated with dignity and respect. Staff sought people's consent before supporting them but did not always follow legal requirements when supporting people who lacked the capacity to make their own decisions. People did not always receive personalised support when they needed it.

At lunchtime, staff were not effectively deployed and people did not receive support that met their individual needs. We have recommended that the provider reviews their staffing levels to ensure there are sufficient staff available to meet people's needs at all times. The provider did not follow safe recruitment procedures to ensure staff were suitable to work with people.

The systems in place to monitor and improve the quality and safety of the service were not effective. There was a lack of leadership and organisation in relation to staff performance and receiving the training they required to fulfil their roles effectively. People and their relatives felt able to raise concerns and complaints but did not always feel action was taken to resolve them. The provider had not listened and acted on people's feedback to ensure improvements were made where needed.

People were supported to take part in activities that they enjoyed to reduce their risk of social isolation and loneliness.

We found a number of breaches of the regulations. You can see what action we have asked the provider to take 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?

Inadequate

The service was not safe.

People's care plans were not always followed to ensure that their risk of avoidable harm was minimised. People's medicines were not being managed safely. Systems in place to ensure people were protected from the risk of abuse were not always effective. The provider did not ensure there were sufficient, suitably recruited staff to meet people's needs at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not being cared for by staff that were trained and supported to fulfil their roles. The principles of the Mental Capacity Act were not being followed effectively. There was a lack of effective monitoring and support to ensure people were supported to eat and drink sufficient amounts. Although we identified some concerns, people felt supported to access other health professionals to maintain their day to day health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always respected by staff and their dignity was not always promoted. Staff had a good rapport with people and cared about their wellbeing. People's relatives were made welcome at the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual needs and preferences. People and their relatives felt able to raise concerns and complaints but did not always feel action was taken to resolve them. People were supported to take part in social activities that they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of management and oversight of the service by the provider. The systems to monitor and improve the service were not effective and they failed to address previous concerns. People's feedback was not acted on to ensure improvements would be made where needed. The registered manager did not feel supported by the provider to fulfil their role and there was a lack of leadership for staff. Some requirements of their registration with us were not being met.

Beechfields Nursing Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 19 June 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a trained nurse, and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information of concern we had received and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We spoke with the service commissioners who are responsible for finding appropriate care and support services for people, which are paid for by the local authority. We had received information of concern from the local authority safeguarding team about how risks to people's nutritional needs were being managed. We used all this information to formulate our inspection plan.

On this occasion, we had not asked the provider to complete 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. However, we offered the provider the opportunity to share information they felt was relevant with us.

We spoke with seven people who used the service and ten family members. We also spoke with four members of the care staff, a nurse, the deputy manager and the registered manager. We did this to gain views about the care and to ensure that the required standards were being met.

We spent time observing care in the communal areas to see how the staff interacted with the people who used the service. Some of the people living in the home were unable to speak with us in any detail about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

We looked at the care records for seven people to see if they accurately reflected the way people were cared for. We also looked at records relating to the management of the service, including medicines administration records, premises and equipment checks, recruitment and training records and staff rotas.

Inadequate

Is the service safe?

Our findings

We found that staff administering medicines did not always follow safe practice to ensure that people received their medicines as prescribed. For example, on some occasions the nurse administering people's medicines had not checked that they had taken the medicine before signing the medicine administration record (MAR). We saw that people's medicines were supplied to the home in personalised pots, which contained the medicines needed for each timed dose. At breakfast time, we saw that at least two people had pots of medicine on the table in front of them. A member of staff came to take one person to the communal lounge when another member of staff noticed that the person had not taken their medicines and went after them with the pot. However, we were unable to confirm if they had taken their medicines. After breakfast, we found a pot of medicines left on the table in the dining room labelled up for a person. Neither the person or the nurse was present in the room. On checking the records, we saw that the MAR had been signed that the medicine had been given that morning. People told us and we saw that medicines were sometimes left in people's rooms. One person told us, "The nurse brings my medication into my room in a pot and leaves it for me; they trust me to take it, but I suppose I could throw it away and they wouldn't know".

We saw that medicines were not always stored correctly to minimise the risks to people and to ensure they remained safe to use. Some people had been prescribed thickeners to be added to their drinks to reduce the risk of them choking. We saw these were kept in people's rooms which meant there was a risk that other people could access them. This meant people were not being protected from the risks associated with this medicine. We brought this to the attention of the registered manager. Following the inspection, they confirmed that this medicine was now being stored securely.

In addition, some people were prescribed topical creams to maintain their skin integrity which were stored in the fridge as required by the manufacturer. We saw that the date of opening had not been recorded on any of the tubes in use which meant the provider could not be sure if the medicine was within its use by date and therefore safe to administer. We discussed this with the nurse administering medicines who could not tell us what the provider's policy was on the safe storage of creams and removed the creams from the fridge for disposal. This meant staff were not always following national and local guidance which recommends that creams in tubes should be used within three months of opening.

At the last inspection, we asked the provider to ensure protocols were in place where people were prescribed medicines on an as and when required basis and saw that the provider had not acted on this. We saw that there was no protocol in place for one person who had been prescribed medicine to reduce their anxiety when they displayed behaviour that challenged their safety and that of others. The medicine had been given on a daily basis for the three weeks shown on the MAR chart. There were no records to identify the reason the medicine had been given and no review of the number of times it was given. This meant there were no suitable systems in place to ensure that these medicines were given in a consistent way.

These issues are a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We found that risks associated with people's care were not always well managed. Where people had been identified to be at risk of losing weight, a nutritional care plan was in place but this was not always followed. For example, one person had lost 2.4kg in weight between January and April 2017. Their care plan stated that they should be weighed weekly and any further weight losses should be reported to the GP or dietician. We checked their records and saw that they were only being weighed monthly and in May 2017, they had lost a further 2.56 kg. There were no further weight recordings after this time and the weight loss was not referred to the GP or dietician. This meant the person was at risk of further weight loss.

We found the provider did not have suitable systems in place to ensure people's nutrition and hydration needs were regularly reviewed and action taken when their needs changed. For example, we saw that staff did not monitor a referral made in April 2017 for a person who had lost 5.8kg in weight. We found they had overlooked a request for further information made by the dietetics service and as a result the person had not been seen by the dietician. Records showed that the person had not been weighed since the referral had been made. The registered manager told us there had been problems with the scales at this time and they had been without them whilst they were repaired. However, no alternative method of assessing the person's nutritional risk had been used during this time. For example by measuring their upper arm circumference to estimate their Body Mass Index. This meant the provider had not taken appropriate action to ensure the person was protected against the risk of further weight loss.

We brought our concerns to the attention of the registered manager. Following our inspection, they told us that these people had been weighed and referred to the dietician for further advice.

We saw that staff did not always follow good practice guidance from professionals and adopt control measures to make sure identified risks were as low as is reasonably possible. One person received their nutrition through a percutaneous endoscopic gastrostomy (PEG) because they had swallowing problems. The nutrition nurse had visited in February 2017 and recommended a change to the person's care plan to reduce the risk of problems that had occurred around the PEG site. Discussions with the nurse demonstrated that they were not following this advice. We checked the person's care plan and saw that it had been reviewed in May 2017 but had not been updated to reflect this advice. This meant the person was being put at risk of avoidable harm.

Risks associated with people's mobility had been assessed and risk management plans were in place to guide staff on how to support people to minimise any identified risks. However we saw that staff did not always follow these plans when they supported people to move using equipment. For example, on a number of occasions, we saw that staff did not ensure footplates were affixed to people's wheelchairs when people were transported around the home, which put people at risk of injury. We brought this to the attention of the registered manager who told us they would remind the staff that footplates should be used at all times.

These issues are a breach of Regulation 12 (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2016, we found that the registered manager had made improvements to ensure pre-employment checks were carried out before allowing new staff to work with people. However, at this inspection we found the improvements had not been sustained. Staff told us the registered manager had carried out a check with the Disclosure and Barring service but they were unsure if their references had been followed up. One said, "I had to wait two weeks for my DBS but I don't know if the manager contacted

my old boss as I didn't work in care before". The DBS is a national agency that keeps records of criminal convictions. We saw that written references were not always obtained for new staff and the registered manager had relied on verbal references, which had not been documented on the staff member's file. The registered manager told us they had not requested an alternative reference to assure themselves that the staff member was suitable to work with people. This demonstrated that the provider did not have a safe recruitment process in place.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt there were not enough staff available to meet their needs. One person said, "There are days when you don't see any staff for ages which I suppose could be a concern if someone has fallen or is unwell". Another person said, "The staff are very nice but sometimes quite stressed trying to run around everywhere". A relative told us, "The staff do their best but there are days when they are really short staffed. On the day of our inspection, a member of staff had called in sick and a member of staff extended their shift to provide cover. We spent time observing the communal areas and although at times there were no staff present for periods of up to 30 minutes, we did not see people waiting for support. Call bells were usually answered within five to ten minutes. However, at lunchtime we found staff were not effectively deployed to ensure people were supported to have a relaxed, sociable dining experience. One person said, "I have my food in my room and by the time I get it it's often cold and not very nice. I also have to have help but the carers are so busy, it is a rush and I have to eat quickly. I cannot have a rest between my dinner and pudding because they have to go to help somebody else". We saw that staff were rushed when taking meals to people's bedrooms and returned quickly to collect another meal which showed they did not spend time with people. In the dining room, there were two staff supporting thirteen people with their meals and they were unable to respond when some people needed encouragement with their meals. For example, we saw a person became upset and their nose was running into their dinner. A member of staff noticed and called out to them but was not able to go over to assist them as they were supporting another person. After some time, the nurse came in and went to support the person, but they had not eaten much of their dinner and by this time it was cold.

We discussed our observations with the registered manager. They could not demonstrate how they determined staffing levels and how staff were deployed to meet people's individual needs. There was no evidence that they reviewed the staffing levels with the provider to ensure there were sufficient staff to meet people's needs at all times.

We recommend the provider reviews staffing levels against people's individual needs to ensure there are sufficient staff at all times.

At the last inspection, we found the provider had made improvements to ensure staff understood their responsibilities to protect people from the risk of abuse. At this inspection, we found the improvements had not been sustained and the staffs' understanding of safeguarding people was inconsistent. New staff had not received safeguarding training and existing staff had not received an update since March 2016. Discussions with staff showed that some were not aware of how to escalate concerns to the local safeguarding team if they felt the registered manager had not taken appropriate action. Our records showed that the registered manager had referred a safeguarding concern to the local safeguarding team and notified us of the incident. The registered manager told us that they contacted the local safeguarding team for advice when staff raised concerns with them. They added that if no further action was required, they did not record these incidents or notify CQC. This meant we could not be sure that they took action to ensure all safeguarding concerns were investigated appropriately.

People told us they felt safe living at the home. One person said, "I have never come to harm or had a fall or anything so I think we are safe here". Relatives we spoke with felt their relations were safe and well cared for. One said, "I feel very confident that [Name of person] is being well looked after and is safe here".

Requires Improvement

Is the service effective?

Our findings

At the last inspection, we asked the provider to make improvements to ensure that they consistently followed the Mental Capacity Act (2005) MCA when they supported people with decision making. The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection, we found that the required improvements had not been made. There were a number of people living at the service who lacked the capacity to make certain decisions for themselves. The registered manager told us they had undertaken training but our discussions with them showed that they did not understand how to apply the legislation on a day to day basis, to uphold people's rights. For example, records showed us that the registered manager and nursing staff had made the decision for some people to have bed rails, to keep them safe whilst they were in bed. However, no mental capacity assessment had been carried out to demonstrate that these people could not make the decision for themselves. Another person's care records showed that the consent form for them to have bed rails had been signed by another person. We saw that their relationship to the person had not been recorded and the registered manager could not identify the signature and could not tell us if the person was authorised to make decisions for this person under a Power of Attorney ruling. This is legal authorisation which enables decisions to be made when a person loses the capacity to make the decision for themselves. This meant we could not be sure that these people's rights were being upheld.

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 saw that the registered manager had submitted applications to the local supervisory authority and an approval had been received. However, we saw that the approver had noted that the staff were making other best interest decisions for this person and had not carried out capacity assessments as required. We discussed this with the registered manager who told us, "I think the GP is dealing with that for us as the nurses don't feel comfortable doing mental capacity assessments". However, the registered manager could not show us any records to confirm this. This showed us that the registered manager and nursing staff did not recognise their responsibilities under the MCA or DoLS.

We spoke with care staff and found that their knowledge of the MCA and DoLS was inconsistent. Some staff were able to demonstrate a basic understanding of the legislation and knew about a DoLS application that had been made for a person. However, other staff lacked understanding and told us, "It's down to the nurses to deal with people who can't make decisions". This meant people could not be assured that their rights would be upheld.

This is a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People told us the staff sought their consent before supporting them with personal care. One person said, "They always ask before they do anything and I am never forced". We observed staff offering people choices such as where they wanted to sit or what they wanted to eat. One person told us, "They do try and encourage me to do things but I never feel forced". This showed us staff understood the importance of consent where people had the capacity to make their own decisions.

At the last inspection, we found that the provider had made improvements to ensure staff were appropriately trained and supported to meet people's needs. At this inspection, we found that these improvements had not been sustained. Records showed that staff training was not up to date and we observed poor practice in the safe management of medicines, a lack of understanding of how to apply the MCA and uncertainty about how to escalate safeguarding concerns. We found the registered manager had failed to introduce the supervision programme they showed us at the last inspection. Staff told us they had not received supervision or an annual appraisal for some time. This meant the registered manager did not have systems in place to review staff performance to identify shortfalls in the care practice and support.

People told us there were new staff working at the service who lacked the knowledge and experience to understand their needs. One person said, "There are a lot of new carers and they are still getting used to who we are and they don't all recognise what I do and don't need and like yet". Another person said, "I am not quite sure what training the staff have, but there have been some new staff recently. They appear to be watching one day what the other carers do and the next day they are doing it themselves". Newly recruited staff told us they had undergone an induction which involved shadowing experienced staff and had received training in safe moving and handling from a senior member of staff. However, the registered manager could not provide us with records to evidence this. The registered manager told us senior staff within the home were accredited to provide safe moving and handling training. However, records showed that their accreditation had expired in May 2017 and it had not been renewed and we could not be sure they were up to date with best practice. This meant people may be cared for staff who do not have the skills and knowledge to meet their needs effectively.

This is a breach of Regulation 18 (2)(a) or the Health and Social Care Act (Regulated Activities) Regulations 2014.

As noted under the question 'Is the service safe?', we found staff were not effectively deployed to ensure people received the support and encouragement they needed to have a relaxed, sociable mealtime experience . People gave us mixed views about the quality and choice of meals. Some people told us they enjoyed the meals but others said the choice of food was limited. One person said, "There could be a bit more choice, as I don't always like what they serve". A relative told us, "There is a cooked meal at lunchtime and there is one main meal choice. If you don't like it then they will do jacket potato or soup, but the choice is very limited". We saw people were offered drinks and snacks at various times throughout the day.

Although we have identified concerns with referrals to the dietician service, people told us they were able to access other health professionals, including the GP, dentist and the optician to maintain their day to day health.

Requires Improvement

Is the service caring?

Our findings

Most people and their relatives told us the staff were kind and caring in their approach. Comments included, "The carers are really lovely and look after me very well" and, "They are a grand bunch of lasses, I can't praise them enough". However, some people felt the staff didn't always listen to them and did not always treat them with respect. One person said, "Most of the staff have a very caring attitude and do as I ask. However, one or two think they know best and don't listen to me". Another person said, "I do sometimes tell them I am not comfortable or that my clothes do feel a bit twisted and not on properly. They don't all listen to me and just say they look ok. This doesn't really help me because I know how they feel and I have to put up with it then". A third person told us the staff did not always treat them with respect when supporting them with personal care. They said, "Sometimes carers will talk over me when they are washing me and don't involve me. They are talking about what they did last night and other personal issues; I don't think this is very respectful".

We observed that staff did not always ensure people's dignity was promoted. We saw that a person was in bed undressed, with the door open. We had to intervene to bring this to the attention of a member of staff who went to support them. Discussions with staff showed that they were aware that the person did not like to wear pyjamas and preferred to have their bedroom door open. However, there was no evidence that the staff were required to check the person periodically to make sure they were covered with a sheet to maintain their dignity. At lunchtime, we saw a member of staff supporting a person with their meal. The member of staff spent the whole time squatted next to them instead of sitting down with them to ensure their dignity was promoted.

At other times, we saw staff respected people's dignity and respected their privacy. We observed they knocked on people's bedroom doors before entering and asked people for their consent and explained what they were doing before supporting people. Staff told us they promoted people's dignity by covering people with a towel when providing personal care and always gave people privacy when they were using the bathroom. We saw staff had a good rapport with people. Staff acknowledged people when they came into the room and commented on their appearance when they had been to the hairdressers. We heard one member of staff say, "Whit woo, your hair looks lovely". Staff checked people were comfortable and brought blankets to cover them when they were sleeping. This showed staff cared about people's wellbeing.

People had a choice over how they spent their day. We saw that most people had a regular chair or place to sit which they had made 'their space'. We saw that one person moved freely around the home using their wheelchair. Staff told us they encouraged people to be as independent as they wished when supporting them with personal care. One member of staff told us, "I always encourage people to brush their teeth and their hair if they are able".

People were encouraged to maintain their important relationships. We saw staff chatted with people's visitors and knew them well. A relative told us, "We are made very welcome".

Requires Improvement

Is the service responsive?

Our findings

We found that people were not always supported to have care plans that reflected how they would like to receive their care and support. People's needs were assessed before they moved into the home and the information was used to draw up a care plan. However, this did not always include information about people's preferences and most told us they had not been invited to take part in reviews. One person's family members told us their relative liked to get dressed each day even though they were nursed in bed. They told us that this rarely happened and most of the time they found the person in their night clothes when they visited each day. They also told us their relative liked to follow a specific routine for their personal care but this was not always respected by staff. We saw that the person's wishes had not been reflected in their care plan.

We also found that people did not always get the right support when they needed it. For example, a relative told us there had been delays in sourcing a new wheelchair for their family member, "[Name of person's] wheelchair is no longer appropriate and they are now confined to bed. We have been seen by the wheelchair service and a new one ordered but this was over six weeks ago. I am concerned that they are stuck in here whilst the weather is better over the summer and they will miss it". Another person's family told us a piece of equipment had been recommended by the occupational therapist but they were delays in trying to source this through the home and interim measures put in place did not meet the person's preferences. Discussions with the registered manager showed that they were aware of these delays. However, they could not assure us that they were supporting these people to obtain the support and equipment they needed in a timely way.

People and their relatives were happy to raise any concerns or complaints. However, some relatives felt their concerns were not always responded to when they spoke with staff informally. One told us, "I have had a meeting with the manager to raise concerns but no action has been taken". Another relative told us, "I recently raised a complaint with the manager. She said she would speak to staff and maybe she has but it hasn't filtered through yet". There was a complaints procedure in place. We saw that formal complaints were recorded and responded to but there was no evidence that verbal complaints were recorded and investigated to ensure people's concerns were always listened to and acted on.

People and their relatives were positive about the activities co-ordinator and told us they enjoyed the social activities and events at the home. One person told us, "[Staff member] is always very jolly and tries to keep us occupied. He does some good events has made a horse racing game which is a good laugh and we like that. He does try and show an interest in us and help us to maintain some independence and keep us motivated. I particularly like the music events". Another person said, "The activities are not that often but they are an enjoyable experience and we have a chance to sing along to things". There was an activities programme displayed in the home. On the day of our inspection we saw that some people were having their nails done and others joined in a game of bingo. In the afternoon there was a party to celebrate father's day, which was well attended by relatives and friends. Relatives were positive about the activities offered at the home. One said, "The activities chap likes to keep people motivated with various events and activities. They

have a drop down screen and put films on". This showed us people were provided with opportunities to take part in activities to avoid the risk of social isolation and loneliness.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at the service who had been in the role since 2014. During this time they told us they had received little support from the provider, evidenced by a lack of arrangements to review their performance and discuss any support needed on a regular basis. The provider visited the service from time to time to check people were receiving a good service. However, these checks had not identified the lack of progress in addressing the concerns raised at previous inspections. There was no documented quality assurance checks and no improvement plan to bring about the required changes. This demonstrates a lack of management and oversight by the provider and a lack of input into the service to support the manager to deliver the required improvements. We found that breaches of the regulations identified at our inspection in 2015 have reoccurred, which gives us little confidence in the provider's ability to deliver improvements for people living at the home.

We found that no improvements had been made to medicines audits since the last inspection. We saw that monthly audits were completed but these had failed to identify the shortfalls we found with the administration, and storage of medicines. The provider did not have suitable policies and procedures for staff to follow. We found there was no procedure for staff to follow when a medicine had been missed. For example, one person was prescribed a weekly medicine which had been missed on 7 June 2017. The medicine was found to be still in the box and the nurse could not give us an explanation as to why the medicine had not been given. Neither the nurse or the registered manager could tell us the provider's policy and what action they should take when a medicine was missed. This meant there was no system to ensure errors would be identified promptly or to ensure people received their medicines as prescribed.

Staff did not consistently follow the instructions provided on the MAR chart where people had refused their medicines. This could lead to confusion and potential for people not to receive their medicines as required. In addition, the checks of medicines that required additional controls were not robust and did not follow good practice. For example, we found that staff did not check the stock of these medicines against the register and it took some time for staff to reconcile a discrepancy we identified. This meant the systems in place were not effective in ensuring people were being protected against the risks associated with medicines.

We saw there was a lack of clinical oversight of monitoring records, which meant that action was not always taken when people's needs changed. For example, the nurse told us they monitored the food and fluid intake charts for concerns. We saw that the fluid charts did not identify a target amount and were only kept for a two day period before being filed so it was not possible to see at a glance if the person had received sufficient food or fluids. One person's care plan stated they should have an average of two litres of fluid per day. We saw that over a two week period, their intake did not reach this level and was under 500 ml on two consecutive days. However, we saw no evidence that this had been reviewed or any action taken. We saw that their food intake chart was not always completed and where they had declined meals or prescribed supplements, there was no evidence of any action taken. This meant we could not be sure that the person was being supported to have sufficient to eat and drink to maintain their health.

At the last inspection the registered manager showed us the monthly audit they would be carrying out on care plans. At this inspection, we saw these checks had not been implemented. Some of the care records we looked at were not up to date. For example, some people's risk assessments had not been updated on a monthly basis as required by the provider which meant there was a risk that they did not reflect people's current needs. The provider had also failed to take action to ensure that people's care plans were locked away to ensure people's personal information was being kept confidentially.

We found that the systems to record and monitor accidents and incidents were not effective. The manager was only able to show us records from April to June 2017 and could not confirm if there were other records missing. This meant we could not be sure that all accidents and incidents were being recorded. In addition, the registered manager told us they had not carried out any monitoring and could not demonstrate what action had been taken to reduce the risk of reoccurrence.

At the last inspection, the registered manager told us the provider planned to make improvements to the front door bell system in response to feedback received from people and their relatives. At this inspection, we found that no improvements had been made. One relative told us, "I have told them so many times about the doorbell but it has still not been sorted". Another said, "You have to wait ages when you arrive for the door to be answered, it is the same sound system as the call buzzers and I have mentioned it so many times to them". This meant the provider had failed to act on feedback to drive improvements in the service.

We found that effective systems had not been implemented and maintained to ensure the environment was safe for people. We saw that a recent fire risk assessment had been carried out and some recommendations had been made. The registered manager told us these improvements had been carried out although they could not provide us with information to evidence this. No checks had been carried out to ensure hot water temperatures were maintained at a safe level and checks to minimise the risks associated with legionella bacteria were not up to date. We saw that areas of the home were cluttered, for example on the first floor, staff did not ensure that hoists, wheelchairs and linen skips were put away after use. This could create a trip hazard and place people at risk of falls. In addition, there was no system for people or staff to report faults such as missing light bulbs to ensure they would be promptly addressed.

We saw that the registered manager did not carry out infection control audits to periodically check that the environment was clean and hygienic, to protect people from the risk of infection. Areas of the home we not as clean as they could be, for example we saw some carpets needed to be hoovered and some were stained. A relative told us, "We clean the room because the carpet isn't always hoovered and the skirting boards aren't wiped clean". We saw that housekeeping staff completed daily cleaning schedules of communal areas but discussions with the registered manager did not assure us that these were checked to ensure the home environment was clean and safe for people. Following our inspection, we raised our concerns with the quality lead at the Clinical Commissioning Group, who has arranged for an infection control audit to be carried out by the local health and social care partnership trust.

These issues are a breach of Regulation 17 (1)(2)(a)(b)(c)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the registered manager had notified us of important events that occurred in the service. However, as noted above we could not be sure that all accidents and incidents had been recorded and notifications sent to us as required. In addition, the registered manager had not recognised the need to notify us of the DoLS approval that had been received. This meant the registered manager was not consistently acting in accordance with the requirements of their registration with us.

We saw that a copy of the last inspection report was on display in the hallway of the home. The registered manager told us they would ensure a copy of their ratings poster was also displayed. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager and staff were not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to continually assess, monitor and improve the quality and safety of the service. The provider did not act on feedback received from people and their relatives, to enable them to evaluate and make improvements in the service. Regulation 17 (1)(2) (a)(b)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not follow safe recruitment procedures to ensure person's employed were of good character. Regulation 19 (2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider was not ensuring there was appropriate induction, training and supervision for staff to enable them to carry out their role.

Regulation 18 (2)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely. Regulation 12(2)(g) Risks to people's safety were not effectively managed. Regulation 12 (2)(b)(c)

The enforcement action we took:

We issued a Warning Notice.