Coate Water Care Company (Church View Nursing Home) Limited

Chapel House Care Centre

Inspection report

Horton Road
Gloucester
Gloucestershire
GL1 3LE

Tel: 01793821200
Website: www.coatewatercare.co.uk

Date of inspection visit:
26 July 2016

Date of publication:
19 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Chapel House Care Centre on the 26 July 2016. Chapel House Care Centre is a residential and nursing home for up to 41 older people. Many of these people were living with dementia. 16 people were living at the home at the time of our inspection. This was an unannounced inspection.

We last inspected in March 2016 and found that the provider was not meeting some of the regulations. We found that people did not consistently receive safe care and treatment, because staff had not always administered their medicines as prescribed. Additionally staff were not always effectively deployed and did not have access to training and support. The provider did not have effective systems to monitor and improve the quality of service people received. Following our inspection in March 2016, we issued a warning notice to the provider requesting they take action to meet the fundamental standards in relation to staffing and good governance by 30 June 2016.

At our inspection on 26 July 2016, there wasn't a registered manager in post. The previous registered manager had left the service prior to this inspection. 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.

The provider did not have effective systems to monitor the quality of service people received. Audits were not consistently carried out and when shortfalls in the quality of the service had been identified, appropriate action was not always taken to drive improvements. People and their relative's views had been sought; however action had not been taken in response to their views. Relatives told us they did not always feel their views had been listened to.

People did not always receive their medicines as prescribed. Staff did not always keep an accurate record of the support they had provided people with their care, treatment and medicines.

People we spoke with were positive about the home. They felt safe and looked after. People enjoyed the food they received in the home and had access to food and drink. People had limited access to one to one activities and external entertainment, and did not always benefit from meaningful engagement from staff.

Staff were deployed effectively to ensure people were kept safe and their basic needs were met. Not all staff had the skills they needed to meet people's needs, because staff did not have access to training and support they needed to meet the needs of people, such as those living with dementia.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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. People did not always receive their medicines as prescribed. Staff did not always accurately record the support they had given people around their medicines.

Staff were deployed within the service to ensure the safety of people and protect them from risk. There was a high level of agency staff working at the service who did not always know people's needs, The management were managing this by recruiting staff.

Staff knew the risks associated with people's care and had guidance to manage them. People felt safe, and staff understood their responsibilities to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. People were supported by staff who did not always have access to the training and support they needed to meet people's needs.

People received support to meet their nutritional needs and had access to plenty of food and drink. People were supported to make choices, however not all staff had received training in relation to the Mental Capacity Act 2005.

People were supported to attend healthcare appointments. Staff followed the guidance of external healthcare professionals.

Is the service caring?

Good

The service was caring. People were supported to spend their days as they choose. Staff respected people and treated them as equals.

Staff knew people well and understood what was important to them such as their likes and dislikes. People were treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not always responsive. People's care assessments were not always current or accurate. Staff did not always keep a record of the care and support they had provided people.

People and their relatives had previously raised concerns about activities. An activity co-ordinator had recently been employed. There was limited evidence of the activities and interactions people received.

People did not always receive their care in a way which was in accordance with their personalised needs.

The provider responded to complaints and people felt confident they could raise concerns to staff.

Is the service well-led?

Inadequate

The service was not well-led. Audits carried out by the provider identified some shortfall or concerns in the quality of the service; however effective actions were not always taken. Audits had not been consistently applied.

People and their relative's views had been sought; however no action had been taken in response to these views. Relatives felt their views were not always acknowledged and they were concerned about the approachability of the management.

Agency staff received information which would enable them to meet people's needs.

The provider had not acted on requirements made following the last inspection and the service had a history of not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Chapel House Care Centre

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 was 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 26 July 2016 and was unannounced. The inspection team consisted of two inspectors.

At the time of the inspection there were 16 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with two healthcare professionals and both local authority and clinical commissioning group commissioners about the service.

We spoke with six people who were using the service and with six people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four care staff, an activity co-ordinator, an administrator, an agency cook, an agency nurse, an operations manager and director of operations working on behalf of the provider. We reviewed eight people's care files, care staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2016, we found staff were not always effectively deployed to ensure people were safe and that their care needs were met. Additionally people did not always receive their medicines as prescribed. People's prescribed medicines were not always stored in accordance with the manufacturer's guidelines. These concerns were a breach of regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of June 2016. At this inspection we found the provider had taken action to ensure there were enough staff deployed to meet people's needs, however people were still being placed at risk of not receiving their medicines as prescribed.

There was evidence that some agency nurses were not always acting in accordance with the proper and safe management of medicines. For example, agency nurses had not always given two people their medicines in accordance with their prescription, however they had recorded they had administered these medicines.

Nursing staff did not consistently keep an accurate record of when they assisted people with their medicines. For example, staff had not always signed to say when they had administered medicines or kept a record of prescribed medicine stocks or when they had opened people's prescribed medicines.

Three people were at risk of not receiving their medicines as prescribed. The dosages of their prescribed medicines were different from their medicine administration records. There was a risk people may not always receive their medicines as prescribed because an accurate record had not always been maintained. This also meant that the provider would struggle to confidently ensure prescribed medicine stocks were correct, or if people had received their prescribed medicines.

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

People's medicines were stored in accordance with manufacturer's guidelines. Nursing staff recording the temperature of the room medicines were stored in. These recordings showed the temperatures were within the recommended range of the manufacturer. People's prescribed medicines were stored securely. This meant the risk of people's prescribed medicines being inappropriately used was reduced.

People and their relatives told us there was enough staff deployed on a daily basis to meet people's needs. Comments included: "Basic needs are being met, but that's it"; "The staff are busy, it's the basic needs they provide" and "There is someone if I need them" and "They come when I press my bell."

Staff told us there usually was enough staff deployed to meet people's needs. Comments included: "I think we have enough staff at the moment"; "staffing is alright" and "We have enough staff on the shifts I work to meet people's needs. It is usually okay."

People's relatives raised concerns around the consistency of staff. One relative told us, "There is no

consistency in staff, there is so much agency being used (to staff the service)." Another relative said, "(One day) only one member of staff, all agency staff. Most of the good staff are gone." Staff reflected these concerns and discussed the impact it had on their workload and people who lived in the home. For example one member of staff told us how they had to support agency staff to meet people's care needs; they explained that as many people were living with dementia, they were often resistive to unfamiliar care staff. They said, "They come and ask how I can do that, because I have more experience. Sometimes I'm asked to do medicines. I don't do anything without the nurse watching."

We discussed relatives and staff concerns of the consistency of care staff with the director of operations and operations director employed by the provider. They explained they were recruiting trained nurses, a new manager and were carrying out interviews for domestic staff. They told us they had booked agency, to ensure there were enough staff deployed to meet people's needs.

Records relating to the recruitment of new care staff showed relevant checks had been completed before staff worked unsupervised at the home. Disclosure and barring checks (criminal record checks) and references were sought for staff member's to ensure they were of good character.

People were protected from the risks associated with their care. Staff had clear guidance regarding assisting people with their mobility needs, and concerns relating to pressure area care. For example, one person's risk assessments provided clear guidance on how staff should assist them to move safely, including the equipment they needed to ensure the person was safe and comfortable. Where people required assistance to reduce the risk of developing a pressure sore, staff had clear guidance to follow and understood the importance of following these guidelines. For example, one member of staff told us how they followed guidance to ensure one person was protected from the risk of pressure area damage. They told us, "We have no concerns."

Maintenance workers carried out tests around the premise to ensure people lived in a safe environment. For example, Portable appliance tests (test of electrical appliances) had been carried out on electronic equipment. Areas of the home which were not safe for people or visitors were safely secured to reduce the risk. Fire safety checks had been carried out and fire safety inspections, legionella's inspections were also carried out.

People and their relatives told us they felt the home was safe. Comments included: "I'm safe here. I wouldn't stand for trouble"; "Absolutely safe" and "I don't feel (relative) is in danger physically."

People were protected from the risk of abuse. Care staff had knowledge of types of abuse, signs of possible abuse which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, "I would go to the nurse in charge, or the manager if they are around." Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to local authority safeguarding or the CQC. They said, "I am aware of local authority safeguarding. I can call them".

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2016, we found that staff did not always have the skills they needed to meet the needs of people living in Chapel House Care Centre. This concern was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action regarding this concern. The provider gave us an action plan which stated they would meet the relevant regulation by the end of June 2016. At this inspection we found appropriate action had not been taken. There had been a significant turnover with care and nursing staff which had an impact on people living at Chapel House Care Centre.

People were not always supported by staff who had access to the training they needed to meet people's needs. People's relatives felt staff had not been adequately trained to carry out their role. Comments included: "The staff are not trained, It's (Chapel House Care Centre) supposed to be a dementia specialist, and it isn't"; "Staff haven't got dementia training. Staff don't know how to deal with dementia. They haven't got the skills."; "Agency staff don't know the people." Healthcare professionals also raised concerns regarding both the consistency and skills of staff within the home. One healthcare professional told us staff tried their best however did not always have the skills they needed. They said, "The home has consistently refused support with training staff. Unfortunately there are no or few regular staff and the home appears dependent upon agency staff. This makes training almost impossible."

Staff told us they did not always feel they had access to the training they needed. One member of staff said, "I was put on dementia training, I couldn't go due to staffing. I can't request training." The service's training records showed only a limited number of staff had received and completed training around fire safety, manual handling and health & safety. Additionally not all staff received training around dementia care, the Mental Capacity Act 2005 (MCA 2005) or the Deprivation of Liberty Safeguards (DoLS). Some staff were employed on a bank (or as required basis). These staff often had employment and trained at other care homes. We spoke with one bank staff member about the training they had received. The member of staff told us the provider of Chapel House Care Centre had not checked this training to see if they had the skills to meet people's needs at the service.

The registered manager had not carried out competency assessments of staff to identify their individual training and support needs. Some staff recently employed by the provider had worked in other adult social care establishments; however no assessments had been done to establish if the provider or registered manager was happy with staff skills.

People were not always supported by staff who access to effective supervision (one to one meetings with their line managers). Staff told us they had not always received supervision or an appraisal from their line manager. Comments included "I haven't" and "Not here, no." There were very few records of supervision meetings on staff care files.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent and agreement was asked for by staff before they delivered their care. We observed on many occasions staff asking people if they were happy for staff to support them with specific tasks. For example, help someone to the toilet, help them to bed or help them to eat. Some staff were aware of the Mental Capacity Act 2005 and the principles that underpin this. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. While not all staff had received training, they all spoke positively how they promote choice and people's individuality. One staff member told us, "Some residents can make simple decisions. We use mental capacity assessments to understand if people can't make a decision." Another staff member said, "Never ever force anyone. Try and offer choice. If people refuse then try and come back."

The provider and representatives of the provider ensured where someone lacked capacity to make a specific decision, mental capacity assessment and if necessary a best interest assessment was carried out. For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they were to leave the service unsupervised. The provider made a Deprivation of Liberty Safeguard (DoLS) application for this person. 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).

People told us they enjoyed their food. Comments included: "The food is alright, sometimes it could be better, it can be difficult to please everyone", "The food is very nice"; "I can eat with my wife, the food is always tasty" and "I like the food".

On the day of our inspection the home's chef was unavailable. An agency chef was working to provide the meals. People told us they enjoyed the food they had this day. Most of the people living at the service chose to go to the dining room for lunch where there was a pleasant atmosphere. Food was generally well presented and the agency chef and care staff were aware of people's dietary needs. One person required a soft diet, and their food was clearly presented in a way in which the person could identify the different colours and flavours.

Where people had specific dietary needs, staff and the agency chef were aware of this. For example, one person needed a gluten free diet. The person was supported to have the diet they needed to ensure their wellbeing was maintained. Where people were losing weight staff took action to ensure they were protected from the risk of malnutrition. This included supporting people with their dietary needs and encouraging calorie rich foods.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People's care records showed relevant health and social care professionals were involved with people's care. For example, records of appointments with healthcare professionals were also scanned onto the services computerised care planning system to ensure information was stored safely and securely.

Good

Is the service caring?

Our findings

People and their relatives had positive views on the caring nature of care staff. Comments included: "Staff seem excellent. Staff are polite, it's a lovely place, they've got their issues, but the care is good"; "Everyone here is alright with me"; "(Relative) is looked after"; "They look after me they do" and "I find them very attentive. I think they're brilliant."

Care staff often interacted with people in a kind and compassionate manner. Care staff adapted their approach and related with people according to their communication needs. For example, one person struggled to communicate verbally. A staff member slowly talked to the person at eye level, which enabled the person to see their face. The staff member looked at the person's body language to ensure the person was comfortable and to enable them to identify if the person was happy when they offered them a choice.

Care staff did not always speak to people by their preferred them. For example, one member of staff used generic terms when engaging with people. There was no negative impact by this and people appeared to enjoy the interaction. We discussed this with the director or operations who was already aware of this, and was planning to discuss this with staff at the home.

Staff spoke to people as an equal and supported them to maintain their independence. For example, we observed the agency nurse assist someone with their mobility. The person was walking with equipment and the nurse stood in front of them, slowly encouraging them. The nurse was able to see the person was tired and offered them clear support of either walking or taking a seat. The nurse supported the person in a friendly and positive way. The person chose to have a seat and was then supported to enjoy their lunch in this chair.

Care staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs with staff, most confidently spoke about them. For example, one care staff member was able to tell us about one person, including how they liked to spend their days and the things which were important to them at tea time, such as a small alcoholic drink with their lunch. The person told us they enjoyed their daily drink and enjoyed life within the home. They said, "They're alright here."

People were able to personalise their bedrooms. One person had items in their bed room which were important to them, such as pictures of people important to them. Staff respected the importance of people's bedrooms. They ensured people's bedrooms were kept clean and knocked on bedroom doors before entering. Staff used a monitoring system at night, which alerted staff to people who walked with purpose at night and were at risk of falling. Staff told us this enabled them to protect people from harm and helped staff ensure people were safe without disturbing their privacy.

People were treated with dignity and respect. We observed care staff assisting people throughout the day. One person experienced a fall during the inspection. Care staff worked quickly to ensure the person's dignity was respected and ensured that they had not suffered an injury. They ensured the person was assisted with their door closed and gave the person reassurance and attention, this had a positive impact on the person

and they were calm.

People were supported to make advanced decisions around their care and treatment. For example, one person was asked for their views of where they would wish to be treated in the event of their health deteriorating. The person, with support from their family had decided they wished to go to hospital and have any treatment which would sustain their life. Another person had made a decision with their family that they did not wish to be resuscitated in the event of cardiac arrest, and this had been clearly recorded on a Do Not Attempt Resuscitation form.

Inadequate

Is the service responsive?

Our findings

At our last inspection in March 2016, we found that people's needs and the support they received were not always accurately recorded. Where people's needs had changed, their care records did not reflect this. This concern was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action regarding this concern. The provider gave us an action plan which stated they would meet the relevant regulation by the end of June 2016. At this inspection we found that while some improvements had been made, people's records were not always current and reflective of their needs.

People's care plans did not always reflect changes in their needs. For example, care staff had recorded that one person had lost a significant amount of weight over one month. Whilst this had been recorded, their care plan had not been amended to reflect this change. Guidance was not documented on how this person should be supported to protect them from the risk of malnutrition. During our inspection this person was supported to be weighed as part of monthly weight checks. This identified the person's weight had increased. We discussed our concern about how staff did not respond to this information with the director of operations and operations manager, who told us they would address the matter.

Care staff did not always keep a record of the support they had provided people within the home. For example, people's daily records had not always been maintained or updated on the provider's electronic care plan system, and paper records stored in people's rooms had not been updated. Additionally a number of people were on food and fluid charts. These records had not always been completed consistently prior to the inspection, and also gave no guidance to staff on how much people needed to drink. There was limited evidence that care staff, nurses or management were reviewing these records. One person required repositioning when they were in bed to protect them from the risk of pressure damage. Care staff did not always keep an accurate record of when this person was assisted with their repositioning during the night and day. Care staff told us the person's pressure area was intact, and they were supported to reposition regularly. Gaps in day time recording were often down to the person leaving their bed, however staff did not always record this change. We discussed this concern with the director of operations. They were planning to review people who were being monitored and ensure staff understood the purpose of why they were monitoring people's intake to ensure their needs were being met.

People's care records were not always current or reflective of their needs. Staff had not always recorded the support they provided people. These issues were a continuation from our March 2016 inspection. These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive consistent personalised care in accordance with their needs. For example, we observed two people required assistance from care or nursing staff with their nutritional needs, which included support to eat and drink at mealtimes. We observed one person who was sitting in a communal space with a cup of tea and plate of toast, the tea and toast had gone cold. Shortly after, we observed a member of care staff assist this person with a cup of tea and some biscuits. The person needed continuous

encouragement and for the member of staff to place the biscuits in their hand. Later the person was given a snack of a drink and crisps; however they were not supported to have their snack. Care staff informed us the person needed encouragement, prompting and support to enjoy their meal; however the person's care plan stated they were independent and did not require support with their meals.

One person's care plan stated they required assistance from care staff to assist them with their meals. The care plan guides staff to provide the person with a visual choice of their meals (show the meal choices or with a picture) to place the cutlery in their hand to help them to start eating. We observed this person at lunch and they did not receive this support. The person was left with the meal in front of them for over 10 minutes until a member of staff came to assist them.

People living with dementia were not always supported in a way which promoted their choice or wellbeing. For example we observed one member of staff assisting people in a communal lounge. The staff member assisted one person with a drink; they approached the person from behind without speaking and lifted the drink to their mouth. The person was agitated, calling out whilst moving their head away from the drink. The staff member put the drink down and said, "I'm not trying to poison you." The same member of staff approached another person from behind and used direct language, saying "You need to drink." The person drank their drink; however this approach did not support the person's choice.

The care and support people received was not always personalised to their physical needs. A number of people were having aspects of their care and treatment recorded such as their food and fluid intake and personal hygiene support requirements even though no individual risks or a therapeutic need had been identified. For example, four people's personal hygiene was being monitored; however there was no understanding of why this was being done, or how this recording was being used to identify concerns or changes in their needs.

People and their relatives told us a range of activities had not always been provided to people living at the service and that staff did not always have time to spend with them. One relative told us, "In two years there has been no activities, we've been promised, it's never happened. There has been odd things, very irregular. Residents are sat in the lounge with no communication, (relative) needs stimulation and consistency. That's just not happened." Another relative said, "There is a lack of stimulation. There is no engagement with staff. The staff are too busy."

The home had appointed a new activity co-ordinator. The activity co-ordinator was new in post and had had shadowed another activity co-ordinator from another home owned by the provider. The activity co-ordinator told us they provided activities to people including knitting and one to one charts. One person told us they enjoyed there chats, "It's nice to have someone to talk to." People enjoyed a singing session provided by an external entertainer. The activity co-ordinator told us the entertainer was booked by the previous activity co-ordinator. One relative told us, "They've had a singer today, it doesn't happen a lot."

Staff did not always take time to talk with people and provide meaningful activities. We observed two staff members sat with people in the afternoon, staff sat with people as they watched TV; however they failed to engage people in a meaningful way. Three people enjoyed a conversation between themselves. People's care records did not show the support people received regarding the activities.

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

People's relatives told us they were informed of any changes to their relative's needs or any incidents. One

relative told us, "I'm happy as things stand. They rang last night, fallen out of bed." People's care records showed often showed where staff had contacted people's family to ensure their needs were being met.

The provider had a complaints policy. People and their relatives told us they knew who to contact if they had concerns around the service. Two people we spoke with told us they would tell the care staff or the nurse if they were unhappy with their care. Since June there had been two complaints made to the service. These complaints were stored on a complaints record and had been responded to in accordance with the provider's policy. The director or operations informed us, that complaints made prior to June 2016 would be stored on people's individual care records. They had recently implemented a new recording system to enable them to build a record of complaints and analyse them.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service in April 2015 we found the provider and former manager did not have effective systems to monitor the quality of the service. The views of people, their relatives and staff were not always acted upon. This concern was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider a warning notice in relation to regulation 17 for the provider to take action by 30 June 2015. At this inspection we identified that while some improvements had been made, these improvements were not consistently carried out and the provider had not taken full action in relation to the warning notice.

Since the service was registered with CQC in June 2014, the service has had five inspections and has never fully met the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider does not have effective systems to identify concerns, such as staffing, staff training and supervision and records to self-regulate and ensure people receive safe, effective care and treatment. Whilst the staff had the skills to ensure people receive safe care and treatment they did not always have the skills to meet the needs of people living with dementia. The provider had not taken effective action to ensure the service met the regulations.

People and their relative's views were not consistently sought or acted upon. The last survey of people and their relative's was carried out in June 2016.The results showed whilst there were positive responses, there were also areas where people and their relatives felt the service was either satisfactory or poor. People and their relatives expressed dissatisfaction with the amount and variety of activities within the home and support around their spiritual and cultural needs. There was no response or actions from the provider in response to these comments. The director of operations stated that due to the significant changes in the management of the home, there had been no relatives meeting and one was not planned in the short term. However they had supplied relatives with information regarding the management changes in the home. Three relatives felt negatively about the management of the service and the lack of continuity with the management. Comments included: "I like the staff. Don't speak to management a lot. The one constant is (administrator) at reception. Always someone I can go to"; "There is no consistency of management. The management say they're going to do something, but it never happens" and "There is something wrong with the management. They haven't got the skills and management. There is no direction." Two healthcare professionals raised concerns about the consistency of the management and staffing of the service. One told us, "There has been about six managers since the service opened. The staff try their best; however they don't have clear direction."

Whilst the provider had some audits which were effective, these audits had not been used consistently. Representatives from the provider carried out audits around management of medicine and people's care records. For example, the medicine audits for June had identified issues around missed signatures and room temperatures being higher than expected. Action had been taken around ensuring room temperatures and a new air conditioning unit had been acquired and was now in use. However, actions around errors in people's medicine administration recordings and possible administration errors had been identified, but actions to ensure these concerns were addressed were not effectively taken. Additionally care plan audits,

showed where concern had been identified in people's care records. However appropriate action had not been taken as concerns were still identified at this inspection.
Audits which had been implemented by the provider following our March 2016 inspection had not been consistently carried out prior to our July 2016 inspection, following the departure of the registered manager. Therefore there were limited effective systems in place to identify and address the concerns identified at this inspection. The provider had a training plan; however this plan was not specific. On the day of our inspection, the provider had no current training matrix record to identify the skills staff had and the support they required. We discussed this concern with the director of operations, who provided us a copy of the services training matrix after our inspection.

The service had a continuous improvement plan. The director of operations updated this improvement plan following our inspection on the 26 July 2016. This plan contained action plans which included ensuring all staff received effective training and for the service to have an overview of the training needs for staff. A number of these actions had been set for completion on the 1 July 2016. These actions had not yet completed, with an action deadline date that had not been reviewed.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns were a continuation of the breach we identified at our inspection in March 2016.

At the time of our inspection the service was reliant on the use of agency staff to ensure safe staffing numbers. Relatives, staff and healthcare professionals raised concerns over the sustainability of the service as a number of staff, including the registered manager and clinical leads had left the service prior to our inspection. We discussed this concern with the director or operations. They told us they were in the process of recruiting a new management team for the service. In the meantime an operations manager for the provider was managing the service on a day to day basis.

Whilst agency staff were being used to provide care and support for people, they told us they had the information they required to meet people's daily needs. For example, an agency nurse had information they needed regarding people's prescribed medicines and healthcare needs. An agency chef told us they received clear information and support regarding people's dietary needs. Agency nurses had access to the service's electronic care planning system although people's records were not always accurate.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. Regulation 9 (1)(a)(b)(c).

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
Treatment of disease, disorder or injury	People did not always receive safe care and treatment. People did not always receive their prescribed medicines. Regulation 12 (f) (g).

The enforcement action we took:

We are imposing a positive condition on the registered provider in relation to Chapel House Care Centre.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not maintain accurate, complete and contemporaneous record in respect of each service user Regulation 17 (1)(2)(a)(b)(c)(e).

The enforcement action we took:

We are imposing a positive condition on the registered provider in relation to Chapel House Care Centre.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Not all staff had the skills to meet people's needs, as they did not always have access to appropriate support (one to one meetings with their manager) or training. Regulation 18 (2)(a).

The enforcement action we took:

We are imposing a positive condition on the registered provider in relation to Chapel House Care Centre.