Sun Care Homes Limited

The Gables Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 September 2016 and was unannounced.

Accommodation for up to 26 people is provided in the home on two floors. There were 12 people using the service at the time of our inspection. The home provides nursing care for older people.

At the previous inspection on 25 and 26 April 2016, we asked the provider to take action to make improvements to the areas of notifications, person-centred care, need for consent, safe care and treatment, safeguarding, meeting nutritional and hydration needs, premises and equipment, good governance and staffing. At this inspection we found that the concerns in the areas of notifications and meeting nutritional and hydration needs had been fully addressed. However, while some improvements had been made, more work was required in all other areas.

At the previous inspection the overall rating for this service was 'Inadequate' and the service was placed in 'special measures'. At this inspection the overall rating for this service is 'Requires Improvement' and the service is no longer in special measures.

A registered manager was in post and was present on the first day of the inspection but not on the second day. 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.

Staff knew how to identify potential signs of abuse; however, restraint was being carried out by staff and they had not received sufficient training or guidance to do this. Staff did not always safely manage identified risks to people. Sufficient numbers of staff were on duty to meet people's needs during our inspection, however, systems were not robust to ensure that sufficient staff were on duty at all times.

Safe infection control and medicines practices were not always followed. The most recent staff member had been recruited through safe recruitment practices; however, records were not available to provide assurance that all recent staff had been recruited safely.

Staff did not receive appropriate training, supervision and an appraisal. People's rights were not always protected under the Mental Capacity Act 2005. People's needs were not fully met by the adaptation, design and decoration of the service.

People received sufficient amounts to eat and drink and external professionals were generally involved in people's care as appropriate.

Staff were kind but did not always respect people's privacy. People and their relatives were not fully involved

in decisions about their care. Advocacy information was made available to people.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective. People and their relatives were not involved nor had opportunities to be involved in the development of the service. However, the provider and registered manager were generally meeting their regulatory requirements.

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

Staff knew how to identify potential signs of abuse; however, restraint was being carried out by staff and they had not received sufficient training or guidance to do this.

Staff did not always safely manage identified risks to people. Sufficient numbers of staff were on duty to meet people's needs during our inspection, however, systems were not robust to ensure that sufficient staff were on duty at all times.

Safe infection control and medicines practices were not always followed. The most recent staff member had been recruited through safe recruitment practices; however, records were not available to provide assurance that all recent staff had been recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive appropriate training, supervision and an appraisal. People's rights were not always protected under the Mental Capacity Act 2005.

People's needs were not fully met by the adaptation, design and decoration of the service.

People received sufficient amounts to eat and drink and external professionals were generally involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind but did not always respect people's privacy.

People and their relatives were not fully involved in decisions about their care. Advocacy information was made available to people and people were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement.

Care records did not always contain information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective.

People and their relatives were not involved nor had opportunities to be involved in the development of the service.

However, the provider and registered manager were generally meeting their regulatory requirements.

The Gables Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 September 2016 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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 service.

Before our inspection, we reviewed the information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with five people who used the service, two housekeepers, the maintenance staff member, a laundry staff member, three care staff and the registered manager. We looked at the relevant parts of the care records of seven people, one staff recruitment file and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 25 and 26 April 2016 we identified that care plans gave staff instructions to use restraint when necessary but staff had not received specific training on safe practices to be used to restrain people. The care plans did not provide sufficient guidance to staff on alternative techniques to gain people's co-operation so that restraint was not necessary. At this inspection we found that the care plans had not been amended and staff had not received training in this area. There had been no improvements in this area and the regulation had not been complied with.

Staff were aware of the signs of abuse and told us they would report any concerns to the registered manager. However not all staff were aware that they could escalate concerns to an external agency and one staff member told us they had not received safeguarding training. Records were not available to confirm whether all staff had attended safeguarding adults training.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. A person said, "I'm not worried at all." Another person said, "I feel fine here. I could talk to any staff here."

A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

During our previous inspection on 25 and 26 April 2016 we identified that risks were not always managed so that people were protected. At this inspection we found that there had some improvements in this area but the regulation had not been complied with.

Individual risk assessments had been completed to assess people's risk of developing pressure ulcers, falls and nutritional risk. These had been reviewed monthly. A moving and handling assessment had been completed which identified the person's support needs when they required assistance to mobilise. When bed rails were used to prevent the person from falling out of bed, a risk assessment had been completed and reviewed monthly.

However, when a person had been identified as being at high risk of falls, the action documented to prevent further falls was very limited and they did not have a falls prevention care plan. Another person did not have a falls prevention care plan despite being at medium risk of falls and needing assistance, due to advanced Parkinson's disease. While risk assessments were reviewed monthly they were not reviewed in response to when a person had a fall so there was a greater risk that actions to minimise risks were not identified and taken promptly.

We saw one person sat on a chair in the lounge with their moving and handling sling still in place. This person told us that they were happy to have the sling in place; however, it was not a sling that should be left

with a person sitting on it. Slings left in place may increase the risk of the development of pressure ulcers.

Two people had concerns about how staff supported them to move. A person said, "My back hurts when I'm hoisted. I've been bashed in it a few times when they're rushing." Another person said, "It's a fact of life that there are some good and some not so good. I find some can be a bit rough. I tell them when they do it."

We observed a person being assisted to move from a wheelchair into a lounge chair. Two carers were assisting the person and supported the person under their arms. The person did not stand properly and the lounge chair had to be moved quickly behind the person and staff helped them to sit down. However, they were taking the weight of the person under their arms for a brief period which placed the person at risk of avoidable harm.

We saw documentation had been completed relating to accidents and incidents, however, we found that documentation had not been completed in relation to a person who had received an injury and falls had not been analysed since July 2016 to identify patterns and any actions that could be taken to prevent them happening.

There were not complete plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were now in place for all people using the service. However, those plans in place were not easily readable in the event of an emergency. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. We were told that fire drills took place regularly but no fire drills had been recorded as having taken place for over two years.

Maintenance checks were taking place and the premises were maintained but we saw that the premises were not always safe and secure. We observed that thickening agent for people who required thickened fluids were not kept securely and it was possible for people to access them. There has been a national safety notice advising how these agents should be stored to restrict access. If these products were consumed by other people they could cause harm. Liquids that could be harmful if swallowed were also not always stored securely and we saw a wheelchair had been left blocking a fire exit.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were not unnecessarily restricted. A person said, "I can go where I want inside. I've not been outside here though. I decide on my bedtimes – I like to go to bed early and get up early."

Pressure ulcer risk assessments had been completed monthly and care plans indicated that steps were being taken to control the risk. These steps included the use of pressure relieving mattresses and cushions. People were also assisted to change their position regularly. A person said, "They always come in and turn me."

At our previous inspection on 25 and 26 April 2016 we identified that there were a number of concerns regarding how medicines were managed. At this inspection we found that there had been some improvements in this area but the regulation had not been complied with.

We observed the administration of medicines and saw the nurse administering medicines stayed with people until they had taken their medicines. However we also observed later that a tablet fell from a person's clothing while they were being supported by staff. One of the staff supporting them picked it up. We followed up on this and talked with the nurse who told us the staff member had given the medicine to them

and they had administered it again to the person. This was not safe practice. The nurse was not sure which of the person's medicines it was. It was not appropriate to re-administer the tablet as the staff member could not be sure the tablet belonged to the person and the tablet had been on the floor and handled by another staff member.

Medicines were stored within locked trolleys and cupboards. During the inspection we saw that the refrigerator used to store medicines was unlocked and the room where the fridge was stored was unlocked on one occasion. Liquid medicines and creams were not labelled with the date of opening to ensure they were only used for a period of time when they were most effective.

Over half of the Medicine Administration Records (MAR) did not have a photograph of the person to aid identification and there was no indication on any of the MARs about the person's preferences for taking their medicines. We found there were gaps on four people's MAR charts indicating a medicine had either not been administered or the administration had not been signed for. This could lead to a person being given their medicines twice.

One person had not been given any of their medicines for 24 hours due to the service running out of stock. MAR gaps included a diuretic, medicines for diabetes, medicine to reduce blood clotting and prevent heart attacks/stroke. Another person had not been given their medicines for Parkinson's disease for two consecutive doses on one day and records suggested that the symptoms of the disease including weakness, rigidity and restricted mobility might have increased for a period of time. This meant that medicines were not being effectively managed to ensure that people received them safely.

Records were not available to provide assurance that all staff had received training and had their competence assessed to administer medicines safely. Medicines audits had not been carried out since August 2016. This meant that processes were not in place to ensure that medicines issues were promptly identified and addressed.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their medicines on time and staff made sure they received them safely. A person said, "They stay with me while I have them."

PRN protocols were in place to provide guidance for staff on when to administer medicines which were prescribed to be given only as required.

During our previous inspection on 25 and 26 April 2016 we identified that staff did not always provide support in a timely manner. At this inspection we found that improvements had been made and the regulation had been complied with. However, more work was required to ensure that robust systems were in place so that sufficient staff were on duty to meet people's needs safely at all times.

People gave mixed feedback on whether there were enough staff to meet their needs. A person said, "At times it feels like too many staff! Always in and out." Another person said, "Generally there's enough but evenings are busy." However one person said, "Sometimes they leave us alone in the lounge if they're busy upstairs. I don't like it at night times when they're busy." Another person said, "They're always busy, busy here."

Staff told us they felt there were insufficient staff to meet people's needs especially in the evenings. During

our inspection the lounge was supervised by staff most of the time. There were enough staff to assist people at lunchtime in order to ensure they were served in a timely way. We saw that staff provided support in a timely manner throughout our inspection.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. Staffing levels were calculated according to the amount of people who used the service. However, no documentation was in place to show whether people's differing dependency levels had been considered when calculating staffing levels. The registered manager told us that they assessed people's dependency levels but had not input those levels into a staffing tool which had been provided to them by a representative of the provider. Staff rotas showed staffing gaps but these rotas did not show whether the gaps had been filled by agency staff or by the registered manager who was working as a care staff member on the first day of our inspection due to staff sickness.

We looked at a recruitment file for the staff member most recent employed by the service. The file contained all relevant information and appropriate checks had been carried out before the staff member started work. We asked whether any other staff members had started since our last inspection and were told that some temporary staff may have been made permanent but records could not be located during our inspection to confirm this.

A person said, "I always say it's so clean." During our inspection we looked at all bedrooms, all toilets and shower rooms and communal areas and all areas were clean. However, we observed that staff did not always follow safe infection control practices. Wheelchairs were stained and were not on cleaning schedules to ensure that they were being cleaned appropriately. This had been identified as an issue at our last inspection.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection on 25 and 26 April 2016 we identified that staff were not receiving appropriate training, supervision and appraisal. At this inspection we found that there had some improvements in this area but the regulation had not been complied with.

A staff member told us they had not receiving safeguarding or mental capacity act training. We asked to see training records but were told that the training figures were unreliable and required updating. We were told that that restraint, dementia awareness or equality and diversity training had not taken place since the last inspection where we had identified this as an issue. This meant that there was a greater risk that staff had not received sufficient training to meet people's needs in these areas.

Most staff told us they had not received supervision or had an appraisal. Records showed that staff did not receive regular or frequent supervision nor had an appraisal. Only five of 33 staff had received supervision since our last inspection. This meant that staff performance was not being assessed to ensure they had the skills to meet people's needs.

These were continued breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "I think [staff] know what to do." Another person said, "Most [staff] are okay with us. I don't see anything bad."

During our previous inspection on 25 and 26 April 2016 we identified that adaptations had not been made to the design of the home to support people living with dementia. At this inspection we found that there had been some improvements in this area but the regulation had not been complied with.

People's bedrooms were not clearly identified and there was no directional signage to support people to move independently around the home. Staff told us that some people who walked around the home independently sometimes became confused about where the bathroom or their bedroom was.

These were continued breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 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.

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).

During our previous inspection on 25 and 26 April 2016 we identified that DoLS applications had not been made and the service was not working within the principles of the MCA. At this inspection we found that improvements had been made and the regulation had been complied with. However, more work was required to ensure that DoLS applications had been made where appropriate and that mental capacity assessment documentation was completed where necessary.

People's views were mixed on whether staff asked their consent before supporting them. A person said, "No, not that I can think of." Another person said, "They don't ask. They take a liberty with us." However, a third person said, "Yes, they do ask me first." At lunchtime, we observed staff putting clothing protectors on people without checking with them first.

We saw that when bed rails were being used to prevent the person falling out of bed consent to use them had been recorded. When the person was unable to make the decision themselves a mental capacity assessment had been undertaken and the best interest decision making process had been documented.

We noted a person had a mental capacity assessment in relation to being assisted to maintain their personal hygiene and the use of bed rails but they did not have a capacity assessment and best interest decision in relation to administering and managing their medicines including the use of a sedative medicine. This meant that there was a greater risk that their rights had not been protected in this area.

Two people presented with behaviours that may challenge during personal care and had care plans which provided information and guidance for staff on the action to take. This gave staff instructions to use restraint when necessary but staff had not received specific training on safe practices to be used to restrain people. This had been identified as an issue at our last inspection.

Although care plans contained some information for staff to take to gain people's cooperation, this information either didn't include steps such as making an attempt to divert the person's attention or leaving the person for a while and returning later, or when they did, it was in very general terms and did not contain any specific information about things they were interested in or ways they could be diverted. Another person had behaviours that may challenge others but their care plans contained no guidance for staff on how to support this person. This had been identified as an issue at our last inspection.

A DoLS application had been made for one person since our last inspection but other DoLS applications had not been made where necessary. Care staff had limited knowledge of MCA and DoLS issues. This had been identified as an issue at our last inspection.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and almost all had been completed appropriately. A representative of the provider agreed to contact the GP to review one DNACPR.

During our previous inspection on 25 and 26 April 2016 we identified that people were not being protected from the risks of insufficient nutrition and hydration. At this inspection we found that improvements had been made and the regulation had been complied with.

People's views on the quality of food were mixed. A person said, "It could be better and more varied. I haven't had no choice. I eat what they bring." However, another person said, "It's excellent. They just bring

us whatever's on. The puddings are very good!"

People felt that they received sufficient amounts to drink. A person said, "I can have a hot or cold drink. I get a mug of tea at breakfast and mid-morning and afternoon plus at meals. I have Horlicks in the evening." Another person said, "The night nurse gives me tea at 6am and another tea for breakfast. Then I have tea mid-morning, with lunch, then again at teatime and at bedtime." A third person said, "There's no drink in our bedrooms but I can have water or squash at mealtimes and I like tea in the day." We observed that drinks were offered throughout our inspection but were not available in people's bedrooms.

We observed the lunchtime meal in the main dining room and lounge. Some people sat in groups at tables, some people sat separately. People received their meals promptly and received adequate and appropriate assistance when they needed it. A person who needed encouragement to eat and sometimes was able to eat independently but at others times required assistance, was presented with their meal in a very positive way and asked if they "Would like to try a little bit?" They were assisted initially and then asked if they would like to try eating on their own. The member of staff checked on their progress and when they stopped eating after a very short period of time, the member of staff supported them. We saw staff sitting with other people who required assistance and assisted them at the person's pace. They picked up cues from a person who did not communicate verbally and offered them a drink at intervals and maximised the amount of food the person ate.

However, the lunchtime experience could be further improved. People's meals were not always explained to them and food choices were written on a whiteboard beside the kitchen door into the lounge and not generally visible to people seated in either room. We did not hear anyone being asked for a choice and all people received the same meal.

Food and fluid charts we reviewed had been better completed than at the last inspection. We reviewed the records of fluid intake for a person who had had a low fluid intake at the previous inspection and found they were now achieving a good fluid intake. A person who we found had lost weight at our last inspection had gained some weight since last time and we observed them eating and drinking well. We saw that people's weights were being regularly recorded and that people at risk of choking were now receiving their own prescribed thickener.

During our previous inspection on 25 and 26 April 2016 we identified that people were not always receiving appropriate support to manage their health conditions. At this inspection we found that improvements had been made and the regulation had been complied with.

People told us that they saw external professionals; however, most people could not remember receiving dental care at the home. A person said, "The chiropodist comes quite often, about two weeks ago last time, and does my finger nails too. I get a trim by the hairdresser." Another person said, "I've been to the hospital dentist. The optician has been but not lately."

We observed that a person with behaviours which others might find challenging had been referred to the dementia outreach team and the team had provided regular input and advice for the staff. We saw some evidence of the involvement of other professionals; however, it was not always easy to find documentation in care records to confirm whether professionals had been involved. This had been identified as an issue at our last inspection. We saw that one person had visited a dentist due to dental problems and a representative of the provider agreed to ensure that preventative dental checks were also made available for people if they wanted them.

Requires Improvement

Is the service caring?

Our findings

People's views were mixed on whether staff were caring and kind. A person said, "Oh, I think they're [staff] kind. I don't think I've seen them shout." Another person said, "Their kindness and willingness to help is good." However, a third person said, "All [staff] are nice to me but I say to them 'Who's the patient?!' when they talk over me using a foreign language." A fourth person said, "There's one [staff member] at weekends who personally I'd say she's a bully but she is a good carer. She frightens some people to bloody death – she forgets people are very old." The provider's representatives agreed to investigate this issue.

Staff interacted with people in a friendly, caring manner. We observed a person saying they were glad to see a member of staff again who had returned from annual leave. The catering staff knew the people well, their requirements for thickened fluids and their preferences and interacted well with them throughout the morning, offering drinks.

People's views were mixed on whether they had been involved in making decisions about their care. A person said, "I don't think I'm involved. I've not been spoken to." Another person said, "That's what's missing. They don't involve us." A third person said, "I don't feel involved." However, a fourth person said, "They know I want to be involved and talk to me. They told me when my medication changed."

We did not see any evidence of the involvement of people in their care plans when the care plans had been updated. Two people's care records contained a form to indicate their involvement in the care record and consent to various aspects of care such as medicines administration, involving their GP and other professionals when necessary and the service holding small amounts of their personal money. One had been signed by the person themselves and the other had been signed by a relative of the person (the person could not consent themselves). One form was dated in 2012 and the other dated 2014; there was no evidence of further or ongoing involvement. The registered manager told us that they discussed care plans with people who used the service but did not record the discussions. This had been identified as an issue at our last inspection.

Advocacy information was available for people if they required support or advice from an independent person. We did not see a guide for people who used the service setting out what they should expect when living at the home. This had been identified as an issue at our last inspection.

People told us that their privacy was not always respected when staff were entering their bedroom. A person said, "Most staff knock and wait but some knock and walk in." Another person said, "Most knock and wait, some just come in." All people told us that staff closed their bedroom door and curtains when providing them with personal care.

We saw staff take people to private areas to support them with their personal care. However, we also saw a staff member enter a person's bedroom while that person was receiving care. The staff member had knocked but had not waited before entering the room. We also saw that people's care records were not always stored securely. This had been identified as an issue at our last inspection.

People told us that they were encouraged, when able, to be independent or assist with their care. A person said, "They let me have a go at washing but I can't do much else." Some people were supported to eat their meals independently through the use of adapted plates. Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction and people we spoke with confirmed this. A person said, "There's no set times. They come and visit most weeks." Another person said, "They're [family members] okay to come in any time of the day."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 25 and 26 April 2016 we identified that people did not always receive support that met their personalised needs, activities required improvement and care records did not contain sufficient information to guide staff to provide personalised care for people. At this inspection we found that there had been some improvements in this area but the regulation had not been complied with.

People gave mixed feedback on whether call bells were responded to promptly. A person said, "It depends what they're [staff] doing – it can be a long wait. This morning I was half an hour knocking on my bed to get them to come as I was so dry and thirsty – I couldn't reach the bell. They came at last." Another person said, "It was 35 minutes yesterday and can be quite a long wait." However a person said, "They can come very quickly." Another person said, "I get help on time when I need it."

People's feedback was mixed on whether they always received personalised care that was responsive to their needs. A person said, "I think they look after me the way I like." Another person said, "I feel like it's all personal to me and they keep me safe." However, a person said, "I'd like a bath more often. They're [staff] not very fond to give you one." Another person said, "[Staff] forget me for bed rest sometimes. I'm supposed to go about 1pm after lunch but have had to watch the clock and remind them as it can be after 2pm."

Two people told us that they hadn't been asked whether they had any preference for the gender of the staff member providing them with personal care. A person said, "I wasn't asked but I'm ok with either now." Another person said, "I wasn't asked but I'm not bothered." However, a third person said, "I prefer the men and usually have them to wash me."

During our inspection, we observed that staff generally responded promptly to people but staff knowledge of people's personalised needs was mixed and staff told us they did not read people's care plans.

Activities still required improvement. We saw limited evidence of co-ordinated planned activities or personalised entertainment. We saw a member of staff engaging in conversation with people, for about half an hour, in the lounge and encouraging them to talk about things they had experienced and were interested in and at intervals during the morning. They offered a person a colouring activity and we observed a person playing with large playing cards.

People we spoke with told us they would like more to do. A person said, "There's not enough to do and we don't have outings - but lately we've played dominoes. A man comes in to do singing and we can join in. We have a church service now and then. We don't get asked about what to have on the TV." Another person said, "I'd like to see more activities and personal entertainment rather than just sitting here. I don't like not going out. I've not sat outside either. Conversation is zero. We have music on sometimes and try and dance." A third person said, "We do get bored. There's a singer every few weeks and now and then bingo and dominoes."

Activities records for three people whose care we reviewed were limited and no activities were recorded for

the three weeks prior to our inspection. There was no displayed activities timetable and the activities coordinator had been absent for three weeks prior to our inspection. A staff member told us that people were bored and said, "It would be nice to take people outside of the home."

Care plans did not always contain sufficient accurate information to support staff to provide personalised care for people that met their individual needs. People's care records contained a "service user profile" and a summary of their care and support needs. Care plans were in place to provide information on people's care and support needs. Some care plans had been re-written in the past two months but some were dated over two years previously. They had been reviewed monthly; however there had been significant changes to the person's needs in the interim and it was difficult to find this information. There was some personalised information in the care plans but details about the person's preferences in relation to their care was variable and some important information was missing.

We reviewed a care plan for a person with diabetes and found their care plan for eating and drinking did not refer to their diabetes, however, they had a diabetes care plan which provided information about how their diabetes was controlled and the symptoms of low blood sugar levels. There was no mention of the need for an annual diabetes review or eye screening. Another person was at risk of falling and we were told they had fallen two months previously. There was no mention of falls in their mobility (walking) care plan and there was no falls prevention care plan.

We noted another person had a wound dressing on their shin. We reviewed their care plan to look at the management of the wound. We could not find any reference to a wound or the requirement for a wound dressing. When we asked the registered manager about this, they told us the person had experienced a skin tear but the wound was healed and the dressing was in place purely to protect the shin. We found no reference to a skin tear and no accident form had been completed. The person's skin integrity care plan consistently stated their skin was intact in the monthly reviews. There should have been information about the requirement for a dressing and the frequency of changes required, even if it was only required to protect the skin.

These were continued breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew how to make a complaint. A person said, "I've not had to complain. I could talk to anyone." Another person said, "I've not had to complain. I'd see the [registered] manager if I did." Staff were able to explain how they would respond to a complaint.

There had been no recorded complaints since our last inspection. Guidance on how to make a complaint was displayed in the main reception. However, the complaints procedure did not make any reference to the local authority complaints procedure or the local government ombudsman. This had been identified as an issue at our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 25 and 26 April 2016 we identified that the systems in place to monitor the safety and quality of the service were not always effective. At this inspection we found that there had been some improvements in this area but the regulation had not been complied with.

The provider had a system to regularly assess and monitor the quality of service that people received, however it was still not effective as it had not identified and addressed the issues we found at this inspection.

Audits were still not taking place regularly. The registered manager had not completed any recent audits in the areas of infection control, medicines, care records or the environment. The provider had completed an audit since our last inspection and a consultant employed by the provider had also carried out an audit which had identified a number of shortcomings. An action plan was in place to address these issues.

Improvements to the service had not been made and sustained following inspections by us. The CQC inspections in 2012, 2013 and 2014 identified breaches in regulations. The inspection in April 2015 found that all regulations had been complied with, however, the service was rated 'Requires Improvement'. At our previous inspection in April 2016 we identified a number of breaches of regulations and a number of areas were also identified as requiring improvement but had still not been fully addressed by the time of this inspection. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

People did not feel involved in the development of the service. People we spoke with said they had not been asked for their opinions or ideas. A person said, "I've not been asked at all." Another person said, "They don't ask us. I don't get the chance to give opinions." A third person said, "We don't get asked anything."

The last meeting for people who used the service and their relatives had taken place in August 2014. There were no notices displayed in the home to inform people and their relatives of the upcoming date for the next meeting. No surveys were in place to obtain the views of people who used the service on the quality of care provided to them. This meant that people were not actively involved in developing the service.

These were continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 25 and 26 April 2016 we identified that statutory notifications had not always been sent to the CQC when required. At this inspection we found that there had been improvements in this area and the regulation had been complied with. We saw that notifications had been sent to the CQC when required.

People were positive about the atmosphere of the home. A person said, "We all get on fairly well here." Staff told us that everyone got on in the home.

A whistleblowing policy was in place. Staff told us they would be prepared to raise issues using the processes set out in the policy. The provider's values and philosophy of care were displayed in the main reception.

People were positive about the registered manager. A person said, "She comes round almost like a carer most of the time. She's okay to talk to." Another person said, "I see her around and she's easy to talk to." A third person said, "She sometimes comes for a chat and is nice and easy to talk with." Staff were positive about the registered manager. They told us she was approachable and responded to their concerns. However not all staff had attended a staff meeting and when we asked to see minutes of the last staff meeting these could not be located.

A registered manager was in post and was available on the first day of the inspection. She was not available on the second day. We saw that all conditions of registration with the CQC were being met. However, the current CQC rating was not clearly displayed in the home which meant that the provider was not meeting their regulatory responsibilities in full. This had been identified as an issue at our last inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was responsive to their needs and activities required improvement. Care records contained some information to support staff to meet people's individual needs but could be further improved. 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks to people were not always managed safely. 12 (1) (2) (a) (b) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Restraint was being carried out by staff and they had not received sufficient training or guidance to do this. 13 (4) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care	Premises and equipment People's needs were not fully met by the adaptation, design and decoration of the service. 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate training, supervision and appraisal. 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Safe medicines practices were not always followed. 12 (1) (2) (g)

The enforcement action we took:

We served a warning notice with a deadline for compliance of 4 November 2016.

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 in place to monitor and improve the quality of the service provided were not effective. 17 (1) (2) (a) (b) (c) (d) (ii) (e) (f)

The enforcement action we took:

We served a warning notice with a deadline for compliance of 22 November 2016.