Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 September 2017 and was unannounced. At the time of this September 2017 inspection there were three breaches of regulations outstanding from our previous comprehensive inspection of April 2017 and an urgent focused inspection of August 2017. These breaches related to supporting people with social engagement, safety relating to medicines administration and infection control and governance arrangements. This September 2017 inspection found that no progress had been made in these matters and that the provider remained in breach of these regulations.

In addition the provider was further found to in breach of regulations relating to supporting people nutritionally, adherence to the Mental Capacity Act 2005, dignity and respect and the reporting of notifiable incidents to the Care Quality Commission (CQC).

Abbeville Residential Care Home provides accommodation and care for up to 38 older people, some of whom may be living with dementia. At the time of this September 2017 inspection there were 20 people living in the home.

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

We found that people were not always receiving their medicines as prescribed for them and found a number or errors over and above what the service had identified themselves. One of these related to the administration of warfarin, a high risk medicine. These errors put people's welfare at risk.

The infection control issues we found at our previous inspection in August 2017 had not been addressed. People's bedding was often unclean. This put them at risk of infection spread by cross contamination. We found unsecured toilet seats, which again had been an issue at our previous inspection.

Where risks to people's welfare were identified, appropriate follow up actions were not always taken.

Improvements had not been made since our inspection in April 2017 in the assessment of people's mental capacity to make their own decisions. The same issues remained.

Some people's meal time experiences were poor. Two people were not suitably positioned to enable them to eat comfortably. One person, who required significant support and encouragement with their nutrition did not receive this.

Some people reported that their preferences for support to be provided in a specific way were disregarded

and that some staff was not respectful towards them.

The service did not provide sufficient support for people to engage with others or to follow their own interests or hobbies. This had been a long standing problem at the service that not been addressed.

The provider's quality assurance systems had not helped ensure that people received a good standard of care and support.

The provider has experienced considerable difficulty in making improvements at this service since 2015. In April 2017 we found that whilst a few concerns remained the provider had made significant improvements. Whilst the service had been in 'special measures' from December 2015 to April 2017 the provider had been unable to sustain and build upon the improvements we found in our inspection of April 2017. Consequently, this service has returned to special measures.

The overall rating for this service is 'Inadequate' and the service is therefore '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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found a continuation of concerns relating to medicines administration and infection control.

Risks to people's welfare were not always appropriately or promptly acted upon.

There was enough staff to meet people's physical needs.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive the necessary support during mealtimes.

A staff training programme was in place. However, due to some training having expired some time ago people were not always supported by staff with current skills or knowledge.

The service was not working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff did not respond to people's expressed preferences in how they wished to be assisted.

The infection control issues we found did not uphold people's dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Concerns remained that there was little time available to support people emotionally or socially.

People knew who to raise any concerns with and were confident that any issues raised would be dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to address the issues we had identified from our urgent inspection of 1 August 2017.

The service, having previously been in and out of special measures, had returned to special measures as a result of this inspection.

Abbeville Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 25 September 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines and an expert-by-experience.
An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out the inspection we reviewed the information we held about the service This included statutory notifications that the provider had sent us over the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also liaised with the local authority.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority for their views on the service.

During our inspection we spoke with seven people and a relative of another person living in the home. We also spoke with the manager, the provider, two care staff and the cook. We viewed the care records for three people in depth, records relating to incidents for seven people and the medicines records for all 20 people living in the home. We also looked at records in relation to the management of the home. These included the recruitment files for three staff members, staff training records, compliments and complaints, quality monitoring audits and minutes from meetings held.

Inadequate

Is the service safe?

Our findings

Our previous focused inspection of 1 August 2017 found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the administration of people's medicines. This September 2017 inspection found that concerns still remained.

A member of the CQC medicines team looked at how the service managed people's medicines and how information in medicines records and care notes supported the safe handling of people's medicines.

Audits were in place to enable staff to monitor medicine administration and their records, however, some records were missing for some medicines so they could not be properly accounted for. The service had recently identified medication errors where people had not received their medicines as prescribed. However, during the inspection we found further discrepancies in records indicating further occasions where people had not being given their medicines correctly.

One person had received an incorrect dose of warfarin following changes to the dose after a blood test. Warfarin is an important cardiovascular medicine and which must be given accurately and appropriately for the safety of people prescribed it. For this and another person we could not reconcile the stock level of their warfarin with the records. The discrepancies indicated that errors may have been made at some point in the four weekly medicine cycle.

Other discrepancies showed that on one occasion a person had not received medicines to control blood glucose levels or high blood pressure that had been prescribed for them.

We noted that for some medicines prescribed for application to people's eyes, staff were not following safe procedures to ensure they were only used for their limited period of time once opened to ensure they were safe for use. We found a container of eye drops in use that had expired.

When people were prescribed medicines on a when-required basis, there was not always written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. In addition, some information was available for medicines which were no longer prescribed with the potential for misleading staff and causing errors. For some medicines prescribed in this way there was a lack of records showing why they were needed when given to people.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities. There were additional records in place for high risk medicines to ensure safety but we noted some gaps in the records. For people prescribed skin patches there were also additional records showing they were applied to people's bodies in a rotational manner and also confirming they were later removed before the next patch was applied. However, there were also gaps in some of these records.

Consequently, the provider remained in breach of Regulation 12 (2) (g) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We noted that there had been improvements in records for medicines prescribed for external use, and charts showing the areas of people's bodies they were to be applied to.

Staff authorised to handle and give people their medicines had had their competence assessed to ensure they managed people's medicines safely. Medicines were stored securely for the protection of people who used the service and at correct temperatures.

People told us that staff responded promptly to requests for pain relief. One person told us, "The carers are quick off the mark."

Our previous focused inspection of 1 August 2017 found that the provider was in breach of Regulation 12 in relation to cleanliness and infection control. This September 2017 found that concerns still remained.

Whilst communal areas of the home were clean we found similar issues relating to the cleanliness of people's rooms and equipment as we had identified previously. Bedding, including sheets, pillows and pillowcases was unclean. Some commodes, hoists, toilets and toilet seat risers were not clean. Some toilet brushes were visibly dirty. One person's bathroom had no towels. Another person's mirrors and toothbrush containers were unclean. One person's waste bin was overflowing with used continence pads.

These concerns put people at risk of infection spread by cross contamination. Consequently the provider remained in breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found one toilet seat riser that was not secured to the toilet bowl. We also found a toilet seat that was loose in another person's bathroom. These concerns put people's safety at risk. Pipework beneath one person's sink became hot when the hot water tap was turned on. This pipework required covering to reduce the risk of accidental scalding.

The service's records showed that seven falls had occurred during August 2017. We reviewed these incidents and found that two incidents had not been responded to appropriately. For example, one person had sustained a head injury but had not been referred to a health professional until three days after the event. Frequent checks had not been implemented after the fall to ensure that their condition did not deteriorate. Another person had not been offered pain relief despite complaining of pain after a fall. The senior care staff member at the time of the incident who was also responsible for administering medicines to people that day had stated that they did not know where the service's homely remedies were kept. Homely remedies are non-prescription medicines used in the home for the short time management of minor conditions, e.g. cold symptoms or occasional pain. The service had identified these concerns and had commenced appropriate actions.

One person's pre-admission records showed that they needed a longer length bed. However, upon admission it was identified that the bed provided by the service was not extendable. Records showed that the person had incurred skin tissue damage on their feet in the past from them being pressed up against the end of a bed that was not long enough for them. Whilst actions were underway to remedy the situation it was not known when a suitable bed would be delivered. The failure to ensure a suitable bed was in place for the person upon admission to the home had put them at risk of developing a pressure ulcer.

The same person had a fall safe mat on the floor on one side of their bed only, despite there being potential

for them to fall out of either side due to the positioning of the bed in the room.

Weight records showed that two people were steadily losing weight. One person who was of a low weight to start with had lost 5.2kg between 21 June and 7 September 2017 when they had last been weighed. Their care plan stated that they were to be weighed weekly, but this was not being done. The dietician had advised on 6 September 2017 that as the person was not taking the supplements prescribed that these were to be discontinued and a trial of new ones would be delivered to see whether the person would take them. The delivery of these supplements had not been chased up despite19 days having passed.

Another person had lost 6kg between 10 June and 20 August 2017 when they had last been weighed. Records showed that there had been contact with the person's GP to request an urgent referral to the dietician on 22 August 2017. However, this had not been followed up when there had been no further progress in relation to this. There had been no action to weigh the person more frequently, amend what foods were offered, monitor their nutritional intake or update the person's care plan in relation to these concerns. Suitable steps had not been taken.

These concerns meant that the provider was also in breach of Regulation 12 (2) (a) (b) (c) (d) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff usually responded promptly when they needed assistance, but that occasionally if they were busy they might need to wait up to 10 minutes.

At the time of this inspection there were 20 people living in the home. Seven people needed two staff to assist them to mobilise.

The morning shift comprised of two care staff and a senior, the afternoon shift comprised of two care staff and one senior with an additional staff member in 8am to 1pm and again between 5pm and 9pm. There were two staff on duty overnight. We were concerned that with seven people needing two staff to assist them that there may not have been enough staff at night. However, no-one raised this as a concern with us. Only one night staff member had been trained in medicines administration. The afternoon shift senior completed the night medicines round before they left at 10pm. The manager said that they and another senior staff member were on call and would come in if someone needed any medicines administered. However, they could not recall when this had last been necessary.

During this inspection we found that whilst there were enough staff to meet people's physical needs, staff were not always deployed effectively. For example, we saw that two staff members were often completing care records in a room out of sight of communal areas at the same time. We brought this to the attention of the management team.

Two of the four night staff did not have up to date first aid awareness training. This had expired two years ago. These staff members sometimes worked on the same night shift. As two staff were required to work nights this meant that on some shifts neither of the staff on duty would have the up to date knowledge necessary. This could put people at risk of harm.

Most people told us that they felt safe living in the home. One person said, "Now that I have a full length cord on my buzzer it's better. The new longer cord reaches right into my bathroom, so if I've got any problems I can call for help." Another person told us when they were in the garden staff kept popping out to make sure they were okay. One person raised a concern, they told us, "One thing that worries me here is the buzzer in the lounge. There was one, but it didn't work so it was taken away. We sometimes don't see any staff for an

hour or more and if one of us was ill it would be difficult to get someone to come." However, the provider thought it unlikely that staff were not seen in the lounge area for that length of time because of the close proximity to the kitchen which had a serving hatch and doorway into the lounge. The manager's office was also nearby and the lounge formed part of the main corridor in the home.

We reviewed the recruitment records for the last three staff members employed. We found that suitable checks were in place to reduce the risks of employing staff unsuitable for their role. These checks included the obtaining of references and Disclosure and Baring Service (DBS) checks before staff members started work in the home.

We saw that safeguarding incidents had been appropriately identified and referred to the local authority as necessary. Safeguarding training was out of date for several staff members. However, this had been arranged for the day after our inspection.

Inadequate

Is the service effective?

Our findings

We observed the lunchtime period. One person was hunched over a portable table that was too low for them to eat comfortably. Another person who took meals in their room was not provided with their usual lap tray. Their meal had been placed on a portable table instead. They had left most of their food and it was cold. They told us that they, "…couldn't manage to eat from the table."

One person fell asleep after eating one chip. A staff member asked if they wanted any more. The person said no and the meal was taken away. The person was not offered any alternative. We saw throughout the day that staff were repeatedly giving the person biscuits. Whilst this was recorded as a preferred snack for the person who was living with advanced dementia, they required better support and encouragement from staff in relation to their nutrition.

People had not been provided with the necessary support to eat their meals. This meant that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about the food. One person told us, "The food is reasonable. I do buy some of my own food and get the kitchen to heat it up. I feel I need to be tempted by nice smells and appealing dishes." Another person said, "We get a choice for lunch, but tea is always the same. Egg or tomatoes on toast or a sandwich. I would like chips with bread at teatime, but it's never on." A third person told us, "The food is pretty good. Staff help me eat when I need them to."
A fourth person said, "The food is quite good and I'm fussy. I have egg on toast for breakfast."

People had made their choice between sausage and mash or pie and chips. However, no vegetables had been served, despite them being prepared and ready. This was because the staff who had taken people's orders did not ask people what vegetables they would like served with their main meal, therefore none were served. One person having received their meal said, "Oh there's no veg". The staff member asked if the person would like some and returned with a very small portion of mushy peas. We asked the person if they usually had vegetables with their meal, and they told us, "No not usually, and I like veg."

For dessert there was a choice of cheesecake or swiss roll with custard. However, people were not offered an alternative to custard as an accompaniment to their dessert. The manager told us that people living in the home always preferred custard. However, they were not given a choice.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. This requires that a mental capacity assessment is needed when a person is unable to make a particular decision at a particular time. However, the service was not formally assessing people's ability to make the decision before coming to the conclusion that the person could not make the decision. For example, the service had decided that some people needed bedrails without assessing the person's capacity to make this decision for themselves.

Where it had been determined that a person was unable to make their own decision about something it was recorded on a best interests decision form. These did not always show who else had been consulted in making the decision or what other courses of action had been considered. There were several best interests decisions records, some of which were related to day to day decisions that did not require a mental capacity assessment or a best interests decision making process to be completed. For example, one record related to a person who was unable to recognize when they might be too hot or too cold. Other decision records that were required, for example, the administration of covert medicines, lacked the initial mental capacity assessment process that might lead to the best interests decision making.

The service was awaiting the outcome of four DoLS applications that had been made to the local authority.

There was poor understanding of the processes required to ensure that the service was working within the principles of the MCA. We had found the same issues at our April 2017 inspection. Despite training that had been undertaken since then, there had been no progress in this area. Consequently, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that staff sought people's agreement before any assistance was provided. However, some people told us that some staff disregarded their wishes in relation to their personal care. This is detailed in the 'Caring' section of this report.

People told us that staff ensured they had access to health professionals, such as their GP or a nurse when they required. A podiatrist was visiting people on the day of our inspection. Records showed that requests were made for the support of specialist health professionals. For example, referrals had been made for dieticians and access to the falls team when necessary. However, we could not be confident that all necessary referrals to health professionals were being made promptly as medical support had not been sought for three days in respect of one person's head injury following a fall.

Staff received training in a range of mandatory areas which had been deemed essential to the job role. These areas included first aid awareness, moving and handling and infection control.

Where training was overdue it had only expired by a few months. However, we found that two of the four night staff had last received first aid awareness training in October 2015. Staff rotas showed that there were night shifts when these two staff members were on duty together. This meant that there would not have been staff present in the home with up to date first aid awareness training. A staff member responsible for domestic duties had not undertaken training in infection control since October 2015. This inspection had identified concerns in this area. Where training was overdue, it had been booked and was due for completion by the end of September 2017. This including training for the above individuals.

Staff supervisions were up to date. We spoke with a new staff member who not worked in the care sector before. They told us they had completed all of their training and shadowed experienced staff before

assisting people on their own. They had had discussions with the manager about whether they felt confident enough to do to this and had undergone assessments of their competency. They said that their induction experience had been good and equipped them well for their role.

There had been some recent improvements in signage in the home. However, we observed one person twice being unable to find their room needing to be directed by staff. The person said, "It all looks the same."

Requires Improvement

Is the service caring?

Our findings

We received mixed views about the way staff supported people. Some people felt that their views were not taken account of or that staff were not sufficiently observant of their needs.

One person told us that they didn't like to have baths. They said, "They help me get a bath once a week. I always complain as I hate having a bath. I haven't been used to having a bathroom and always just had a wash down." Another person told us, "Staff give me a shave. I say I can do it myself, but no, it gets done for me." This approach did not promote the person's independence. A third person told us, "I don't think they have fully realised that I need watching more with my health conditions starting to cause me more and more problems." A fourth person told us, "Staff must listen to me."

One person told us that staff complained to them about their continence. They said, "I do wish they would stop moaning at me and understand that when I get the urge I can't help it and have to go there and then." Another person said, "There is one carer who is demanding. I just tell them straight."

One person had been given a cup of tea. They said it was too hot. The staff member twice said that they couldn't do anything about it as they had nowhere to tip some of the tea away. A conversation about this ensued. We had to intervene in order to resolve the situation. The person said to us afterwards, "She's no carer is she?"

These concerns and the infection control issues previously referred to were not indicative of a service that consistently upheld people's dignity, demonstrated a caring approach or involved people in making decisions about their care or support. Consequently, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were connecting communal areas on the ground floor with the main corridor running through them. A small group of people who were able to chat sat companionably together in one area. In the other two areas were people who were less able to communicate and who could not mobilise without the support of staff and equipment.

One person who was unable to mobilise independently had been sat at 90 degrees to the television and very close to it. The volume level was set very high. If they had been interested in watching the television it would have been very uncomfortable to view it from this angle for any length of time. The other person in the room spent most of their day asleep, only waking when prompted by staff. Other than when people required assistance there was limited interaction from staff with people in the communal areas.

We did see some good interactions from some staff members. One staff member approached a person with a significant visual impairment. They gently tapped their arm to gain the person's attention and said who they were and what they proposed to do. The person smiled in recognition and acknowledgement. We also saw some relaxed and friendly conversations with people to which they responded well.

There were periodic meetings for people living in their home and their family members to attend. The minutes from these showed that people were able to ask questions and share their views about the home.

Requires Improvement

Is the service responsive?

Our findings

Our previous comprehensive inspection in April 2017 identified a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to assessing and ensuring that people's needs were met.

There had been no improvement in the social support provided to people. One person told us, "Not much goes on. There's not enough outings in the nice weather. We missed the good weather this year." Another person said, "We don't have much going on. There used to be bingo and quizzes. The staff member who used to do this is off so there's no-one to organise anything now." A third person told us, "I've got a nice big room. There's not much point going downstairs because there's not much going on. At least if I stay here I've got my telly and I can watch what I like." One person said, "Staff tell me that the activities person is the only one trained to take me out in a wheelchair, so it doesn't happen often."

People seated in one lounge told us that most of the activities organised that were displayed on a chart on the wall did not take place. One person told us, "We haven't had our nails manicured for some time." Another person added, "There is nothing to do all day usually."

During this September 2017 inspection we saw that the same two people living with mental health conditions we saw during our April 2017 inspection were again sat in the lounge all day with no stimulation, and were disengaged with their surroundings. Other than when staff assisted them with meals and carried out care tasks there was no stimulation or activity to occupy people.

One person told us that the service had run out of hearing aid batteries so they were having problems hearing. They said they were waiting for a family member to sort this out for them.

The service was not taking appropriate follow up action when referrals or requests had been made to health professionals. Whilst the initial referrals were made, there had been no attempts to follow up matters. One person's GP had visited them six weeks after a request had been made for an urgent referral to the dietician. The GP had visited for an unrelated matter. No attempt had been made to follow the request for the referral up. It was only followed up when we raised queries following the inspection. The manager was not confident that the initial referral had been made.

We saw that two nutritional care plans had not been updated for two or three months. Both people's nutritional requirements had changed in this period.

Consequently, the provider remained in breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans showed how people wished to be cared for and what was important to them. Consequently, we could see that people's preferences had been identified by the service. However, in practice some people said that these preferences were not being taken account of.

People told us that if they required assistance urgently that staff were quick to respond. One person told us about a fall they had had a few weeks ago. "One of the carers stayed with me for ages as I couldn't lift my head up."

People were also confident that if they had any concerns they knew who to speak with and felt that their concerns would be addressed appropriately. One person said, "If I was bothered by anything I'd speak with [the manager]." Another person said, "The manager would be very approachable with anything like that." A third person told us, "If you've got any worries, someone will sort it."

Inadequate

Is the service well-led?

Our findings

Our previous focused inspection of 1 August 2017 found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the governance of the service. This September 2017 found that concerns still remained.

Following our August 2017 inspection the provider sent us an action plan detailing extra checks they would be implementing to ensure the safe administration of people's medicines. These checks had not proven effective as we again found concerns in relation to medicines management.

The provider had implemented daily management floor walks which included sampling the cleanliness of two people's bedrooms. There was also a dining with dignity audit. This September 2017 inspection found concerns in both these areas. These checks had not been effective in ensuring people received a good standard of service in these areas. The provider felt that the mealtime experience of people on the day of our inspection was not a typical reflection of mealtimes in the home as other audits had not identified any concerns. However, we were concerned that there had been no effective oversight of the lunchtime period despite having care staff and a cook on duty who were not fully familiar with people's requirements.

The standard of falls recording was poor and did not provide a full account of incidents that had taken place. The computerised form automatically recorded when the record was made. However, the time of the actual event and when follow up actions were taken were often not shown. Some of these issues had been queried with the staff concerned. However, little clarity was established in these matters. Consequently, the provider could not be assured that timely and appropriate interventions were made

The provider had still not ensured that people were sufficiently supported socially, or mentally stimulated. This particularly affected those unable to occupy themselves. Six hours a week was available to support people and this was mainly targeted towards those who were able to participate in events. There was little effort made to support people to any meaningful extent with their individual hobbies or interests. The provider had been in breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to this issue since our inspection in May 2016.

The provider's governance systems had not ensured that risks to people's welfare were identified and remedied or that the quality of the service that people received was adequate.

Consequently, the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the governance of the service.

The service had been in special measures from previous inspections in December 2015, May 2016 and October 2016. Our inspection in April 2017 found that substantial progress had been made and the service was removed from special measures. However, as a result of the findings from this September 2017 inspection, the service will be re-entering special measures.

The manager and provider told us that they felt that one of the home's main issues stemmed from the calibre of some staff members and that these matters were being addressed. The provider was planning to move some experienced and reliable staff members from a domiciliary care agency they owned to the home. They felt that this would improve the standard of service that people received.

Whilst safeguarding referrals had been made to the local authority appropriately, the necessary statutory notifications had not been made to us.

This meant that the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People living in the service knew who the manager was and were confident to approach them. Most of the people we spoke with told us that they would recommend the home. One said, "I've no fault to find." Another person told us, "Yes. I've even sent brochures to people I know. However, one person said, "It's difficult. I think people must come and judge for themselves."