Veecare Ltd

Sevington Mill

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 27 and 28 March 2017 and was unannounced.

Sevington Mill is registered to provide personal care and accommodation for up to 50 older people. There were 39 people using the service during our inspection; some of whom were living with dementia and/or conditions such as diabetes or impaired mobility.

Sevington Mill is a very large detached property situated in a residential area outside Ashford. There was a comfortable lounge/dining room with armchairs and a TV, a separate dining area and a bright conservatory where people could sit and enjoy views of the garden.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives gave us mixed feedback about the safety of the service. We found some aspects that were not safe and required improvement to address them.

There were not enough staff deployed to consistently meet people's needs. Morning medicines rounds took from 8am until 10:30am to complete, taking two senior staff off the floor for that period. Call bells rang for up to 15 minutes before they were answered.

Some risks to people had not been properly reduced. Special air flow mattresses were not all on the correct settings to provide people with appropriate relief from pressure on their skin. Water temperatures were found to exceed safe limits, but were rectified during the inspection.

Records about wound care and other areas were scant and did not provide a full picture about people's care and treatment. Some people's meals were delivered to them cold, which they said happened regularly.

Staff supervision did not always include opportunities for staff to discuss training needs. Records showed that only one staff had received training about care of dying people. End of life preferences and choices were not as full or detailed as they could be.

There was no designated activities staff and activities for people were insufficient. Care and catering staff were providing entertainment where possible. There was not enough social stimulation for people who stayed in their rooms.

Actions arising from the last inspection had not been fully completed, leaving some risks to people's safety and well-being unaddressed. There had been insufficient oversight to pick up on the shortfalls found during

this inspection and the service had been rated as requires improvement or less at four inspections over a two year period.

Equipment had been regularly safety-checked and accidents and incidents were properly documented. Staff knew how to recognise abuse and how to report it.

Records about fluid intake had improved and there were plenty of drinks available. Some people said they enjoyed their meals and tables were pleasantly laid up with cloths and flowers.

Staff had received mandatory training in a range of subjects and 16 staff had achieved National Vocational Qualification (NVQ) in health and social care.

People's consent to their care and treatment had been appropriately sought and staff acted in accordance with requirements of the Mental Capacity Act 2005 (MCA).

Staff were considerate and kind and people and relatives praised them for their efforts. People's privacy and dignity were consistently respected and they were encouraged to be as independent as possible.

Complaints were managed effectively and feedback was sought and acted upon.

We found a number of breaches of Regulation and made the following recommendations:

We recommend that the provider reviews the lunchtime service with a view to ensuring that all people receive their meals at a suitable temperature.

We recommend that the provider expands the supervision process to include feedback from staff about their own developmental needs and any concerns.

We recommend that the provider schedules end of life care training for all care staff from a reputable source.

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.

There were not always enough staff deployed to support people.

Medicines were not consistently well-managed and safe.

Not all risks had been properly assessed and minimised.

People felt safe and staff knew how to recognise and report abuse.

There was a safe recruitment process in operation.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health was monitored routinely to help maintain their well-being but records about this were lacking.

Plenty of drinks were available but there were mixed views about food

Staff had received training to help them provide effective support. Supervision was mainly observation-based.

Staff understood how to protect people's rights in line with the Mental Capacity Act (MCA) 2005.

Is the service caring?

Requires Improvement

The service was mostly caring.

End of life care required improvement to ensure people's wishes were documented and staff understood how to give appropriate care.

Staff delivered care with consideration and kindness.

People were treated with respect and their dignity was protected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plan information was not always up to date.

There was not enough stimulation for people.

Complaints had been documented and responded to within timescales set out in the provider's policy.

Information about people's life histories had been sensitively prepared.

Is the service well-led?

Inadequate

The service had not been consistently well-led.

Warning Notices issued after our last inspection had not all been fully met, and other breaches of Regulation had emerged. The service had been rated as Requires Improvement or less at four inspections carried out over two years.

Systems designed to assess the quality and safety of the service were not sufficiently robust.

Feedback had been sought from people, staff and relatives but not all relatives and staff felt able to speak openly with any concerns.

Staff said there was good teamwork in the service.

Links had been forged with the local community.

Sevington Mill

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 27 and 28 March 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience, who had cared for an older relative and had other experience of care services. Before our inspection, we usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we did not do so in this case because our inspection was carried out earlier than originally planned. This was because we had received some information of concern and because we wanted to check that Regulations had been met since our last inspection.

We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with twelve of the people who lived at Sevington Mill. We also spent time observing the support people received. We spoke with six people's relatives and two professionals who had experience of working with the service. We inspected the service, including the bathrooms and some people's bedrooms. We spoke with five of the care workers, the registered manager and the area manager.

We 'pathway tracked' eight of the people living at the service. This is when we looked at people's care documentation in depth; obtained their views on how they found living in the service where possible, and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included four staff training and supervision records,

four staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We last inspected Sevington Mill in June 2016, when it was found to require improvement. Following that inspection we issued three requirement actions and one Warning Notice.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people and relatives about whether they felt safe living in the service. One person told us "I was such a worrier and became depressed living at home on my own. Being here has made such a difference. I love it here. It's been such a relief because I don't have to worry about anything". A relative said "I'm happy with this place. I couldn't manage my relative at home any more. All the girls are very friendly and I have no complaints at all. They give him his medications, and the doctor comes if needed, the food is good and he has company here."

However, other people were concerned about delays in call bells being answered. One person told us "The staff are lovely but we wait too long for the call bell to be answered. It's always very busy at night". A relative commented "They take too long to answer call bells. If my relative needs to use the commode, she tries to get up herself. The staff tell her not to as she has had falls; they tell her they have to make sure that she's safe but she needs to use the commode urgently. It's a matter of dignity. If she has an 'accident', she gets very distressed." A further person told us they were offered plenty of drinks "But if I drink too much, I have to keep going to the toilet and it's very difficult as I have to call someone. It's worse at night. The staff are so busy".

Our observations found that there were not always enough staff to meet people's needs. Call bells were ringing for periods of up to 15 minutes before being answered in the morning of the first day of our inspection. On arrival we heard a bell ringing for more than 10 minutes and went to the person who was pressing it. They told us that they had been "Waiting for ages" to use the commode. A senior staff went to find care staff to assist this person. Another person was sitting in their bedroom with a plate of cold toast in front of them. They told Inspectors that they could not eat it without their dentures and that staff had not brought them for them yet. They said they were "Fed up with waiting" and "I don't ask for much in life".

Lunchtime of the first day of our inspection ran smoothly with enough staff supporting people. On the second day however, one person had to ask staff to remember to bring a meal for another person who was unable to let them know they were waiting to be served after everyone else had their meals. Some people waited more than 25 minutes in between the main course and pudding and were becoming impatient. One person said to others "Shall we start singing 'Why are we waiting'?" We spoke with staff who said that they had only just finished serving main courses to people throughout the service and that everyone had to finish these before dessert could be given out.

There were two senior and five care staff on duty in the mornings, two seniors and four care staff in the afternoons and one senior, one care staff and one sleep-night staff on shift overnight. Rotas showed that these staffing levels had been consistent in the weeks prior to our inspection. Staff told us that there was not always enough of them to be able to give people the support they needed promptly. The two senior staff were busy giving out medicines from 8am until around 10:30am which meant care staff got people washed and dressed and helped them use the toilet or commode. Staff explained that some people using the service needed two staff to deliver their personal care, so they felt that having six care staff rather than five in the mornings would enable this to work better. One staff told us "If I'm giving care to one person I can't just leave if the buzzer goes off. We feel guilty we can't go to people quicker. When there are six staff it is much

better and safer and residents happy".

The lack of sufficient staffing is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we felt there were enough staff overall to meet people's needs but almost 40% at that time were agency staff. At this inspection the registered manager showed us that agency usage had decreased to around 5%. The area manager told us that recruitment of permanent staff was on-going and they would also look at increasing staffing levels in the mornings.

At our last inspection we found that people's medicated creams had not always been applied as often as the prescriber had intended. At this inspection this situation had not been fully resolved. We continued to find that some people's creams for regular use had not been applied as frequently as directions stated. For example, one person's steroid cream was supposed to be applied twice daily but had only been applied once on four days out of seven. Another person had a pain relieving gel prescribed at three times daily but records showed it had been applied only once or twice per day in a ten day period. People were not receiving consistent benefits from the creams prescribed for them.

During our inspection the medicines round took until 10:30am to complete, having started at around 8am. Staff told us that two senior staff carried out medicines administration with a trolley each; one on the ground floor and one on the first floor. They told us that medicine rounds always took this long to carry out as many people had several medicines. One person was given 'As and when needed' or 'PRN' Paracetemol at 10:15am on the first day of our inspection but when we checked the medicines administration record (MAR) it gave the impression that the Paracetemol had been given at 8am. We asked staff what would happen if this person asked for further pain relief later in the day, as there was no way of telling from the MAR whether there was a safe gap between doses. Staff told us that they would remember the time that this person had their first dose of medicine. This was not safe practice and relied on one staff member being able to accurately recall which PRN medicines people had taken and when. There was a risk that people would be given doses of their medicines without the appropriate time gaps between them.

The failure to manage medicines safely is a continued breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection there were no proper protocols for people who took blood-thinning medicines. There are certain signs and precautions which staff should be aware of for these people. At this inspection guidance had been produced for staff to ensure they understood the things to look out for and report.

Medicines about which there are special legal requirements had been stored securely and checked regularly. Two staff had signed a register to show when people had received these medicines; which is good practice as a double-checking process. The temperature of the medicines room and fridge had been routinely documented and showed that this had been monitored to make sure medicines were stored at correct temperatures. Where people had medicines in patch form, records were kept to show that the site of the patch had been changed each time to prevent any skin irritation. MAR had been neatly and consistently completed by staff to show that people had received all of their medicines.

At our last inspection special air flow mattresses for people who were at risk of pressure sores were at the wrong settings. At this inspection some mattresses were correctly set but others were not. One person who had a current pressure wound had an air mattress and staff had checked the pump setting five times in the 17 days leading to our inspection. On each occasion staff had documented 'Pump shows low pressure', but

no actions were recorded. We brought this to the immediate attention of the area manager who physically checked the mattress and reported back that the pump was not inflating it correctly. They sourced a replacement mattress and pump during the inspection for this person, but they had been on a mattress which was not sufficiently inflated and did not therefore provide the full benefits of having it. Another person weighed 66.2 kgs but their air mattress pump was set at 90kgs which again meant that they had not received the therapeutic effect of the mattress.

During the inspection we became aware that the water in some rooms was excessively hot. The acceptable maximum temperature is 42 degrees but when we asked maintenance staff to immediately check, they reported that the water temperature in one upstairs bathroom was 55 degrees and in a toilet was 46 degrees. The water supply to sinks in two people's bedrooms gave readings of 49 and 52 degrees. This created a risk of scalding and we advised the area and registered managers to take urgent action to rectify this during the inspection. When we left the service at the close of the inspection, all temperatures had been brought down to safe levels. Following the inspection the area manager contacted us to confirm that thermostatic valves had been adjusted and a new boiler was on order. However this problem should have been identified and rectified through regular maintenance testing. The failure to do so had placed people at risk.

The failure to identify and minimise risks is a continued breach of Regulation 12 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other assessments of risk to people were detailed and actions to reduce risk were appropriately taken. For example, there was step by step guidance for staff about how to safely support one person to reposition in bed. Staff followed the instructions in practice and checked that the person was comfortable and reassured throughout the manoeuvre. Another person had an assessment in place about the risks to them when moving about the service. We observed staff following guidance to make sure this person had their Zimmer frame and support from staff every time they wished to move from place to place.

Records had been made of regular electrical and gas safety tests. The passenger lift, hoists and special bathing equipment had all been regularly serviced to ensure they remained safe for use. Weekly checks been undertaken on: fire control panels, call points, fire equipment, emergency lighting, means of escape and fire doors. The fire alarm had been tested weekly and people had personal emergency evacuation plans in place. These highlighted any particular needs that people might have in the case of fire and gave staff detailed directions about how to support them if this happened, including any equipment such as hoists which may be needed.

At our last inspection recruitment processes had not been carried out robustly enough to ensure that staff were suitable for working with people living in the service. At this inspection we checked documentation and files for staff and found that this area had been improved. All of the files we reviewed had correct information about job applicants, including: background checks, full employment histories, a current photo and identity papers to evidence that staff had the right to work in the UK. References had been sought and followed up where necessary and records of interviews showed that the registered manager had explored applicants' skills and attitudes to ensure they were the right staff for the jobs.

Accidents and incidents had been appropriately recorded by staff and there was evidence of actions taken following them. For example; if people had falls, special equipment such as alarm mats was considered to help prevent recurrences.

Staff had received training about safeguarding people from abuse and harm. They were able to tell us some

of the possible signs of abuse and knew how to report any concerns. The registered manager was aware of their responsibility to escalate some types of issue to the local safeguarding authority so that they could be independently investigated. People appeared relaxed and comfortable with staff and one person told us "They [Staff] wouldn't hurt a hair on my head. They treat me lovely and I trust them".

Requires Improvement

Is the service effective?

Our findings

People told us that staff supported them effectively. One person said "I couldn't manage if I wasn't here. I can't walk very well and I get lots of help here". A relative commented "Staff are very good at using the hoist and helping those with mobility problems. They are very careful and very aware of people who could fall".

Some people had pressure wounds or other skin breakdowns which required input from visiting district nurses. Records about people's skin wounds were sparse and did not include information or guidance from the district nursing team following their visits. For example; staff told us that two people had current skin problems but there was no information in care plans or risk assessments about these issues. There was no record either of any instructions given by the district nurse team when they visited. We spoke with two district nurses during the inspection who both said they had no concerns about these people's wound care management and felt that people were being well looked after. However, the lack of accurate and up-to-date records made it impossible for us to track the progress of people's wounds and created a risk that they might not receive appropriate support.

The failure to maintain accurate records is a continued breach of Regulation 17 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's health was monitored by staff and the GP was involved if there were any concerns. People had access to a chiropodist and to dental and optical appointments as needed. One person told us "I can always see a doctor if I need one, they're really good here". Another person said "I have the chiropodist in to do my toe nails very few weeks, which is a big help".

At our last inspection, records about people's fluid intake had not been accurately or properly completed. At this inspection fluid charts were now being regularly filled in and showed that people were receiving adequate amounts to drink. Drinks were offered to people at regular intervals and people had jugs of water or squash in their bedrooms which we observed staff using to give people drinks throughout the day. One day of our inspection was particularly warm and people were treated to milkshakes and ice cream floats in the afternoon. Target fluid amounts were recorded for each person and prompts for staff had been produced to illustrate what 250mls looked like for example; to help them in correctly gauging how much people had drunk. One person remarked "We are always eating and drinking here" but one relative said that their loved one was often very thirsty when they visited.

Most people told us that they enjoyed the food on offer. One person said "The Cooking is good. There's a choice of having breakfast in our rooms or the dining room and you can have a cooked breakfast if you want one. You can have whatever you want from the kitchen." Another person commented "We are told to just ask if there is anything we want." A relative said "The food always looks very nice. It's so important as it's a big part of their day". Meals appeared well-presented and appetising and tables in the dining room had been laid up with bright tablecloths and flowers. There was soft classical music playing through the lunch period to make more of an occasion of having a meal.

However, people who spent their days in their rooms told us that their meals were often cold when delivered to them. We asked one person if they had enjoyed their lunch and they replied "It was cold as usual: look, come and feel. It's cold." The meal and plate did not feel warm. This person was confused because they told us lunch had come "Very early". We noticed that the two clocks in their bedroom room had not been put forward from the weekend before our inspection, when British Summertime started, so this person thought they were having lunch at 11:30am. Clocks in other rooms had not been changed which was disorientating for people living with dementia.

We recommend that the provider reviews the lunchtime service with a view to ensuring that all people receive their meals at a suitable temperature.

Menus were displayed on a board in the dining room. However the meals offered were different to those shown on the first day of the inspection. Later in the morning staff wrote on a blackboard with the options for that day. At a meeting with the cooks in December 2016 the registered manager had raised that menus were not being updated on the display boards, but this continued to happen. At around 11:30am, kitchen staff were observed asking people what they would like for lunch on the following day. Many people were living with dementia and this approach could be confusing for them. In a recent survey one person had responded 'I would like to choose [meals] on the day'. There were no picture menus being used to support people living with dementia to make their selection during the inspection, although the registered manager told us these were available. This is an area for improvement.

Staff had received a range of mandatory training to help them carry out their roles effectively. Courses included health and safety, food hygiene, infection control, moving and handling, first aid and fire safety. Most staff had also received safeguarding, MCA and dementia training and some had completed specialised training around diabetes and medication administration. 16 of the staff had achieved National Vocational Qualifications (NVQ) level 2 or 3. NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job. We observed that staff appeared competent when carrying out their duties. One relative told us "You don't get staff like this everywhere you know. They're really on the ball and it's obvious they've had good training".

New staff received a detailed induction and some were completing the Care Certificate; which is a set of standards that social care workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. This meant staff had a good basic understanding about their roles and expectations before they began.

The registered manager told us that all staff received regular supervisions and records evidenced that they routinely carried out observation of staff practice and competency. However, these sessions did not always document that staff had been asked about their training needs or for any feedback about working in the service. There had been missed opportunities to debrief with staff and gain their views on any changes or improvements that could be made.

We recommend that the provider expands the supervision process to include feedback from staff about their own developmental needs and any concerns.

At our last inspection people's consent to their care and treatment had not always been appropriately obtained. At this inspection, assessments of people's capacity to make their own decisions had been made in accordance with the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Where people were assessed to have capacity for specific decisions, they had signed their own consent forms. In

cases where people were assessed as lacking capacity for particular choices, best interest decisions had been reached with input from family and professionals.

Staff had received MCA training and were observed asking people if they minded wearing a food protector at lunch, for example. Staff were able to tell us how they ensured that people were involved in making straightforward choices by for example, showing them two sets of clothing to select from.

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 are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had made applications for DoLS and received authorisations from the relevant authority.

Requires Improvement

Is the service caring?

Our findings

We looked at how people were cared for at the end of their lives. We received negative feedback before and during the inspection about the care provided to a person who was at the end of their life. There was a specific end of life care plan in place for this person which detailed funeral arrangements, any religious input required and that the person wished to stay in the service for their final days. However, a checklist for end of life care which was designed to document any repositioning or pain management needs for example was completely blank. Repositioning charts for this person showed that they had generally been supported to turn in bed every few hours but on one date turns happened at 4pm, 7pm and 1am only. This person's air flow mattress was found to have been faulty during the inspection and had not been inflating properly. Staff said that they tried to make people as comfortable as possible at the end of their lives but some staff were less able to say how they would do so. One staff said "We need to give more focus to them, check every half hour, make sure enough fluids and foods" but there were no specifics documented about for example, which foods would be best for this person or what they might like to taste. Some other people's end of life care plans held scant information which did not include any detail about people's preferences or wishes.

Training records showed that only one staff member had received training in Care of the dying. We asked staff if anyone was reaching the end of their life and received different responses from them. Communication about the person who had been deemed by a GP to be in their final days had not been effective and there was risk that they would not receive appropriate care as a result.

We recommend that the provider schedules end of life care training for all care staff from a reputable source.

We asked people and relatives about their experiences of the care given in the service. We received mostly positive feedback about staff. Although people raised issues with us about poor call bell response times, they were clear that this was not the fault of staff, who they said "Work like Trojans". One person said "I'm very grateful for everything they do for me. It can't be easy. The staff are always very busy and they have so much to do. My room is lovely, I'm well fed, my washing is all done for me. I've been here a long time and am very happy." Another person told us "They [Staff] are very kind. I can't fault them". A further person remarked "The staff are very good; they work very hard. I feel very safe here and have everything I need. I have a problem walking so couldn't live on my own as I couldn't get around. Everything is done for me here and I don't have to worry."

When staff spoke with people it was always with a friendly demeanour. They entered into light- hearted banter with some people and were generally jolly and consistently kind. Staff were courteous and patient when supporting people with walking aids to move around the home and considerate in making sure people's spectacles were clean or their feet were raised for comfort. One person had their cushions plumped by staff and told us "They get to know us well and are always patient and kind."

Some people liked to have their bedroom doors open and others preferred them to be closed. People were given the choice about this and their preferences were respected. People told us that staff always knocked

and called out before they entered. We saw this happening on many occasions during the inspection and heard staff explaining to people why they were there or asking how they could help them.

People said they were treated with dignity and we observed people's legs being discreetly covered when dresses had ridden up and clothing being sensitively rearranged when people came back to the lounge from the toilet. Staff protected people's privacy and confidentiality by speaking to them quietly to remind them about using the toilet and ensuring that care plan information was kept locked away when not in use. Staff did not discuss people or their care in front of others but made a point of speaking with each other in office areas or in a discreet manner.

Care plans documented where people could be independent in some aspects of care. For example one person's care plan stated that they were able to wash their hands and face but would need assistance with other areas. The care plan had been discussed with this person, who had commented that they 'Would like to do what she can for herself'. People who were mobile could move about freely in the home and bring themselves down for meals or activities as they pleased. One person told us that they had been able to have their own rise and recline chair in the conservatory so that they could get themselves up from it without needing staff assistance, to maintain their independence for as long as possible. They said this was really important to them and that staff had listened to what they wanted. Other people went out in a taxi and staff facilitated these outings for them so that they could continue to experience the things they had always enjoyed.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were written in a person-centred way so that people's individual personalities and preferences were documented. However, the information held was not always an accurate reflection of people's current needs. For example, one person had unusual sleeping arrangements which staff told us was because they had breathing difficulties. This person gave us a different reason for their choice of sleeping position. The care plan made no reference to any problems with breathing and recorded incorrect details about the person's current sleeping preferences.

Another person had a cream in their bedroom which had been prescribed for them, but there was no reference to this cream in any of their care plan records and it was not listed on the MAR. Staff told us that this person applied their own cream but there was no risk assessment or other information in the care file about this. Senior staff told us that this person had all their medicines and creams administered to them, but there was a confused picture about how and who applied this cream and whether it should still be in use.

The failure to keep accurate and complete records is a continued breach of Regulation 17 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's bedrooms had been personalised with pictures, photos and other possessions that were important to them. Information had been sought from people and their families to compile folders about each person's life before they lived in the service. Some of these folders were more complete than others but it was clear that staff had made efforts to find out how people had lived previously and their achievements. One person told us "They [Staff] know me well by now and they know the things I like".

There was no activities coordinator working at the service during our inspection. They had left at the beginning of February 2017 and a replacement was being recruited. In the meantime care staff and the cook were offering activity sessions to people when they could. Bingo was played on one afternoon and armchair exercises were led by a visiting instructor on another. The people who took part in the exercise session appeared to enjoy it and one person said "I do like it but it's only once a fortnight you know".

People told us that there was very little being offered day to day by way of activities. One person said "There's precious little to do unless the cook can get out of the kitchen". Another person stayed in their room throughout the inspection and told us "There is nothing to go down for; when there are things, I go down but there is nothing at the moment." There were two notice boards advertising daily activities but the information differed on each of them for the same day. This was confusing for people living with dementia. On the day of the inspection one board showed a coffee morning and the other a quiz. Neither of these events took place; but there was a game of bingo in the afternoon in which three people took part. Staff knew nothing about the coffee morning that was advertised. On the second day of the inspection 'Pampering' and card games were listed but armchair exercises took place instead.

People who stayed in their rooms told us that there was nothing for them to do except watch TV or read the

paper. One person said they rarely went downstairs for activities. They said "The staff are very busy and they do not encourage us to go down. There is nothing to go down for anyway." In a recent survey about people's experiences of living in the service, some people had asked for more activities to be provided. One person wrote 'Not enough entertainment' and another that 'I would like an activity lady'. Care plans contained social and leisure risk assessments, but in some cases these were completely blank. There were records about the social activities people had been involved in for March but entries had only been made on five days in that month. These showed that for example; five people played bowling or three residents played Ludo.The highest attendance at any of the activities shown was seven people out of the 39 living in the service. Prior to the March activities records the most recent had been completed in December 2016.

The lack of activities to meet people's need for social stimulation is a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they knew how to make a complaint; A copy of the provider's complaints protocol was displayed in the foyer and detailed how complaints would be responded to, with timescales. One person said "Oh yes, I know how to complain, but there really isn't anything for me to complain about". Two complaints had been logged since the last inspection. One of these was very recent but the other had been investigated and responded to within the time limits set down in the provider's policy. A respondent to a recent survey commented 'Any queries dealt with and professionally resolved'. Complaints were audited monthly to monitor the number and types of complaint received and whether complainants were satisfied with the outcome.

The service had received a number of thank you cards and compliments one of which read 'Thank you for looking after [Person's name] over the last 12 months- your care was much appreciated'.

Inadequate

Is the service well-led?

Our findings

The service had not been consistently well-led and had been rated as requires improvement or less in this area for four inspections over a two-year period. There had been insufficient oversight by the registered manager, area manager and provider to highlight the shortfalls in safety and quality that we found during this inspection. The registered manager told us that they and staff had worked tirelessly to make and sustain improvements but we found several breaches and continued breaches of Regulation during this inspection.

Following our last inspection we took enforcement action by way of a Warning Notice. The provider sent us an action plan to state that all areas had been addressed. This included the completion of cream charts, air flow mattress settings and other records. Although other areas of the Warning Notice had been met at this inspection, creams charts continued to have gaps and not all air flow mattresses were on the correct settings or in good repair. Minutes of a staff meeting in January 2017 recorded that the completion of creams charts needed improvement. The registered manager told us that they had introduced new sheets for senior staff to check that creams were being regularly applied. However, when we looked at these sheets for people and dates where we had found missed entries, these had not always been picked up or actioned by senior staff. Record-keeping had not significantly improved at this inspection and meant that some aspects of people's care were not appropriately evidenced.

In addition to the Warning Notice we made three requirements. These related to consent, recruitment and medicines management. The provider sent us an action plan to state these areas had been addressed. At this inspection, consent and recruitment had been improved but the management of medicines continued to be of concern. Medicines audits had been carried out but had not identified that medicine rounds were taking a long time and that records of administration times were misleading. These audits did recognise that creams charts were incomplete in February 2017 but no effective remedial action had taken place.

There had been no audit of call bells which could have drawn attention to those that were ringing for long periods. This information might have highlighted the need for more staff but had not happened.

The lack of effective auditing and oversight is a continued breach of Regulation 17 (1) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The area manager had completed a detailed audit of the service in the days before our inspection, but this had yet to be shared with the provider and registered manager.

We received mixed feedback about the management and leadership of the service. Some people and relatives told us that they got on well with the registered manager. One relative remarked "The manager is very good and I find her very obliging". Two people agreed with this but added "We don't see much of her". In a recent survey some people had indicated that they did not see the registered manager on a regular basis.

Staff understood their responsibility to escalate any unaddressed concerns outside of the service. This is

sometimes called whistle blowing. They told us that they always did their best for people but were very busy all the time. One staff told us "I love working here, there's great teamwork and I go home feeling I've made a difference". Another staff said that there was an open culture which allowed them to speak out freely with any concerns. They added that they could also write anonymous feedback to the registered manager if they preferred this method.
However, other relatives and staff told us that they felt the registered manager could be rude and unhelpful at times. As a result, not all relatives and staff felt able to speak to the registered manager with concerns. One relative said that the registered manager was dismissive when they raised issues and a staff member told us that the registered manager was "Not a people person and can be really off-hand". We discussed the concerns raised with the provider who said they would take action to ensure the situation improved.

Other staff said they felt supported by the registered manager and that they had confidence in them to make changes and improvements to the service as necessary. Some staff said that they had told the registered manager that six care staff were needed in the mornings and that they had agreed to recruit extra staff. They said that the registered manager was responsive to any feedback they shared with them. Staff had been asked to complete a survey in November 2016 and the results of this were generally positive, with staff reporting that they felt listened to and could comfortably approach the registered manager.

Feedback had also been sought from people and their relatives about their experiences of various aspects of the service. The responses were mostly very positive with the only areas receiving lower ratings from some people being; activities and visibility of the manager. One person had requested that a call bell be placed in the conservatory 'So that carers know when people need the toilet'. The registered manager had arranged for this to happen and we observed this in use during the inspection. People had commented on the quality of care staff by saying for example; 'All staff are second to none' and 'I like and get on with all the staff who are kind and considerate' and 'I'm very well looked after here'.

The registered manager told us they felt supported by the provider and any requests for equipment or extra staffing were met promptly. The provider had employed an area manager since our last inspection, who carried out quality assurance checks on the service and line managed the registered manager. Meetings took place between the managers of the provider's services for the purpose of sharing best practice and development. The registered manager said that she kept abreast of updates and changes in adult social care through an on-line resource system.

Links with the local community had been fostered for the benefit of people living in the service. Holy Communion was given by ministers from a local church and choirs from nearby schools visited on occasion to entertain and chat with people.