Abbey Healthcare Homes Limited

Wrottesley Park House Care Home

Inspection report

Wergs Road
Tettenhall
Wolverhampton
West Midlands
WV6 9BN

Tel: 01902750040

Date of inspection visit:
04 January 2017
05 January 2017

Date of publication:
27 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 4 and 5 January 2017. At the last inspection in January 2016, we found the provider was meeting all of the requirements of the regulations we reviewed, however improvements were required in relation to medicines management, staffing levels, activities and involvement and consultation with people living at the home. At this inspection we found although some of our concerns had been addressed there were other areas where no improvements had been made.

Wrottesley Park House Care Home is registered to provide accommodation and personal care for up to 63 people with physical and learning disabilities as well as complex health needs. On the day of the inspection there were 46 people living at the home.

There were two registered managers in post. One of the registered managers was the area manager for the provider, and the other had been appointed in August 2016 and was responsible for the day to day running of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were placed at risk of harm from the environment of the home. Equipment used to lift people had not been serviced in accordance with the legal requirements. Individual risks had been assessed; however these assessments had not given consideration to the condition of the building. Not all staff were aware of how to report concerns to people's safety and well-being. There were not always enough staff available to meet people's needs. People received their medicines as prescribed, although some improvements were required to the way prescribed creams were stored. Recruitment checks were carried out to reduce the risk of unsuitable staff being employed.

People did not always receive support from staff who had up to date knowledge and skills. Staff did not always feel they were supported in their role. People were asked for their consent before care and support was provided. People's capacity had been assessed and recorded so that staff knew how to support people when making choices and decisions. People had access to external healthcare professionals when required and people's health needs were monitored by staff.

People were not always supported in way that upheld their dignity. People expressed concerns about not being supported to maintain their independence, where possible. Most people felt involved in decisions about their day to day care and support. People described staff as kind and staff responded to people's need in a compassionate and caring way.

Although some activities were available people were not always supported to participate in activities that interested them. People and relatives knew how to complain, however were not always satisfied with how their concerns had been dealt with by the registered manager. People were involved in the assessment and

planning of their care and staff were aware of people's individual preferences.

The provider had not always notified of us of events and incidents as required by law. People told us they did not feel involved in the running of the home and had not been consulted about planned changes. Staff did not always feel involved in decisions made about the home and some staff had not received regular supervision or support from senior staff. The provider had not responded to the recommendations of recent health and safety audits. There were systems in place to monitor the quality of care people recede, however these had not always been effective at identifying areas of concern or driving improvement. People continued to be placed at risk of harm as the provider had not taken action to address the condition of the home environment. Staff told us they felt supported by the colleagues and felt able to approach the registered manager if they had any concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

During the inspection 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive care in an environment that was safe.

People were at risk of potential harm as not all staff members were aware of how to report potential abuse correctly.

People were not always supported by sufficient numbers of staff.

Risks to people had been assessed but did not reflect the potential risks posed by the home environment.

Recruitment practices protected people from the risk of being supported by unsuitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

A number of staff had not received up to date training or supervision to ensure they had the skills and knowledge required to meet people's care and support needs.

People were asked for their consent before care and support was provided. Where people's rights were restricted this was legally authorised as required by the Mental Capacity Act (2005).

People were happy with the food and drink provided and people were supported to access healthcare service when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported in a way that upheld their dignity.

People's independence was not always encouraged or promoted by staff.

People felt staff were kind and friendly.

Most people felt they were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to take part in activities that interested them.

People and relatives expressed dissatisfaction with the way in which their concerns were dealt with.

People were involved in the assessment and planning of their care and staff knew people's likes, dislikes and individual preferences.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not submitted notifications about safeguarding incidents to us as required by law.

People had not been asked to give their feedback about the care provided.

People and staff were despondent about the plans for the refurbishment of the building and did not feel they had been involved or consulted in the planned changes.

Systems in place to monitor the quality of care provided had not identified the issues found at the inspection.

The provider had not acted on recommendations from audits carried out in relation to the condition of the home environment or matters of health and safety.

Staff spoke positively about the registered manager and felt they could approach them with any concerns.

Wrottesley Park House 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 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 4 and 5 January 2017 and was unannounced.

The inspection team consisted of three inspectors and a specialist advisor who was a nurse with specialism in mental health. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted the local authority and commissioners for information they held about the service. This helped us to plan the inspection.

During the inspection we carried out observations of the care and support people received. We spoke with eight people who lived at the home, two visitors, nine staff members, the registered manager and the area manager who is also registered. We looked at seven records about people's care and support, two staff files, five people's medicine records and systems used for monitoring the quality of care provided.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2016 we rated the provider as "requires improvement" under the key question of "Is the service safe?" We found improvements were required to ensure there were enough staff to support people and ensure people received their pain relieving medicines at night. At this inspection we found some improvements had been made in these areas, however we identified other concerns that meant people were not always safe.

People were not always kept safe by the environment of the home. The home environment and equipment used to support people were not always managed or maintained in a way that protected people from avoidable harm. Parts of the home were in poor condition and required immediate attention in order to keep people safe. A number of fire doors were not fit for purpose. We observed one fire door in the dining room where there was a gap between the door and the frame. This meant there was a risk that the door may not prevent a fire or smoke from spreading in the event of a fire. We saw another fire door where the electrical wires required for the self-closing mechanism had been severed, wires were exposed and hanging from the door. This meant the door may not automatically close in the event of a fire, potentially placing people at risk.

Some people's bedrooms were also in poor condition. We observed electrical sockets that were not secured to the wall leaving exposed gaps with access to electrical wires. In one person's bathroom we saw a broken radiator cover with exposed metal, which may cause an injury. Flooring in some areas of the home also presented a possible risk to people's safety. In some people's bedrooms the flooring had been damaged and not repaired or replaced and in other areas the floors were uneven due to water damage. This posed a risk to people as they mobilised as they may trip or fall as a result of uneven flooring.

Equipment used to support people with their mobility had not been serviced in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). These regulations state; "Where people are being lifted - whether the lifting equipment is designed to lift them or not - the equipment must be thoroughly examined at six-monthly intervals". Records showed that the required testing had not taken place. This placed people at risk of harm, as equipment such as hoists had not been checked to ensure they were safe to use.
People were not always supported to manage their risks safely due to the condition of the building or equipment used. We found although people's individual risks had been assessed and staff were aware of how to support them safely, consideration had not been given to the condition of the building or the equipment used to support them. This meant people were placed at risk of harm. We found lighting was poor throughout the home; some areas were dimly lit due to lighting not working. We spoke with one person who told us how this affected them. They told us, "I have glaucoma which means I struggle to see. So it is much better when the lights are on." We found parts of the home were poorly lit for the duration of the inspection and we observed staff struggling to locate records due to poor lighting. The registered manager told us the provider was aware of issues with the lighting and on the day of inspection maintenance staff were carrying out work at the home.

We saw one person needed the use of a specialist shower chair. The shower chair was unstable and in a poor state of repair, some parts were rusting. We discussed our concerns about the use of this chair with the area manager. They told us the chair had recently been taken out of use, but as the person using the chair was unhappy about this, it had been reinstated. They told us they had made a referral to the relevant agency for a new chair two months ago, but this had not been followed up. They told us the person had been asked to sign to say they were happy to continue to use the shower chair, despite its poor state of repair. This potentially placed the person at risk of harm as the chair was unstable and therefore could tip while the person was using it.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they felt safe. One person said, "There are staff around, I feel safe." Staff we spoke with were able to identify possible signs of abuse and knew how to report concerns relating to people's safety. One person told us, "If I had concerns I would bring it to the attention of the nurse and if the situation was being caused by the nurse, or another member of staff I would go to the manager or CQC." However, not all staff we spoke with were aware of how to escalate concerns to the relevant authorities. We discussed this with the registered manager who told us they had identified this as a training need prior to the inspection. They informed us that appropriate training had been booked to ensure staff were confident to report any concerns with regard to people's safety.

Most people we spoke with told us they felt there were enough staff available to support them. One person told us, "There are always staff around if you need them." A second person said, "If I press the call bell the staff are usually here in a minute. I find this reassuring." A third person told us they felt there were enough staff for the majority of the time, but sometimes there was a delay in receiving support with washing, as staff were "busy". Staff we spoke with told us they felt there were enough staff to meet people's needs and respond when people needed support. One staff member said, "I think there are enough staff. If a number of people are off sick at short notice that can be difficult, but most of the time it's ok." We observed staffing levels throughout the inspection and saw staff were available when people needed them. Staff carried out regular checks on people who were cared for in bed to ensure they were comfortable and had what they needed. However, there were periods of time during the day where people were left alone in the dining room. We observed people sitting with food in front of them and no staff were present to offer support to help them eat. Other people had finished their meals and were sitting in front of empty plates waiting for support to return to their living areas. We found during busy there were times there were not always enough staff available in communal areas of the home to support people.

People told us they were happy with the way staff supported them with their medicines. One person told us, "I do get my tablets regularly, staff support me." We reviewed systems used to manage and administer medicines and found people received their medicines as prescribed. Medicines were stored safely and records reflected people received their medicines as prescribed.
Where people used 'as required' medicines there was not always clear guidance available for staff to follow about when people should be given these medicines. This could lead to inconsistencies for people in receiving their medicines. Some people living at the home received support with their medicines through a feeding tube. During the inspection we observed two people's feeding pumps had not been effectively cleaned. We observed cover guards had been left open and there were spillages on the pumps, which may put people at risk of infection.

We had received concerns about the general condition and cleanliness of the home from relatives of people who lived at the home. We shared these with the local authority commissioning team. During the inspection

the area manager told us they had developed a service improvement plan as a result of a recent infection control audit conducted by the Clinical Commissioning Group (CCG). We asked to see a copy of the improvement plan, but were told it was not available on the day of inspection. Following the inspection the CCG advised they would be conducting a further audit of the home to check on the provider's progress in addressing the issues raised.

We looked at two staff files and saw relevant checks had been carried out before staff were able to start working with people. Staff told us, and records confirmed, that the provider had conducted recruitment checks including requesting references from people's previous employers, identity checks and Disclosure and Barring Service (DBS) checks. DBS checks help providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people. People were supported by staff who had been recruited safely.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff had the skills and knowledge required to support them. One person said, "The staff are very good. They help me with anything I ask for." We received varied feedback from staff about whether they felt supported in their role. One staff member said, "I had a good induction, everything was explained to me. I had a good introduction to the people living here." However, some staff told us they did not receive regular one to one meetings to discuss their work. One staff member said, "People do have meetings with the management team, but I've no idea how this works. I've not had any formal support from the last two managers, if I need anything I just go to my colleagues." This meant they did not receive feedback on their performance and therefore there was a risk they may not understand their roles or responsibilities.

We reviewed the training matrix which is a tool used to log staff members and the training they have completed. Records showed that some staff members had not received recent training to ensure staff knowledge was up to date and in line with current legislation and best practice. For example, not all staff had received training in infection control, Mental Capacity Act (MCA) and manual handling. The registered manager told us they had recently reviewed the staff team's understanding of key training subjects and further training had been arranged to ensure staff knowledge was up to date.

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 told us they were asked for their consent before staff provided them with care and support. One person said, "I was advised by the nurses that I need to spend more time with my legs elevated. We discussed it and I agreed. I am not told what to do but advised and given choice." We observed people being asked if they were happy with staff supporting them with their mobility or if they needed support with personal care.

Staff we spoke with understood the basic requirements of the MCA and were aware of the need to act people's best interests. Staff told us they looked for signs of consent when people were unable to consent verbally. This included observing people's behaviours, facial expressions and body language. One staff member told us, "[Person's name] cannot speak, but they communicate so much with their eyes and face. If you ask a question and give them time, you will know if they are happy with something or not." Where people lacked capacity to make certain decisions we saw their capacity had been assessed and the outcome recorded. We saw one person's care records contained detailed guidance for staff about how to support the person to make their own decisions. Staff were able to describe how people would communicate their consent, and sometimes used people's previous decisions or choices to help guide them.

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). MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that one person currently living in the home had a DoLS authorisation in place and applications had been submitted for a number of other people. We reviewed the details of this authorisation and found the provider was meeting the required conditions. We spoke with staff who supported the person and they were aware of the DoLS authorisation and the reasons for it. The registered manager had a good understanding of their responsibilities in this area. They shared with us how consideration had been given to people who lived at the home and whether or not they were being deprived of their liberty. These assessments had been shared with the staff team to ensure people received up to date support that did not restrict their rights.

People told us they enjoyed the food and drink provided and received a balanced diet. One person told us, "Meals are good. You get a choice of two main meals for lunch. I don't like either today, so I have been offered something else that I like. There is always an alternative if you don't like something." Another person said, "I am able to have a hot breakfast if I want one." We observed people being offered hot and cold drinks throughout the day and people who requested drinks received them. We spoke with a member of staff responsible for meal preparation and they shared with us information relating to people's specific dietary needs. They told us, "The care staff let us know if there are any changes to people's needs, so we can make sure people get food they like at the right consistency." Other staff we spoke with were aware of people's dietary needs as well as their likes and dislikes. This ensured people were supported to maintain a healthy diet.

People's healthcare needs were monitored by staff and they had access to healthcare professionals when required. One person told us, "I do get the assistance I need from extra health services like the opticians or chiropodists." Staff were able to explain how people's ongoing physical and mental health needs were catered for and when they would contact relevant healthcare professionals. One staff member told us, "If there are signs or symptoms of a resident not being well I would contact their GP. In an emergency I would not hesitate to contact paramedic services." We observed one staff member assessing a person's physical health which had deteriorated. The staff member responded appropriately by contacting the person's GP and followed their advice to ensure the person received appropriate medical attention.

Requires Improvement

Is the service caring?

Our findings

We observed that people's dignity was not always maintained by staff who supported them. On the first day of the inspection we saw one person was drying their incontinence aid on a portable radiator in a communal area of the home. Despite staff being present throughout the morning, there was no consideration given to the dignity of the person, or assistance offered during this time to see if the person needed assistance with their continence or to remove the item.

Two people we spoke with shared concerns about how their independence was promoted. One person told us they had asked staff to replace the remote control for their television but this had not yet been done. They said, "I don't like it as when I am in bed I have to call the staff to turn over my TV for me. That is not what I like. I like to be independent but can't even change the TV channel." By not replacing the remote control, the person's independence had been taken away. Another person we spoke to told us staff were sometimes too busy to promote their independence. They said, "I'd rather have a shower every day, but staff say they are too busy. The first time I had a shower I found out I could wash my upper body myself, and it's nice to have some independence. I keep asking for a shower, but staff support me with a bed bath instead. I get fed up of asking." This demonstrated people's dignity and independence was not always promoted by the staff team.

Staff we spoke with were able to share examples of how they maintained people's privacy. One staff member told us, "I always knock on people's bedroom doors before going in, keep curtains closed when supporting people with personal care." We observed throughout the inspection staff respected people's privacy by knocking on bedroom doors before entering and discreetly asking people if they required personal care. We spoke with the registered manager about people's privacy and dignity. They told us they were looking to introduce 'dignity champions' shortly. A dignity champion is someone who acts as a role model to other staff and is committed to taking action to create a system that has compassion and respect for people using services.

We asked people whether they were involved in decisions about their care and support and received varied responses. One person shared with us the discussions they had with staff about their care and they felt this was a positive experience. Another person told us, "It's important for me to feel that staff know me and I think they do. Staff know what I want." However, a third person had a less positive experience. They told us, "I don't feel involved in decisions, particularly about my room. I have had no involvement." We saw records that demonstrated some people living at the home had been supported to express their views about their care and support. Staff were aware of people's communication needs and we observed people being involved in day to day decisions such as where and how they would like to spend their time.

Most people we spoke with told us they felt staff were caring and treated people with kindness. One person said, "Staff are nice to me and help me." Another person told us, "Over Christmas staff gave me presents and cards. It made me feel good and cared for." A third person said, "Staff are kind, they have a laugh with me. They support me with things I need." We saw staff interacted with people in a warm and friendly manner. Staff recognised the need to spend time with people, although some staff told us they wished they could do

more for people. One staff member said, "We try and do our best with the numbers we have for residents in our care." Where people expressed discomfort or concern staff responded to them in a compassionate way.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we highlighted concerns about a lack of stimulation and activities for people. At this inspection we found people were still unhappy about the support they received to take part in their interests and hobbies. One person told us, "We used to go out and about, to the zoo, parks and shopping, but nothing happens now. Not even to the cafe for a coffee." Another person told us activities were available, but they would like to see more consultation around activities that were offered, commenting, "There is usually something to do if you want to. There are games and we play for sweets which is a bit of fun. We are told what is happening and not asked what we would like to do." Staff we spoke with also expressed concerns about how people spent their time. One staff member told us, "There should be better facilities here, and access to transport so we can get people out." We asked other staff about the vehicles owned by the provider and were told they were no longer in use. The registered manager confirmed they were not aware of any plans to make these vehicles available for people's use. People who were not able to access community transport facilities were therefore restricted further in terms of places they could visit or spend their time.

During the inspection we observed activities were available and organised by an activities co-ordinator. A small group of people were involved in card making and later in the day a number of people gathered to watch a film together. However, people's individual interests had not always been considered. One person told us, "There is some stuff to do, but none of it suits me." We discussed our concerns regarding the lack of a person cantered approach to activities with the area manager. They told us they planned to recruit a second member of staff responsible for activities so that people could be supported more on a one to one basis to follow their interests.

People told us they knew who to contact if they were unhappy about the care they received, however we received mixed views on people's experiences of raising concerns. One person told us, "I have never needed to talk to anyone, but I am confident they would respond and address anything I needed." Another person told us they had repeatedly tried to raise concerns about the home environment, but felt they were not taken seriously. Relatives and visitors we spoke with told us they also had poor experiences. One relative commented, "I raised a concern and still don't know what has been done about it. I kept calling to speak to the manager, but my calls were not returned." A visitor told us, "Things here are not good, but there never seems to be anyone around to talk to about things." We reviewed the complaints log and saw recent complaints had been recorded and an explanation of actions taken in response to concerns was also detailed. However, people and relatives still felt more could be done to improve their experiences of raising concerns and offer them assurances that the provider was listening and taking appropriate action.

People we spoke with told us their needs had been assessed when they first moved in to the home, or stayed there as part of a planned respite stay. One person said, "When I first moved in the manager came to see me. They went through what I needed and agreed I could move in." We saw some people had been asked about their care and support and where appropriate, people's relatives had also been involved in reviewing the support people received. Staff had a good understanding of people's needs and were able to share with us examples of how they were considerate of people's needs and preferences. One staff member

told us, "It's important to get to know people and understand how best to support them." The staff member shared with us an example of how they communicated with one person by reading their facial expressions. Care records we reviewed had been regularly reviewed to provide staff with up to date details of people's care needs.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in January 2016 we rated the provider as 'requires improvement' for the key question, "Is the service well-led?" This was due to a lack of consistent leadership and a failure by the provider to actively seek feedback from people who used the service and their relatives. At this inspection we found people had still not been asked for their views and people we spoke with told us they had not been involved in decisions relating to the planned refurbishment of the home.

Prior to and following the inspection we reviewed the information we held about safeguarding incidents within the home. We also contacted the local authority safeguarding team for information they held about the service. We found that the provider had not always completed appropriate notifications about incidents or allegations that had taken place within the home. We were aware of incidents or allegations of abuse that had not been reported to CQC as required by law, despite the registered manager being aware of them.

This was a breach of Regulation 18 Care Quality Commission (Registration) 2009.

People told us they did not feel actively involved in the development of the home and had not been asked for their views. One person told us, "I have never been asked what I think, or to give feedback on what it is like here. There is just no involvement in the place." We asked the registered manager how people living at the home had been involved in decisions relating to the planned refurbishment of the home. They told us the provider had made the decisions relating to the colour scheme. One person told us, "I know there is going to be some redecoration, but I have no idea what is happening." We discussed this with the registered manager who told us group resident' meetings had proven ineffective in terms of gathering people's views, so instead they took a more informal one-to-one approach by talking to people individually. However, we were not able to find evidence that people's views had been taken on board by the provider.

People we spoke with expressed concerns about how the home was supported by the provider. One person told us, "There is a feeling the providers are penny pinching and don't invest in the property. Sometimes the staff ask to borrow my personal equipment because theirs have run out. I don't mind helping out, but they should ensure staff have the equipment they need to help people." Another person told us, "I don't feel that Abbey Healthcare is investing in this place. There has been a high turnover of senior staff and this has been very disconcerting and makes me feel insecure."

Staff told us they had, in the past, been consulted about planned changes to the home, but felt despondent about the condition of the home. One staff member said, "Managers come and go but nothing really changes. We keep being promised remodelling, but nothing ever happens." Some people and staff told us they felt staff morale was low. One staff member said, "As a team we feel unsupported and unappreciated. We just get on with our job and are never asked for any feedback. The only time we were asked our opinions were ignored."

We found there were processes in place to monitor the performance of the service. However, these were inconsistently applied. For example, the registered manager and area manager had raised concerns with the

provider about the condition of the fabric building and the risks to people's health and safety, but we found little evidence to suggest improvements had been made. The registered manager and area manager told us the provider was committed to making significant improvements to the building; however when we asked to see an improvement or development plan, we were told this was not available. The registered manager and an external health and safety company had carried out auditing which had identified some of the concerns raised at the inspection. We were told these had been shared with the provider in October 2016; however the risks identified, for example, in the health and safety report, had not been rectified. As a result people continued to be placed at risk of harm.

We saw that a range of checks were completed on care plans, individual risk assessments and medicines including stock counts. However, we found that some of the issues highlighted in our last inspection had not been addressed by the provider. At the last inspection we highlighted concerns about the lack of activities and stimulation available to people. At this inspection we found some people were still not supported to follow their interests or hobbies. At the last inspection we found people did not always feel involved in what happened at the home. At this inspection people told us they had not been asked for their views or feedback on the service they received.

We were aware of concerns raised by a number of agencies about the overall condition of the home. The home was subject to an improvement plan with the local authority who carried out regular reviews of the quality of care provided. We found improvements had not always been sustained as identified by further visits undertaken by external agencies and our inspection.

The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. The provider had not acted on feedback from relevant persons for the purposes of continually evaluating and improving the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there was an open culture amongst the staff team and nurses supported the care staff where possible. One staff member said, "I can go and ask the nurse about something and they will help." Staff we spoke with also expressed positive views about the registered manager. One staff member said, "The manager is approachable and does seem to sort things out on a day to day basis. I needed clarity on a certain matter and this was provided." We spoke with the registered manager who told us they were aware of the significant improvements required to the home environment and had met with the provider to convey their concerns. They told us the area manager was supportive of them and they were hopeful the planned improvements would take place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) 2009. The registered person had failed to notify the Commission without delay of (e) Any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (d) The provider had not ensured the premises used were safe to use for their intended purpose. (e) The provider had not ensured equipment used to provide care and treatment was safe for such use.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure systems were in place to; (a)Assess, monitor and improve the quality

and safety of the services provided.
(b) Assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk.

(e) Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity for the purposes of continually evaluating and improving such services.