Pinebird Ventures Limited

Fermoyle House Nursing Home

Inspection report

Fermoyle House Nursing Home
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 31 January 2017.

Fermoyle House Nursing Home provides accommodation, nursing and personal care for up to 32 older people, some of whom are living with dementia. There were 20 people living at the service at the time of our inspection.

At our last inspection on 28 July 2016, we found the provider was breaching legal requirements. Medicines were not managed safely and potentially harmful substances were not stored securely. There were not enough nursing staff on each shift to provide effective nursing care. Allegations of abuse were not appropriately reported. Staff had not been supported through training, supervision and appraisal. Restrictions had been imposed on people without legal authority. People were not supported to maintain adequate nutrition or to access treatment when they needed it. People were not always treated with dignity. Staff did not always respect people's privacy when providing personal care. There were not enough activities to keep people occupied and meaningfully engaged. There was inadequate management oversight of the service and records failed to demonstrate that people were receiving the care they needed. The overall rating for the service was 'Inadequate' and the service was therefore placed in 'Special measures'.

Following the inspection, the provider submitted an action plan telling us how they would make improvements in order to meet the relevant legal requirements.

The registered manager in post at our last inspection was no longer managing the service. Until a new manager was recruited, the service was being managed by an acting manager with support from the provider. 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 and associated Regulations about how the service is run.

Changes in the management of the service had led to a lack of clarity for staff about who they should take their lead from and who they should look to for leadership and advice. Monthly quality assurance checks failed to consider key aspects of the service, such as checks on care documentation and recruitment documentation. As a result the shortfalls identified during our inspection had not been identified through the provider's quality monitoring process. There was insufficient evidence of learning from accidents and incidents or of actions taken to minimise risks to people. There were inconsistencies in the recorded information about people's capacity. The daily care notes made by staff were task-focused. The provider had not established effective systems for people to contribute their views about the service or recorded any feedback they had received informally.

People were not adequately protected by the provider's recruitment procedures.

Care plans did not record people's preferences regarding end of life care, which meant their wishes were not known to the staff who cared for them. Two people told us one member of staff was not sufficiently careful when providing their care, which negatively affected their experience of receiving care. Although staff were being supervised they had not been observed in practice to ensure they were competent. People's privacy was not always protected because one of the shared bathroom doors was not able to be locked or effectively shown to be in use to prevent others entering. We have made recommendations about these concerns.

People were not always able to exercise their choices regarding their care. Some people told us they did not have sufficient choice about when and how often they showered. They said they did not feel comfortable requesting a change to this regime. Care plans did not record sufficient information to enable staff to engage with people about their lives before they moved in to the service.

There were additional nursing hours on the rota each day, which meant nurses had more time to provide the care people needed. The management of medicines had improved and the risk of people coming into contact with potentially harmful substances had been removed. People were better protected against the risk of abuse because staff had attended safeguarding training and were aware of their responsibilities if they suspected abuse was taking place.

Supervision and appraisal had been introduced for staff, which meant they received feedback about their performance and were able to discuss their professional development needs. Staff had attended training in key areas such as safeguarding, dementia and falls prevention and training was available for registered nurses to keep their professional development up to date.

Staff had attended training in the Mental Capacity Act 2005 and understood how the principles of the Act applied in their work. Applications for DoLS authorisations had been submitted to the local authority where people were subject to restrictions to keep them safe. People were being supported to maintain a healthy weight. Staff monitored people's weight and took appropriate action if people were at risk of inadequate nutrition. Although two people told us they did not feel they had the same choices of food when on a texture modified diet we found they were offered a choice. The cook had received training in providing special diets. People were supported to access advice and treatment when they needed it.

An activities co-ordinator had been employed, which had increased the range of activities available to people. There was a schedule of group activities and the activities co-ordinator said they also spent time each day visiting people in their rooms. Some people had been supported to engage with activities outside the service.

Some aspects of the management of the service had improved. The provider had begun to make monthly monitoring visits and produced a brief report of each visit. A monthly quality assurance check to be carried out by the manager had been implemented.

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

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?

Requires Improvement

The service was not consistently safe.

People were not adequately protected by the provider's recruitment procedures.

There were enough staff to keep people safe and to provide the care they needed.

Staff understood safeguarding procedures and knew how to report any concerns they had about abuse.

There were plans in place to ensure that people's care would not be interrupted in the event of an emergency.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People who required a texture-modified diet had a choice of meals and all were supported to maintain adequate nutrition. .

Staff had access to the training they needed to carry out their roles.

Staff received feedback about their performance through one-to-one supervision.

Staff implemented the principles of the Mental Capacity Act 2005 in their day-to-day work.

Applications for DoLS authorisations had been submitted where people were subject to restrictions to keep them safe.

People were supported to obtain medical treatment when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Two people told us one member of staff was not sufficiently careful when providing their care.

People's privacy was not always adequately protected.

Care plans did not record people's preferences regarding end of life care.

People told us staff were kind. They said they had positive relationships with staff and enjoyed their company.

Staff encouraged people to maintain their independence where possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People were not always able to exercise their choices regarding their care.

Care plans did not record sufficient information to enable staff to fully engage with people.

The range of activities available to people had increased. People had opportunities to engage with activities outside the service.

There were appropriate procedures for managing complaints.

Is the service well-led?

Inadequate

The service was not well led.

There had been changes in the management of the service, which had led to a lack of clarity for staff. The provider was in the process of recruiting a permanent manager.

Quality assurance checks were not effective in identifying shortfalls.

There was no evidence of learning from accidents and incidents or of actions taken to minimise risks to people.

The provider had not established effective systems for people to contribute their views about the service.

Daily care notes required improvement to fully reflect people's well-being. There were inconsistencies in the recorded information about people's mental capacity.	

Fermoyle House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 31 January 2017. The inspection was unannounced and was carried out by three inspectors.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We also reviewed feedback from the local authority, which had been carrying our regular monitoring visits since our last inspection. We had not asked the provider to complete a Provider Information Return (PIR) as we were following up concerns identified at the previous inspection. The PIR 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.

During the inspection we spoke with eight people who lived at the service, one relative and a visiting healthcare professional. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff. We spoke with nine staff, including the acting manager, care, nursing, catering, activities and housekeeping staff. We looked at the care records of five people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at the recruitment files of five staff and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

Requires Improvement

Is the service safe?

Our findings

People were not adequately protected by the provider's recruitment procedures. The provider had failed to obtain evidence of suitable character in previous employment for all staff employed. We checked recruitment records for six staff employed since our last inspection. Each prospective employee was required to submit an application form with details of two referees, one of whom the form stipulated should be a previous employer. In one case, an applicant had supplied the name of only one referee on their application form. The acting manager had sent a reference request but this had not been returned. There was no evidence any further efforts had been made to obtain the reference before the person started work or to establish why the applicant had provided only one reference. In another case, an applicant had supplied the name of two referees on their application form, one of whom was their previous employer and the other a personal reference. The personal reference had been obtained by the provider but no reference had been received from the person's previous employer.

Staff recruitment files contained evidence that the provider had obtained other relevant documents, such as proof of identity and proof of address, before staff were appointed. One member of staff had started work before their Disclosure and Barring Service (DBS) certificate had been obtained but the provider was aware of the need to ensure this member of staff always worked under supervision until an appropriate DBS certificate was received. DBS checks help providers identify applicants unsuitable to work with people who use care and support services.

Failure to ensure all staff were of good character and had the necessary competence, skills and experience was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, people's medicines were not managed safely. People were at risk because medicines were left unattended and there were no protocols to support staff to know when to administer medicines prescribed 'as required'.' At this inspection we found the management of medicines had improved. Medicines were stored securely and in an appropriate environment. There were protocols in place for the administration of medicines prescribed 'as required' and a process for recording the administration of topical medicines. Staff authorised to administer medicines had completed training in the safe management of medicines and had undertaken a competency assessment where their knowledge was checked. We observed that the member of staff who administered medicines was confident with the systems in place and competent in their practice. There were appropriate arrangements for the ordering and disposal of medicines. Nursing staff carried out medicines audits each month to check stocks and ensure people were receiving their medicines correctly. The medicines administration records we checked were accurate and up to date.

At our last inspection, there were not enough nursing staff deployed to meet people's needs safely and effectively. Nursing staff told us being the sole nurse on each shift meant they could not fulfil their role to the standard they wished. At this inspection we found an additional nurse was employed on the morning shift, which enabled nursing staff to spend more time with people. We observed that nursing staff were available

when people needed them. One nurse told us, "It's much better now. We have time to spend with the residents and care for them better." A member of care staff said, "There are enough staff. We're not full at the moment so it's never a problem." A healthcare professional told us that nursing staff were available to discuss people's needs with them when they visited the service. The acting manager was able to demonstrate that the number of nursing and care staff needed on each shift was calculated by assessing the support each person required. The acting manager told us the number of nursing staff deployed on each shift would increase should more people be admitted to the service.

People told us staff were available when they needed them. They said staff kept them safe when using any equipment involved in their care. One person said, "I do feel safe. I feel safe for the simple reason there are staff here." Another person told us, "Staff come fairly quickly when I press the alarm." A relative said there were sufficient staff on each shift to provide the care their family member needed. The relative said, "I'm confident she is safe here. There are enough staff around to meet her needs. They make sure her call bell is within reach when they are not there."

At our last inspection, people were at risk because potentially harmful substances were not stored securely. At this inspection we found the risk of people coming into contact with potentially harmful substances had been addressed. All potentially harmful substances were stored safely and repairs had been carried out to storage areas where necessary. Staff had attended training in the control of substances that are hazardous to health (COSHH) Regulations and followed appropriate COSHH procedures in their working practices during our inspection.

At our last inspection, people were not adequately protected against the risk of abuse because allegations were not appropriately reported and staff had not been regularly trained in safeguarding. At this inspection we found improvements had been made to address these concerns. The acting manager was aware of the local multi-agency safeguarding procedures and confirmed these would be followed in the events of any further allegations of abuse. Safeguarding training had been provided for staff and the staff we spoke with were able to describe the correct procedures to follow should they suspect abuse was taking place.

Risk assessments had been carried out to identify any risks to people and the actions necessary to minimise the likelihood of harm. For example staff evaluated the risks to people of developing pressure ulcers and those at risk of inadequate nutrition. Where risks were identified, staff implemented measures such as repositioning regimes to reduce the risk of pressure ulcers and food monitoring charts to address the risk of inadequate nutrition. A relative told us staff followed the guidance about their family member's care to minimise risks. The relative said, "She has not had any pressure sores because they turn her every two hours. They use the hoist to transfer her from her bed to the chair because she can't do that herself."

There were plans in place to ensure people would continue to receive care in the event of an emergency, such as loss of utilities or severe weather. Health and safety checks were carried out regularly to ensure the premises and equipment were safe for use. The provider had carried out a fire risk assessment and staff attended fire safety training in their induction. A personal emergency evacuation plan (PEEP) had been developed for each person, which detailed the action to be taken to keep them safe in the event of a fire.

Good

Is the service effective?

Our findings

At our last inspection we found staff had not received regular supervision and appraisal, which meant they did not receive feedback about their performance or have opportunities to discuss their training and development needs. We also found that staff had not attended all the training they needed to carry out their roles effectively. Many staff had not attended training in key areas such as safeguarding, dementia and falls prevention. No training was provided for registered nurses to keep their professional development up to date, such as wound care, male catheterisation and the management of syringe drivers.

At this inspection we found arrangements for staff supervision, appraisal and training had improved. Staff had received one-to-one supervision in October 2016 and supervisions were taking place in January 2017. Staff had also received an annual appraisal within the last 12 months. There was evidence that staff had contributed to the appraisal process and had opportunities to discuss their professional development. This schedule was in line with the provider's policy, which stated that staff should have a minimum of four individual supervision sessions and an annual appraisal each year.

Training in key areas had been provided for staff since our last inspection. Much of the training had been provided by the local Clinical Commissioning Group's Care Home Support Team. The Care Home Support Team comprised a consultant geriatrician, a pharmacist, a dietitian and a community nurse and worked with the service to improve the care people received. Members of the team had provided training in areas including medicines management, nutrition and wound care. The provider had also sourced training in safeguarding, dementia and falls prevention and nursing staff had received training relevant to their roles. Staff were positive about the training that they had attended. They said they felt better equipped to carry out their roles and provide effective care for people. A nurse told us, "We have done lots of training. In the last few months I've done phlebotomy training and male catheterisation and I have wound care coming up soon." A care worker said, "The training has been very good, I've learned a lot."

We saw evidence that staff who had been employed since our last inspection had had an induction when they started work. The acting manager told us all new staff would complete the Care Certificate following their induction. The Care Certificate is a set of nationally recognised standards that care workers should demonstrate in their daily working lives.

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 application 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 and whether any conditions on authorisations to deprive a person

of their liberty were being met.

At our last inspection we found there were restrictions placed upon people that had not been authorised. For example, people were unable to go out unaccompanied and were subject to constant supervision by staff. There was a lack of understanding of the MCA and its principles at all levels from the provider and registered manager to care staff. For example staff said they used bedrails to keep people safe but were unaware that this decision required an assessment and recorded decision before it could be implemented. Staff had not received training in the MCA to enable them to understand its purpose and how they should apply it in their work. Where mental capacity assessments had been carried out, these were generic rather than decision- specific. In cases where people had been assessed as lacking capacity, no meetings had been arranged to ensure that decisions taken about them were made in their best interests.

At this inspection we found staff's understanding of the MCA and how they applied its principles in their work had improved. Staff had attended training in the MCA and told us this had given them the knowledge they needed to put the principles of the Act into practice. Staff were aware that people must be assumed to have capacity unless demonstrated otherwise and that people's capacity may fluctuate. Staff understood the importance of consent and people told us staff asked for their consent before providing their care. Applications for DoLS authorisations had been submitted to the local authority where people were subject to restrictions to keep them safe.

At our last inspection we found people were not supported to maintain adequate nutrition. Staff weighed people regularly but did not respond appropriately when people lost significant amounts of weight. Nutritional assessments carried out by staff for three people recorded that they were 'severely underweight' but no food monitoring charts had been implemented or referrals made to healthcare specialists. Where guidance had been issued by a speech and language therapist, this guidance had not been followed.

At this inspection we found people were being supported to maintain a healthy weight. The service had benefited from the input of the dietitian from the Care Home Support Team, who had provided training for staff in nutrition. Staff were continuing to weigh people regularly and there was evidence that action was taken if people were at risk of inadequate nutrition. For example food monitoring charts had been implemented where people were at risk of losing weight and we saw these were being maintained by staff. We saw that nursing staff had provided the cook with information about people's dietary needs, including any allergies, their likes and dislikes and whether they required high calorie or texture-modified meals on the advice of the dietitian.

People who required a texture-modified diet told us they did not always have a suitable choice of meals. They said they were not able to choose from the same range of options as people who did not need a texture-modified diet. However we were provided with evidence following the inspection that people having texture modified diets did have access to menu options and apart from a few items that could not be texture modified these were the same as other people. The cook had received training in how to prepare nutritious texture modified diets.

At our last inspection we observed that everyone ate their meals either in their bedrooms or in armchairs in one of the lounges. At this inspection we saw that people were encouraged to eat together at the dining table, which had been set for lunch. Clothing protectors were available to people if they needed them and staff were available to help people who required support to eat. People told us they enjoyed their meals and that they could have additional helpings if they wished.

At our last inspection we found people were not supported to access treatment when they needed it. A

person had reported feeling unwell for several days. A care worker had told the nurse on duty the person was unwell and an appointment with a GP should be made. No appointment had been made for the person. A GP visited on the day of our inspection but was not asked to see this person. We told the registered manager to arrange an urgent appointment with a GP and to inform us of the outcome. After the inspection the registered manager advised that a GP had visited the person and prescribed antibiotics for a chest infection.

At this inspection we found people were supported to access advice and treatment when they needed it. People told us staff arranged for them to see a doctor if they felt unwell. Two people said they had asked to see the doctor and a healthcare professional visited them during our inspection. The healthcare professional told us staff referred people for appointments appropriately. They said they were confident people were receiving effective care to maintain their health. People's care records demonstrated they had access to healthcare professionals according to their needs. The outcomes of all appointments were recorded and any advice or guidance incorporated into people's care plans.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found people were not always treated with dignity and their privacy was not always respected. At this inspection we found some of these concerns had been addressed but further improvements were needed.

People told us they said they had positive relationships with staff and enjoyed their company. One person said, "I love it here. I get on well with the staff. Some of them you can really have a laugh with." People told us most staff were kind and caring in their approach and took care to keep them comfortable when providing personal care. One person said they did not like using the hoist but staff made this procedure as comfortable as possible and reassured them throughout the process. The person told us, "I don't like using it but the staff know what they are doing and make sure I'm all right." Another person said, "The staff look after us well." People told us they were treated with respect and a relative said staff provided kind and compassionate care for their family member. The relative told us, "I'm 100% happy with her care. I have never had cause to complain. The staff are kind and caring, they treat her with respect."

Two people told us one member of staff was less careful in their approach when providing personal care. They said they had not suffered injuries as a result but the practice employed by this member of staff had made them uncomfortable and affected their experience of receiving care. We discussed this with the acting manager, who agreed to observe and supervise this member of staff and ensure any shortfalls in their practice were addressed. The provider had not arranged for staff to be observed to ensure they always worked with care and compassion prior to this.

We recommend the provider review staff practice to ensure people's support is always delivered with care and compassion.

We found people's privacy was not always protected because one of the shared bathroom doors was not able to be locked. Staff placed a 'Do not enter' sign next to the bathroom door when it was in use but this was not effective in protecting people's privacy by preventing others opening the door when it was occupied. We discussed this with the acting manager, who agreed to make arrangements to ensure people's privacy was protected when using this bathroom.

Care plans did not record people's preferences regarding end of life care, which meant their wishes were not known to the staff who cared for them. The care planning system used in the service required staff to record where people wished their end of life, care to be provided, any spiritual needs the person had and how these would be met and the outcomes of any discussions regarding the discontinuation of medical interventions. This information had not been recorded in the care plans we checked, which meant the provider could not be sure staff were providing end of life care in accordance with people's wishes.

We recommend the provider review all end of life care documentation to ensure people's wishes are recorded and known by the staff who care for them.

We observed staff showing kindness to people during our inspection. For example we saw staff provide immediate emotional support to a person when they became distressed. The atmosphere in the service was calm and relaxed and staff spoke to people in a respectful yet friendly manner. Staff encouraged people to do things for themselves where possible to promote their independence. For example staff encouraged people to eat their meals as independently as possible and supported them to do so where necessary.

People had access to information about their care and the provider had issued each person with a statement of terms and conditions, which included the complaints procedure. The provider had a written confidentiality policy, which detailed how people's private and confidential information would be managed. Staff understood the importance of maintaining confidentiality attended confidentiality training in their induction.

Requires Improvement

Is the service responsive?

Our findings

We found that people were not always able or encouraged to exercise their choices regarding their care. Three people told us they did not have sufficient choice about when and how often they showered. One person said, "Once a week I am given a shower. They let me know which day I have the shower." The person told us they did not feel comfortable requesting a change to this regime as "Staff are very busy and I wouldn't want to cause a fuss." Another person said, "We have a shower once a week. I would like one every day if I could but I think there are too many people here for that." People's choices and preferences had not been recorded about how often they would wish to be assisted with a bath or shower so care personal to their preferences could not be delivered. Staff had also not encouraged them to express their views about how often they would like a shower or bath.

Care plans did not record sufficient information to enable staff to engage with people about their lives before they moved in to the service. Care plans contained sections for staff to record details of important relationships and events in people's lives but in some cases these had not been completed. The care planning format also required staff to record details of people's previous employment, where they had lived and any hobbies and interests they had. These details had not been recorded in the care plans we checked. We discussed our findings with the provider in feedback at the end of the inspection. The provider told us much work had been done on improving this aspect of people's care plans since our last inspection. We did not find evidence to support this in the care plans we checked.

Some people's assessments recorded that they had a religious faith but their care plans contained no evidence of how they wished to follow their faith or the arrangements to support them to do this. One person's care plan recorded that they were of the Christian faith but staff had entered 'Not Applicable' in the section of the care plan designed to record how people's religious and spiritual needs would be met.

Failure to ensure people's care was planned and delivered to meet their needs and reflect their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In July 2015 and again at the last inspection in July 2016 we found that people did not have access to meaningful activities and were at risk of social isolation. One member of staff had been allocated 90 minutes each weekday to provide activities but this was insufficient to provide a range of appropriate activities to keep people occupied and engaged. Since our last inspection, an activities co-ordinator had been employed for 31 hours each week, which had increased the range of activities available to people. People told us they enjoyed the new opportunities to take part in activities. One person said, "The activities are better. I enjoy the entertainers, I always make sure I'm there for that." An activity was provided during our inspection and people were engaged and enjoyed their participation. Other people chose not to participate but indicated that they enjoyed the activity going on around them.

There was an activity planner for each month listing activities planned both in-house and externally. Two members of the Royal Philharmonic Orchestra had visited the week before to play for people living at the service. A volunteer visited the service in the afternoon to play bingo with those who wished to join in. The

activities co-ordinator told us they spent time each day visiting people in their rooms if they did not wish to participate in group activities or were cared for in bed. The activities co-ordinator visited people in their rooms during our inspection. People had also been supported to engage with activities outside the service. For example staff told us some people now attended social events arranged by the local church.

There were appropriate procedures for managing complaints. The provider had a complaints procedure that listed agencies complainants could contact if they were not satisfied with the provider's response. The relative we spoke with told us they knew how to make a complaint if they were dissatisfied but had not needed to do so. There had been no formal complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our inspections in July 2015 and July 2016 we found the service was not well led. There was insufficient management oversight of the service and risks to people's safety had not been identified or acted upon. The registered manager had been unaware of the concerns identified during our inspections until these were outlined during feedback at the end of the inspection. The provider did not carry out or record monitoring visits to the service. As a result, the registered manager and provider were not always aware when people were receiving inadequate care and treatment.

The registered manager in post at our last inspection was no longer managing the service. A new manager had been appointed and started work but had left their post shortly prior to this inspection. Until a new manager took up the post, the service was being managed by an acting manager with support from the provider. We found this had led to a lack of clarity for staff about who they should take their lead from and who they should look to for leadership and advice. Staff said the acting manager provided support to the best of their ability. The provider had begun the process of recruiting a permanent manager, interviewing two candidates on the day of our inspection.

The provider had begun to make monthly monitoring visits, each of which focused on a different aspect of care and support, including spot checks at night. A monthly quality assurance check to be carried out by the manager had been implemented but these were not effective in identifying shortfalls. We found that there had been some improvement in activities since our last inspection but people were still not receiving a service that took their preferences into account and was planned to meet their individual needs. We have also made recommendations about the recording of information about people's mental capacity and that the provider ensures all staff are providing compassionate care to people at all times.

Information was recorded on the monthly quality assurance check regarding hospital admissions, infections and accidents and incidents but did not address key areas of the service such as checks that care documentation was complete and accurate or that all necessary recruitment checks had been completed before staff started work. As a result these shortfalls identified during our inspection had not been identified through the provider's quality monitoring process. We also found that the information recorded in monthly monitoring checks was not always accurate. For example no accidents or incidents had been recorded in monthly quality assurance checks, which was not consistent with the information recorded in the accident/incident log.

The provider had not established effective systems for people to contribute their views about the service. Neither residents' nor relatives' meetings took place to provide people with opportunities to give feedback or make suggestions for improvements. We identified this concern at our last inspection in July 2016. At that time we found feedback given by people and their relatives was not always acted upon. For example the provider had not implemented the suggestions made by relatives in satisfaction surveys. The provider has informed us since the inspection that people and relatives are reluctant to attend formal meetings so they seek views informally. However no evidence was made available to show when this had been done, the results of the feedback or any actions taken as a result.

Failure to effectively assess, monitor and improve the quality and safety of the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An accident/incident log had been implemented in December 2016 and recorded three falls in December 2016 and two falls in January 2017. In some cases the member of staff completing the log had recorded how the accident/incident had been investigated and the actions taken to prevent a recurrence. In one case, this section of the log had been left blank. This meant there was evidence of learning from accidents and incidents or of actions taken to minimise risks to people in most cases, but not in one case. Where necessary following a fall the provider had made a referral to a health care professional and their advice had been followed.

All the completed accident/incident forms recorded 'no' in the section of the form asking whether or not people's relatives had been informed of the accident. The acting manager confirmed that all the people for whom accident/incident forms had been completed had relatives. The acting manager told us that relatives had been contacted when their family members had suffered a fall. The acting manager said this contact had been recorded in people's daily notes. The provider supplied evidence of this following this inspection.

At our last inspection we found some people's care records did not demonstrate they were receiving the care and treatment they needed. For example staff had not implemented a re-positioning chart for a person who needed turning regularly in bed to minimise the risk of developing pressure ulcers. At this inspection we found staff had implemented recording systems where necessary to demonstrate people were receiving the care they needed. Regular re-positioning was recorded for people at risk of developing pressure ulcers and food and fluid charts had been implemented for people at risk of inadequate nutrition and hydration. The healthcare professional we spoke with told us the care notes maintained by staff were sufficient to demonstrate people were receiving effective care.

Although the recording of care provided had improved, the majority of the entries made by staff were task focused. We discussed this with the acting manager, who agreed to monitor and improve the daily care records maintained by staff. Whilst the way in which staff implemented the principles of the MCA in their day-to-day work had improved since our last inspection, there were inconsistencies in the recorded information about people's capacity. One person's care records stated they had full capacity and that staff should ensure they were fully involved in any decision making process. However elsewhere in the person's care records staff had recorded that they lacked the capacity to make decisions for themselves and required support from others to do so.

We recommend the provider review information in held in care records relating to mental capacity to ensure people receive their care in line with the MCA.