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Angel Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 10 and 11 April 2018 and was unannounced. At the last inspection on 30 November and 04 December 2017, the provider was rated as Requires Improvement and found to be in breach of Regulations 9, 10, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although some of these regulations were now being met, others remained in breach and additionally, new breaches of regulation have been identified.

Following the last inspection, we met with the provider to ask the provider to complete an action plan to show what they would do and by when to improve each of the key questions of Safe, Effective, Caring, Responsive and Well Led to at least good. The provider submitted this action plan to us and we reviewed this during the inspection. We found that although some of the actions recorded were in progress, it was clear that the provider had not had much input into the action plan and as a result concerns were raised about their ability to make and sustain improvements at the service.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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.

Angel Court Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and

the care provided, and both were looked at during this inspection.

Angel Court Residential Home accommodates up to 30 people in one adapted building. At the time of the inspection there were 19 people living at the home.

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

People were not supported to manage risks to keep them safe. Where actions had been identified to mitigate risks, these actions were not being consistently applied and this left people at risk of harm. Staff were not always safely recruited and there were not always sufficient amounts of staff available to support people other than to support with immediate care needs. Staff knew how to report concerns where people may be at risk of abuse and medications were given in a safe way.

Staff received training and supervision but it was not clear if this included training in people's individual needs. People had their dietary requirements met but the choices of meals lacked variety. The decoration of the service required improvement to ensure people were able to move around independently. People had their rights upheld in line with the Mental Capacity Act as staff understood the need to gain consent and the actions to take where people lacked capacity.

Although staff were caring, the culture at the service meant that staff did not often have time to spend with people in order to develop friendly relationships with them. People were not consistently treated with dignity and there was instances where privacy was compromised. People who were able were supported to maintain their independence.

There was a lack of activities available that met people's individual interests and hobbies. People felt unable to make a complaint and the complaints procedure was not consistently applied by the provider. People were given opportunity to express their preferences with regards to their care.

The provider had not made sufficient improvements to the service following a previous inadequate rating. The quality assurance systems in place were ineffective and the provider lacked oversight of the service as a result of this. Feedback given by people was not acted on in a timely way. The provider had not ensured that records held were up to date and accurate.

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.

Risks were not managed to ensure people were safe. Where risks were identified, action was not consistently taken to ensure people's safety.

Staff were not always recruited safely and there were not always sufficient numbers of staff to support people.

Infection control practices were not consistently followed.

Medication was given in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training but it was not clear that whether staff also received training in relation to people's individual needs.

People's specific dietary requirements were met but there was a lack of variety with meals.

Further work was required to the decoration of the service to support people's independence.

People had their rights upheld in line with the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Systems in place did not support staff to develop caring relationships with people.

People were not always treated with dignity and privacy was at times compromised.

People were supported to be independent where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records held personalised information about their preferences but did not consider people's individual interests in relation to activities.

Complaints made were not always responded too and the complaints procedure was not consistently followed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The providers systems to monitor and improve the service had been ineffective. Risks to people had not been monitored and where actions were in place to ensure quality, these were not consistently acted upon.

Feedback given by people was not responded too in a timely way.

Records kept in relation to people's care needs was not accurate nor up to date.

Angel Court Residential 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.'

The inspection was prompted following a previous inspection in November 2017 in which the provider was rated as Inadequate in the key question of 'Is the service well led?' The service was placed in special measures for a second time following this inspection.

This inspection took place on 10 & 11 April 2018 and was unannounced. The inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with five people who lived at the home, two relatives and one visiting health professional. We also spoke with three members of staff, the deputy manager and the registered manager who is also the provider.

As some people living at the home were unable to share their views with us, we used the Short

Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records for five people, three staff recruitment files, six medication records and records held in relation to accidents and incidents, complaints and quality assurance.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to identify and act on potential safeguarding concerns. This resulted in a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that whilst action had been taken to meet this breach, further breaches of regulations were found.

We found that where risks were posed to people, these were not always managed well to ensure people were safe. We saw that two people had catheters in place. A catheter is a small tube inserted through the bladder to remove fluid. Risk assessments were in place to guide staff on how to support with this to reduce the risk of infections. The guidance stated that each person should be given a minimum of two litres of fluids to drink per day. We checked the fluid charts held for these people and found that they had not consistently been given the two litres of fluids they required. In addition, it was not always accurately recorded how much fluid had been drank. For example, the records would state that the person was given 'a jug of water' but did not specify how much of that jug had been drunk. This meant it was unclear if the person had been given the required amount to drink that day. We also found that the running total of fluids consumed was not checked and so it was unclear if these people's daily intake was being safely monitored. We raised this with the provider who informed us that they had been told that as long as each person drank approximately two litres per day, then this was safe. However, they could not provide evidence of this advice in their records. Staff we spoke with could not explain why they were recording the amounts of fluid taken nor did they know that there was a minimum amount of fluids to be taken each day. This meant that the risks could not be mitigated as staff did not understand why they were taking the required action.

The provider had previously made us aware of an incident where one person had threatened another person. The provider had taken immediate action to mitigate this risk by ensuring the person who had displayed the threatening behaviour remained under the supervision of staff. We looked to see that the provider had acted to ensure people's continued safety. The person's care records did not identify the risks they posed to others or provide staff with guidance on how to mitigate this risk. We spoke with staff who gave us conflicting information on how they support this person. One member of staff informed us that the person had one to one support of staff at all times, whilst another member of staff felt one to one support was only given when in communal areas. We saw throughout the two days of inspection that this person was regularly within communal areas without staff supervision. This had meant that the initial actions the provider had taken to ensure safety had not been effectively shared with staff or implemented. As a result, it was not clear whether people were being effectively protected from risk of harm.

We found that where people were at risk of falls, their environment had not been fully assessed to minimise the risk of falls. One person had been assessed as being at high risk of falling. We found that in their bedroom there was a free standing heater that had been placed there due to the person being cold. There was no risk assessment in place for this and the provider had not considered the risk this heater posed to the person should they fall. The heater was placed at the end of the person's bed and had the potential to cause injury should the person have fallen near to this due to the level of heat being emitted. We intervened

to ensure the person's safety and requested the provider removed the heater and looked at other alternatives to ensure the person is kept warm.

There were areas of the home that had not been kept safe. In one bathroom area, we found a large wooden wall panel placed above a toilet that was loose. This panel had the potential to fall from the wall due to its positioning and the failure of the screws that were meant to secure this to the wall. This had not been identified by the provider or any staff accessing this bathroom. We raised this with the provider immediately due to the risks posed. The provider then made arrangements for this to be secured. We also found that in bathrooms around the home, the emergency pull cords in place should someone require support had been cut. This had left them out of reach of anyone using the bathrooms. This meant that should an accident occur in these areas, people would be unable to call for help as the call systems were not accessible.

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

Staff told us that prior to commencing work, they had been required to complete checks that included providing references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS would show if a prospective employee had any criminal convictions or had been barred from working with adults. However, records we viewed showed that these checks had not been consistently completed. One member of staff had left their employment and then re-joined the home two years later. However, when the staff member recommenced their employment, the provider had not completed any new checks. This meant that the provider had not assured themselves that people would be safe by applying for and checking the staff members most up to date DBS check. Following the inspection, the provider submitted evidence to show that they had now applied for this check to be completed. For other staff members we found that the provider had not reviewed any gaps in staff member's employment history or sought references from previous employers where these were available. Where character references had been provided for one staff member, we were unable to see that these had been verified by the provider.

People gave mixed feedback when asked if there were enough staff to meet their needs. One person told us, "Only if I see them [staff]. I hardly see them anyway. I don't bother with them". Another person said, "They come and go but are caring on the whole". Staff we spoke with also gave mixed views on the availability of staffing. One member of staff told us, "No there isn't enough staff, we could do with an extra pair of hands". Another staff member said, "My personal opinion is that there is enough staff".

We saw that staff were visible around the home and that where people required support, this was mostly provided in a timely way. We saw that there were times where staff were not available in communal areas and this had led to people needing to wait for support. We saw one person who wanted staff support in the communal lounge. As no staff were present, they walked out of the lounge to try and find someone. The person returned a few minutes later and told the room, "I can't even find anyone". However, for people who were in their rooms, we saw that they were responded too promptly when they called for support. Whilst staff were able to meet people's care needs, we found that the levels of staff meant that there were no opportunities for people to spend time with staff outside of having their care delivered. The support provided by staff was seen to be limited to care tasks only.

The provider had used a dependency tool to assess the numbers of staff required to support people. However, we found that this was not being consistently applied. The provider informed us that the tool used had identified that five staff were required during a morning. When we looked at the rota for the previous four weeks we saw that this was not being adhered too. On the morning of our first day of inspection, we saw that there were five staff available. However, the provider sent one member of staff away to work at the provider's sister home. We raised this with the provider as this then left the home one staff member short

and were informed that "We can manage with four". However, this was not in line with the recommendations made in the dependency tool. In addition, we found that there was a link between the dates in which there were not the required five members of staff and the dates in which people did not receive the amounts to drink that they needed. This meant that the provider was not safely applying their own dependency tool to ensure safe staffing levels to meet people's needs.

This is a breach of Regulation 18 of Health and Social Care Act (Regulated Activities) Regulations 2014.

We found that although the home was generally clean, there were some areas that required further improvements to ensure that the risk of infection was prevented. For example, we found that in one toilet, there were no paper towels available for hand drying and the electronic hand dryer had been turned off. The switch to turn this on was high up on the wall and would not be easily accessible for people to use to dry their hands. This meant that adequate hand washing facilities were not always available. In this toilet we also found that aerosol sprays that should be kept securely locked away had been left on the shelf. In the dining room, there was a chair with a large tear along the back of the seat. This also could pose an infection risk. These issues had not been identified by the provider.

Although the provider had learnt from the issues found at previous inspections in relation to the reporting of safeguarding concerns, we could not see that the provider consistently learnt from incidents to ensure people were safe. For example, concerns had been raised previously around the numbers of staff available to support people. The provider had initially acted on this but we found at this inspection, that the improvements had not been sustained and there continued to be concerns in relation to staffing. This meant that although the provider was able to respond to incidents and put actions in place to address these, the actions were not sustained to ensure people remained safe.

We observed people being supported with their medication and saw that this was done in a safe way. We found that medication was stored safely and where people had been prescribed 'as and when required' medications, there was guidance available for staff informing them on when these should be given. We looked at the quantities of medication available and this matched what had been recorded on the Medication Administration Record (MAR). This indicated that people had been given their medication correctly.

Requires Improvement

Is the service effective?

Our findings

When asked about the staffs knowledge and skills, one person told us, "Anyone can get a certificate in one day and get a job. What they [staff] don't understand is that people have individual needs".

Some staff we spoke with had been working at the home for a long period of time and could not recall if they had an induction. One member of staff told us, "I can't remember if I had an induction". Other staff told us they had received an induction and that this was given to them by the provider. We saw that new members of staff were enrolled on the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too.

We spoke to staff who informed us they had received training in various areas of care and that this was refreshed regularly to keep their knowledge up to date. Some staff told us that they did not think the training they received had been effective. The staff member said, "It [training] is not helpful, you sit in a room and just get talked at. There are no visual aids". Other staff told us they would like extra training to support them. One staff member told us, "I think we need a little more training on Dementia". This meant that although training was being made available for staff and staff displayed a good understanding of their role, further work was required to ensure that this covered people's individual care needs and that staff benefitted from the training provided.

People gave mixed feedback about the meals provided. Some people told us that the food was "Good" while others responded that it was "Alright". One person commented, "There could be a bit more variety". We saw that although there were choices of meals available, these lacked variety. For example, the two meal options on the day we visited were chicken pie or meat pie. This showed a lack of choice for people as the two meals were strikingly similar. The provider had ensured that people who had meal requirements related to their culture had these met and we saw one person being provided with a curry. Three other people saw this and commented how they would have liked to have also had a curry for lunch but had not been offered this. This meant that although people's cultural requirements were being met, the provider had not considered whether these options could be offered to all people to ensure more choice and variety in the meals provided. We saw that people who had specific dietary requirements had these needs met. People also had access to drinks throughout the day.

People's individual needs were not consistently met by the decoration of the service. We found that the provider had taken steps to improve the signage in the home to support people's independence but this had not been consistently applied. For example, we saw a door within the communal lounge that was unlocked and led to a person's bedroom. There were no signs placed on the door to ensure people were aware that this was someone's bedroom to prevent them from accidently entering the room. We also found hallway doors on the first floor were closed with no signs to inform people that these doors led to the hallway. The provider informed us following the inspection that this was due to one person taking down signs as they moved around the service. However, the lack of timely action to resolve this meant that people accessing this area would not have been easily able to find the hallway and could have entered other people's rooms as a result.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with understood the need to gain consent before supporting people and could explain how they do this for people who were able to communicate as well as those who could not. One member of staff told us, "I gain consent by asking people. If people cannot communicate, we use signals such as body language". We found that DoLS applications had been made appropriately and that staff understood what this meant. Staff were able to inform us of who had a DoLS authorisation in place and what these were for.

We found that prior to moving into the home, people had taken part in an assessment of their needs. These assessments looked at people's medical and care needs and also addressed any protected characteristics under the Equality Act. For example, people had been asked about any religious or cultural needs they may have.

People had access to healthcare services where required. Records we viewed showed that people had been supported to see their GP, dentists and opticians. We spoke with a visiting health professional who spoke positively about the staff team and told us, "They [staff] know people well. I have no concerns about the timeliness of their referrals to us [when needed]".

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2017, we found that people were not always treated with dignity and respect. This resulted in a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that there were continued concerns around dignity and the breach of Regulation 10 had not been met.

We found instances where people's dignity and privacy had not been respected. In the ground floor bathroom, we saw a large window that gave a view of a hallway leading to other people's bedrooms. There was a blind available but this was rolled up and the cord to pull this down was inaccessible due to its height. This meant that any person using this bathroom would be in view of people using the hallway. We saw this bathroom being used but staff had not identified that people's privacy and dignity was being compromised by the lack of a blind.

We saw one person required a catheter bag. This was positioned on their leg. We saw the person sat in the communal lounge with other people and their trouser leg had rolled up exposing the catheter bag. This meant that all the other people in the room were able to see this. During the time this person was in the communal lounge, staff and the provider were present and had not acted to cover the catheter bag and ensure the person's dignity.

A further person had a large stain on their jumper following their lunch. They were supported by staff throughout the afternoon but staff did not act to support the person to change. This meant the person was left in an undignified way as they spent the afternoon in clothes that were visibly unclean.

This is a breach of Regulation 10 of Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that staff were kind and caring towards them. One person told us, "Staff are very respectful and polite". Another person said, "They [staff] care for me very well". Our discussions with staff demonstrated that the staff team were caring and were keen to ensure people had a good quality of life. One member of staff told us, "We are caring people". However the systems and processes implemented by the provider meant that the staff team were unable to consistently provide a caring service to people as their interactions were limited to tasks only. This meant that staff did not consistently have the time to spend developing relationships with people to ensure a caring service.

We saw that people were being given choices and staff we spoke with could give examples of how they ensure choices are provided. We saw that people were given choices of where they would like to sit and what they would like to drink. Staff told us they encouraged and supported people to maintain their independence. One staff member told us, "I don't just go right in and do something, I will always ask what help the person would like". We saw that where people were able, they were encouraged to complete tasks such as going to the bathroom and accessing drinks independently. We saw that people who were able to leave the home independently or manage their own money, were supported to do this.

The provider was aware of where people may require the support of an advocate. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. We spoke with the provider about this and they understood when an advocate may be required and how they could refer people to this service if required.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to ensure person centred care. This resulted in a breach of Regulation 09 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that whilst action had been taken to meet this breach, further work was required to ensure that people received consistently personalised care.

The provider had taken action to ask people about their individual needs and preferences with regards to their care. For example, we saw that people were being asked about their life history including places they had lived and places they had worked and were also asked for their preferences in regards to their bedtime, clothes they like to wear and whether they wish to have a bath or shower. We also saw that consideration had been given to people's religious needs and had been asked about any requirements they had in relation to this. However, people's individual hobbies and preferences had not been taken into account when it came to activities. One person told us, "There's nothing to do." Another person said, "I am boxed in, the doors are kept locked and I can't go anywhere. I just sit down here, there's nowhere to go is there?" We saw that there were a lack of activities available for people. We found that people spent most of their day watching television, and this was confirmed by one person who told us, "I watch TV most of the time". There were no opportunities for people to go outside unless they were able to do so independently or had family able to take them out. We spoke with staff who agreed that activities required improving and did not consistently meet people's individual interests. There were board games available for people but one member of staff told us that people did not want to take part in these. The staff member said, "We get told [by people] 'I am not a child, I do not want to play'". This showed that the activities available did not meet people's own interests or capabilities and as a result, the level of engagement in activities was low. We raised this with provider who felt that the activities made available for people were adequate and did not agree that they were not personalised for people's individual needs. Following the inspection, the provider forwarded evidence that people had since taken part in a cookery activity.

People felt that staff knew their needs well. One relative told us, "They [staff] know what is going on and have their finger on the pulse". We saw that staff had a good understanding of people's care needs and had identified that further work was required to improve activities for people but were limited in the action they could take with regards to this due to the availability of staff. We saw that people's care needs were being reviewed and updates made to the care plans where required. People had been involved in these and given opportunity to state their preferences with regards to their care.

People told us that they had made complaints in the past but that these had not been listened too. One person told us, "They [the provider] listen but don't do anything about it". Other people felt unable to complain and one person said, "I can't talk to staff because they do not listen. I haven't complained and I keep things to myself".

We found that there was not a clear complaints procedure in place. A complaints procedure was available but this was not made available in accessible formats. We raised this with the provider who took action and

printed off a large print version of the procedure for people. Where complaints had been made, there was no clear record of the complaint made and the actions taken to investigate and resolve this. We found evidence of three complaints being made. For one complaint, the deputy manager was able to verbally inform us of the action taken but could not provide evidence of this. The provider was unable to locate the information relating to a second complaint made and we found that the third complaint had been investigated and resolved. This meant that although a procedure was in place, this was not being consistently followed to ensure that complaints were investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to monitor and improve the quality of the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We checked to see if improvements had been made and found that sufficient improvements had not been made and the provider remained in breach of regulation.

The provider has been rated as Inadequate in the key question of 'Is the service well led?' in their previous two inspections. As a result, concerns were shared with the provider about their lack of understanding and knowledge of their responsibilities as the registered person. Following the last inspection, the provider recruited a care consultant who had been providing guidance on how to drive improvements at the home. However, our findings at this inspection are that the care consultants are driving change within the service with minimal input from the provider. We could not see that the provider had taken sufficient action to improve their own personal development and knowledge of their role. This raises further concerns about the provider's ability to make and sustain improvements at the service without outside support.

Following the last inspection, the provider alongside their care consultants submitted an action plan detailing how they intended to make the required improvements to the service. We went through this with the provider to see what progress had been made in acting upon the identified actions. We found that although some actions were being met; others were not. For example, the action plan identified that an environmental risk assessment would be completed but this had not been done. When we raised this with the provider they informed us that they did not believe this was needed and was not aware that it was in the action plan. Further discussions with the provider found that they had not fully reviewed the action plan that had been completed by the care consultants prior to submitting this. This meant that the provider lacked oversight into their own plans for improvement as they had not been actively involved in this.

The systems in place to monitor the service were ineffective. We found that the provider had been guided by their care consultants in implementing a new auditing system but the provider had not yet embedded this into the service. The new audits had been in place for one month and we saw that they had been completed once by senior members of staff. However, these had not been fully completed and we could not see that any actions were recorded. We raised this with the provider who was unaware that the new audit had not been completed. This meant that the provider had lacked oversight on their newly implemented auditing system to ensure this was effective in identifying areas for improvement. Previous audits completed were not robust and contained tick boxes only. We were unable to see from these that the provider was being pro-active in identifying and acting on areas for improvement.

The audits completed had not identified the areas of risk we found at this inspection. As the audits completed did not monitor or analyse areas of care such as falls risks, ensuring people had the required amounts to drink or that all areas of the home were safe, the provider had not been able to identify or act on these to ensure people were safe. The failure to adequately monitor all potential risks had meant people were not always safe. Where the provider had identified risks in relation to staffing levels, these had not been acted on these to ensure people were safe and supported by sufficient numbers of staff. The provider had

implemented a staffing dependency tool that indicated that the required number of staff during a morning would be five. Rotas we looked at showed that this amount of staff was not consistently available. This meant that although there were systems in place to monitor the level of staff required, the provider had failed to act on the information gathered to improve the quality of the service provided.

People told us they were given opportunity to feedback on their experience of the service but did not do so as they did not feel listened too. One person told us, "They [staff] ask me but I don't attend, Not much point is there?" The person went on to explain they had previously made a request regarding a window in the communal lounge as they feel the room needed more air and was disappointed that no action had been taken to address this. We looked at records held in relation to service user meetings and found that feedback given was not always acted upon. For example, we saw that people had said they would like more outdoor activities to take part in. We were aware that this had not been actioned and raised the issue with the provider. The provider informed us that they intended to plan more outdoor activities in the summer but had not considered whether this request from people could be met sooner. This had meant that people were having to wait to have their requests to access the community met.

The provider had not ensured that people's care records were completed accurately and were up to date. We found that one person who had a specific dietary requirement had three risk assessments in place for this with each one providing different guidance. For other people, we found that records held in relation to mental capacity and best interest's decisions had not been fully completed. We raised this with the provider who felt this was due to a planned changeover of care records onto a new system. The provider was intending to re-write all care records with a view to improving these. However, they had not ensured that an action plan was in place for this to ensure that staff continuously had access to the information they required to support people. As a result, records held information from both old and new care plans and this led to duplication and conflicting information being available. This had not been identified as an area of concern by the provider.

This is a breach of Regulation 17 of Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with told us they felt supported by the provider. One member of staff told us, "I am supported and I know any concerns would be acted on". Staff had access to regular supervision and team meetings in which they could discuss their work and any concerns they had. Staff were aware of how to whistle blow and one staff member told us, "I wouldn't be frightened to whistle blow, I would go to the police or call Care Quality Commission myself".

The provider is required by law to submit notifications to us about incidents that occurred at the service. We found that the provider continued to submit these notifications as required and so was meeting this regulation.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that although the provider did not have a website, they had displayed their rating in the reception area of the home and so had met this requirement.