Adbolton Hall Limited

Adbolton Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 January 2017 and was unannounced.

The provider is registered to provide accommodation for up to 53 people in the home over two floors. There were 32 people using the service at the time of our inspection. We were advised during the inspection that only 45 people could be accommodated in the home and an application would be sent to the CQC following the inspection to amend the registration to reflect this.

The registered manager was no longer working at the home. They had left the previous month and the deputy manager was working as the acting manager. They were available during the inspection. 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.

Appropriate action was not always taken in response to potential safeguarding issues. Staff did not always safely manage identified risks to people. Sufficient numbers of staff were not on duty to meet people's needs. Safe infection control and medicines practices were not always followed. However, staff were recruited through safe recruitment processes.

Staff received appropriate induction and supervision but training levels required improvement. People's rights were not fully protected under the Mental Capacity Act 2005. People received sufficient to eat and drink but their mealtime experience could be improved. External professionals were involved in people's care as appropriate; however, their guidance was not always followed. People's needs were not fully met by the adaptation, design and decoration of the service.

Interactions between staff and people who used the service were mixed. Most interactions were kind but some were very task focussed. People and their relatives were not fully involved in decisions about their care. Staff did not always respect people's privacy and dignity. However, advocacy information was available to people and visitors could visit without unnecessary restriction.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. However, a complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, their comments were not always acted upon. The provider was not fully meeting their regulatory requirements. Some systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective.

We found two 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 this 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?

Requires Improvement

The service was not consistently safe.

Appropriate action was not always taken in response to potential safeguarding issues. Staff did not always safely manage identified risks to people.

Sufficient numbers of staff were not on duty to meet people's needs. Safe infection control and medicines practices were not always followed.

Staff were recruited through safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate induction and supervision but training levels required improvement. People's rights were not fully protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink but their mealtime experience could be improved. External professionals were involved in people's care as appropriate; however, their guidance was not always followed.

People's needs were not fully met by the adaptation, design and decoration of the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Interactions between staff and people who used the service were mixed. Most interactions were kind but some were very task focussed.

People and their relatives were not fully involved in decisions about their care.

Staff did not always respect people's privacy and dignity.

Advocacy information was available to people. Visitors could visit without unnecessary restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement.

Care records did not always contain information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, their comments were not always acted upon.

The provider was not fully meeting their regulatory requirements.

Some systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective.

Adbolton Hall

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 10 and 11 January 2017 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, two relatives, three visiting health and social care professionals, a domestic staff member, a laundry assistant, three care staff, the care coordinator, a nurse, the administrator, the acting manager and the operations director. We looked at the relevant parts of the care records of eight people, three staff files and other records relating to the management of the home.

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

Requires Improvement

Is the service safe?

Our findings

Most people did not raise any concerns about staffing levels. However, a person said, "Staff are good on the whole, but it would be nice if they had time to stop and chat more, but they are always busy and sometimes short staffed if there is a bug going round." A relative said, "I've seen no evidence that they are under staffed. Sometimes staff shortages mean [my family member] doesn't get a bath on their day but if that happens they always get a bath on the following day."

Domestic, laundry and kitchen staff all felt that they had sufficient time to complete their work effectively. However, all care staff told us that there were insufficient care staff on duty. A staff member told us that staffing levels were their main concern and with the correct levels, "accidents would half." Another staff member told us that staffing levels were, "Dangerous. Not safe at all." They told us that they were unable to supervise lounges and described incidents where people had fallen unwitnessed by staff in communal areas. A third staff member said, "Staffing levels shouldn't go on numbers, they should go on people's needs."

Our observations indicated that the current staffing levels were not sufficient to meet people needs and keep them safe. The monitoring of people in communal areas was inconsistent and there were times when staff were not aware of people's distressed behaviours. A person was newly admitted to the service during the afternoon of the first day of the inspection and was very anxious and disorientated. We observed them wandering into other people's bedrooms and although staff frequently assisted them back to the lounge they were very restless. Staff were busy with other tasks and did not give any dedicated time and attention to the person. Staffing levels did not allow staff to effectively support this person.

We observed staff assisting people with breakfast and lunch and providing care during the morning. At these times staff were very task focused and were frequently interrupted during interactions with people using the service, to assist others. Staff flitted from one person to others both at mealtimes and during the day, frequently not completing a task fully before moving on to others. When staff brought in a trolley with hot drinks, biscuits and cakes mid-morning and mid-afternoon, it took considerable time to distribute drinks as staff were interrupted constantly. Several members of staff took over the task at different times which meant it was difficult to determine whether anyone had missed being offered a drink. A visitor intervened on one occasion to point out some people had not been given a drink.

A staff member told us they were aware the provider used a matrix to determine staffing levels based on the dependency of people using the service. However, they felt there was not always enough staff on the floor as senior care staff and the care coordinator were often engaged in administrative tasks. We also saw a number of accident forms described people being found on the floor in communal areas during the day indicating that there were insufficient staff to supervise people safely.

Staffing levels were decided upon by the head office of the provider. The acting manager told us they sent people's dependency levels to the provider and then were told what the staffing levels should be. Documentation showing how the staffing levels were calculated was not available at the home. This meant

it was not possible to assess whether a staffing tool was being used by the provider and, if it was, whether robust decisions on staffing levels were being made.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe staff recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People raised no concerns about their safety. A relative, when asked whether their family member was safe, said, "Yes, I've never seen any signs to the contrary. [My family member] feels safe." Staff were aware of safeguarding procedures and the signs of abuse. They said they would report any concerns to management. A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

However, a potential safeguarding issue had not been referred to the local authority for advice at the time of the incident. This meant that there was a greater risk that appropriate actions had not been promptly taken to ensure people's safety. The acting manager confirmed that this referral had been made shortly after our inspection. One of the people involved in the incident had been involved in a similar incident at the previous care home they lived in. A visiting professional told us that it was important that this person was closely supervised by staff to minimise the risk of these incidents taking place. We observed that this person was not closely supervised during our inspection and staff were not aware of their whereabouts. This meant that there was a greater risk of a further incident taking place and the person and other people living in the home were not fully protected from avoidable harm.

We observed other examples where people were not protected from the risk of avoidable harm. We saw a number of people at risk of skin damage sitting in armchairs for long periods of time without their feet being supported with a foot rest to minimise the risk of skin damage or circulation issues. We looked at the documentation for a person at risk of skin damage who required the support of staff to change their position in bed. The documentation indicated that the person was not always re-positioned as frequently as required in their care plan. This issue had also been identified at our last inspection.

We observed a number of potential risks around the home during our inspection. Powder used to thicken drinks to make them easier to swallow was stored in the dining rooms and was accessible to people using the service. This powder should not be left unattended and people were put at risk of avoidable harm. Other harmful substances were also left unattended, for example, a cleaning material containing bleach. One person was in bed and had bedrails in place, however, these bedrails were not covered with protectors to minimise the risk of avoidable harm.

We saw that a bath was being run by staff who left the bathroom door open on a communal corridor for a number of minutes without supervision. The rooms used by the maintenance staff were unlocked and contained equipment which if accessed by people who used the service would put them at risk of avoidable harm.

Accidents forms did not provide sufficient space to document actions taken to minimise the risk of re-occurrence. Falls were analysed, however, the tool used did not analyse all relevant factors. This meant that there was a greater risk that appropriate actions would not be identified and taken to minimise the risk of people falling again. We also saw that risk assessments and care plans were not reviewed in response to falls

which meant that there was a greater risk that prompt actions were not taken to minimise the risk of people falling again.

Individual risk assessments had been completed to assess people's risk of falls, developing pressure ulcers, choking and moving and handling. These had been reviewed monthly. There was some evidence of interventions being put into place to reduce these risks but they were not always reflected in people's care plans or consistent with the care plans. For example, people at risk of falls did not have a falls prevention care plan which meant that there was a greater risk that appropriate actions would not be taken to minimise the risk of people falling again.

Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We observed people were assisted to move safely and staff used moving and handling equipment safely. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People raised no concerns regarding medicines. A relative said, "There's never been a problem with the medicines." We observed the administration of medicines and found staff checked against the medicines administration record (MAR) and stayed with people until they had taken their medicines. The medicines trolley was locked when unattended but on one occasion the medicines were left on top of the trolley. When we raised this with the staff member concerned they told us they were unaware they had done this and normally always put the packs back into the trolley before locking it.

MARs contained photographs of people to aid identification, a record of any allergies and their preferences for taking their medicines. MARs had been completed consistently and there were no gaps to indicate medicines had not been given due to lack of availability. Systems were in place for the regular order and supply of medicines. A staff member told us they had received training in medicines management and had had their competency checked on two occasions within the last six months. They said all the registered nurses had undertaken the medicines training at the same time.

Medicines were stored in locked medicines trolleys which were secured to the wall when not in use. However, the area where the medicines were stored was frequently above the recommended maximum temperature. This meant that there was a greater risk that medicines were not being stored at an appropriate temperature to ensure they remained effective. Approximately half of the liquid medicines and topical creams being used were not labelled with the date of opening. This meant that there was a greater risk that they would be used beyond their effective date.

Protocols to provide additional information about medicines which were to be administered only 'as required' were not always in place. One was a sedative medicine given for agitation and it is important there are clear directions for the use of this medicine to prevent over use. This issue had also been identified at our last inspection.

We looked at the cream chart for one person and it had not been completed consistently so it was not clear whether or not the cream had been administered. The chart also did not provide guidance for staff on where

to apply the cream. These issues had also been identified at our last inspection.

People raised no concerns regarding the cleanliness of the home. A relative said, "I see cleaners in my [family member's] room every day. The laundry is excellent too."

We observed that the environment was generally clean though some carpets in bedrooms and communal areas required further cleaning. Wheelchairs were also stained and required cleaning. We observed that staff did not follow safe infection control practices at all times and some equipment required replacement to allow effective cleaning to take place.

Requires Improvement

Is the service effective?

Our findings

People raised no concerns regarding whether staff were sufficiently skilled and experienced to support them effectively. A relative said, "In general, the vast majority of staff are excellent. The level of checking of new staff's work is very good."

Staff told us they had received an induction and felt they had had the training they needed to meet the needs of the people who used the service. However training records showed some staff had not completed a number of training courses or were overdue for refresher training. Issues observed during our inspection indicated that staff required further training to improve their practice.

Most staff told us they received regular supervision and appraisal. Supervision and appraisal records contained appropriate detail. Issues observed during our inspection indicated that staff required more effective supervision to improve their working practices.

A person said, "I get help washing and dressing, but I can choose my clothes." A relative confirmed that their family member was offered choices and those choices were respected by staff. We saw that most staff asked permission before assisting people and gave them choices. However we observed at lunchtime that some staff put clothing protectors on a number of people who used the service without explanation or asking the person whether they wanted one or not. Staff also moved people in wheelchairs and hoists without explanation at times.

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 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). We checked whether the service was working within the principles of the MCA.

When people did not have the capacity to make decisions for themselves, mental capacity assessments had been completed and a best interest checklist were in place. However, the best interests documentation was not always well completed to clearly document the reasons why making a specific decision was in the best interests of the person lacking capacity. This meant that there was a greater risk of these people's rights not being fully protected.

We saw some evidence that when people's freedom was being restricted in order to keep them safe, DoLS applications had been submitted to the local authority. However, no staff member we spoke to knew how many DoLS applications had been made and how many DoLS applications had been authorised by the local

authority. A visiting social care professional told us that a DoLS application had not made, when required, for a person who used the service. This meant that there was a greater risk of people's rights not being protected.

Staff did not always effectively support people with behaviours that might challenge and care records did not contain sufficient guidance for staff on supporting people with behaviours that might challenge. This issue had also been identified at our last inspection.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. Three of the four DNACPR forms we reviewed were completed appropriately and indicated the person and their relatives, where appropriate, had been involved in the discussion about the decision. However, one person did not have the capacity to make the decision about resuscitation and the documentation had not been completed to indicate this. This meant that there was a greater risk that people's rights had not been protected in this area.

We asked people their views on the food offered to them. A person said, "It's okay. There are some things I don't like, but I haven't gone hungry. The cook does come round and tell you what we have got the next day but it's usually right after we have eaten and I find it hard to remember what she said. The portion sizes are also a bit big and I hate waste." Another person said, "The food is pretty so-so. I am not a great fan of pasta and we get a lot of it here. It is also cold by the time it gets to me. I have complained, but if I don't eat it I don't get offered something else and just end up having a pudding." They also said, "We get very little at teatime. Tiny little sandwiches and sometimes they run out because the cook has gone home." However, a relative said, "[My family member] has sufficient to eat and the quality and variety of food is very good."

During breakfast and lunchtime we saw that people were not always effectively supported by staff. At breakfast, some people, who required prompting to eat, were left without prompting for a significant period of time. Some of these people fell asleep or stopped eating and stared out the window. When staff returned they did not offer to replace the food which was now cold.

During the lunchtime meal we saw that some people's mealtimes were interrupted as health and social care professionals had arrived to provide support for them. We saw one person say to a visiting professional, "I don't know what this is for, but you will have to wait until I have finished my pudding." Other people went with professionals and returned later to their food. When they returned staff did not offer to replace the food which was now cold.

We observed the lunchtime meal in both dining rooms. In one dining room, some people waited over 30 minutes from arriving in the dining room to receive their meal. People were served with their meals without any explanation of what was being provided. Seven of the people who used the service required assistance and considerable encouragement to eat. Staff moved between them assisting a person for a short period, then moving to another table to provide assistance to two other people and then moving back to the first table to provide assistance to others. This meant the meal was disjointed for people and they did not receive dedicated attention from a member of staff. We also observed two people's hot desserts were served and put on their table before they had finished their main course.

Upon arriving in the second dining room we heard a staff member saying that two people had already left the room as they were not enjoying the food. We asked if they had been offered an alternative and were told that they had not been. We heard people saying that the gammon steak was very tough, far too large and the portions generally were large. A lot of food was not eaten. People did not receive sufficient assistance to eat their meals in this dining room. One person was observed trying to cut their gammon with a fork and

another person was putting their food into their water cup. The cook came into the room while people were still eating and started to clear tablecloths from the tables while saying several times, "I feel awful, I want to go home."

Records indicated people were being weighed monthly and most people were gaining or maintaining their weight. When people lost weight staff increased their monitoring and weighed people on a weekly basis. Risk assessments had been completed when people were at risk of malnutrition. Eating and drinking care plans were in place and gave the main information about people's eating and drinking requirements but they lacked any detail about the person's preferences. We also saw that it was not clear from records whether staff had taken appropriate advice for a person losing weight. The acting manager agreed to check whether the appropriate professional had been contacted.

A relative said, "The GP has been excellent and comes in every week. [My family member] has had a hearing test and opticians come into the home to carry out checks. The chiropodist comes in about every six weeks and [my family member] has seen a dentist twice in the last year."

People's care plans indicated they had been referred to other health professionals for advice and support where appropriate but the documentation in relation to this was inconsistently recorded. We some evidence of the input of a dietician, speech and language therapist, GP, social worker, and dentist. A visiting healthcare professional told us that their advice was followed by staff; however, we saw that advice given by other health and social care professionals was not always followed. This meant that there was a greater risk of these people suffering avoidable harm.

People's needs were not fully met by the adaptation, design and decoration of the service. Directional signage was not in place to support people to move around the home independently and no showers were available for the people who used the service. The small lounge was still being used by some staff as a thoroughfare to access the outside area during their breaks. These issues had also been identified at our last inspection. We saw that not all people's bedrooms were clearly identified. A number of carpets were stained and people did not have access to a secure outside space.

Requires Improvement

Is the service caring?

Our findings

A person said, "The staff are very kind to me." Another person said, "I enjoy a bit of banter with the [staff] and that makes the day go round." However, they also said, "I have never seen anyone being badly treated, although some [care staff] can get the grump sometimes if someone keeps playing up." A third person said, "Some of [the staff] can have a bit of an attitude at times but I think that is when they get stressed." Another person said, "I have made some friends to talk to, but then they just go. [Staff] don't tell us if people go back home or even if they die. I would really like them to explain as otherwise we never know what has happened." A relative said, "The staff are very caring. They know [my family member] well and appear to know everyone's idiosyncrasies."

Some staff interacted well with people using the service showing an understanding and empathy for them. However, the pressure of work and task focus of other staff resulted in brief stilted exchanges. We also heard some staff responding to people using a poor tone or choice of words. One staff member said to a person, "Why are you being so aggressive?" Another staff member said to a person who wanted to go home, "You're not going home!"

Staff response to people who were anxious or in distress was inconsistent. Some staff responded well, listening to the person's concerns and provided reassurance in an empathic way. However, in general staff had very brief interactions with people when they were anxious or distressed and almost immediately afterwards they showed continuing signs of anxiety. We also observed some people in distress were not responded to by staff at times.

People could not recall being involved in the initial care planning process. There was limited evidence to show that people or their relative, when appropriate, had been involved in the care planning process. This issue had also been identified at our last inspection.

Clear communication care plans were in place for people with limited or no ability to communicate verbally. Advocacy information was available for people if they required support or advice from an independent person. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

A person said, "I respect the staff and they respect me." Another person said, "The staff are really good at making me feel comfortable. I don't think I have ever felt embarrassed even when it was a male [staff member]. It's their job." A relative said, "Everything is done by staff to ensure people's dignity is upheld. Everyone's polite, always a please and a thank you."

However, we saw examples of people not being treated with dignity. We saw a person had been left in their wheelchair facing the dining room wall for five minutes and another person had been left in a very stained top after being moved to the lounge following their breakfast. A visitor told a staff member that a person had spilt their drink on a portable table. The visitor asked the staff member to mop it up and the staff member responded that the person would just do it again and did not mop up the spillage until shortly afterwards

when the person tipped the contents of their beaker over the floor and both spillages were dealt with. This did not respect the person's privacy or dignity.

We also saw other examples of people's privacy not being respected. We saw staff talking about a person who used the service in front of another person who used the service. Personal information about people's continence needs had been left in a corridor accessed by people who used the service and visitors. The correspondence and personal belongings for three people, who had died recently, were not stored securely.

A person told us that they had internet and phone access and was therefore able to be quite independent which they preferred. A relative said, "[My family member] brushes their own teeth. They are happy doing that and no one tries to do it for them."

Relatives were able to visit their family members without unnecessary restriction. Information on visiting was in the guide for people who used the service. Relatives visited throughout our inspection. A relative said, "I can visit whenever I like really."

Requires Improvement

Is the service responsive?

Our findings

People's views were mixed on whether they received care that was responsive to their needs. A person said, "[Staff] will do anything I want." Another person said, "I can choose what I do to a certain extent, but they have so many people to get washed, dressed and fed there has got to be a routine." A third person said, "A lot of the [staff] that used to cut my nails for me have now left, but the night staff mentioned it twice and have asked the day shift to cut them for me." We asked how long ago that was and they said, "Oh it was a good few days ago." We looked at their nails and they required attention. Another person said, "Sometimes when I ring my buzzer they [staff] just stick their head around the door and tell me they are busy and will come back, then they never do."

We observed that people did not always receive prompt care that met their personalised needs. We observed people waiting to be supported to use the toilet, move from the dining room to the lounge or be supported to move from their wheelchair to an armchair. For example, one person waited 20 minutes to be taken to the toilet and another person waited 50 minutes to be moved from their wheelchair to an armchair. This issue had also been identified at our last inspection.

Care plans did not always provide sufficient guidance for staff to provide personalised care for people that met their individual needs. Care plans contained most of the basic information necessary to provide care for the person but lacked detail and information about people's preferences in relation to their care. For example, care plans for personal hygiene did not contain any information about the person's preferences, how often they liked to have a bath, or arrangements for the care of the nails and hair. Two people with urinary catheters did not have care plans for catheter care so it was unclear as to how often they should be replaced, the size of the catheter being used, or any other catheter management issues such as bag changes.

A person with diabetes did not have a diabetes care plan although their eating and drinking care plan stated they had diabetes, and risk assessments had been undertaken identifying the risk of hypo and hyperglycaemia with a description of the symptoms. The result was the information required was difficult to find and some information was missing like the need for annual diabetes reviews, the frequency of blood glucose monitoring and arrangements for foot care and eye checks.

We reviewed the care plans of a person with pressure ulcers. The care plan did not contain detailed information about the preventative measures or details about the care of the wounds. There were no wound management care plans to indicate the dressings which should be used and the frequency of dressing changes.

One person had a DNACPR form in the front of their care records but their end of life care plan which was undated, stated the person had not considered their end of life wishes and wished to be resuscitated in the event of a cardiac arrest. This meant there was conflicting information in the care records regarding the decision which would put staff at risk of a legal challenge regarding their actions in the event of a cardiac arrest.

A relative said, "Yes, I've seen the care plan. I also talk with the nurses regularly." We did not see any evidence in the care records of involvement of people or their relatives in reviews of their care. This issue had also been identified at our last inspection.

People told us that there were not many activities available to them. A person said, "I used to go out to the club down the road when I first came here, but nothing like that happens now." Another person said, "We used to go out but we haven't for a long time. We have a singer on a Thursday and when the activities man is here two days per week we do different things." A third person said, "I do join in with snakes and ladders sometimes or throwing things." However, a relative said, "The activities coordinator is very good and the activities are too. [My family member] enjoys the singing on Thursday and a game of dominoes now and again." A staff member said, "There needs to be a lot more activities. People need more interaction, more sensory activities."

We did not see any activities for people on the first day of inspection. This issue had also been identified at our last inspection. On the second day of inspection we observed skittles and a balloon game taking place but there were no activities taking place to more effectively engage people living with dementia. We saw a person watching the television in the small lounge. The television picture was obscured by a notice on the screen requiring use of the remote control to remove it. The person was unable to do this and despite staff coming into this room the notice was not removed by the remote control and remained on screen for over 45 minutes.

Documentation indicated that the level of activities was limited and especially for people who remained in their room. The last entry into the records of activities for one of the people whose care we reviewed was over six months previously whilst the activity records for two other people whose care we reviewed were blank. This issue had also been identified at our last inspection. The activities coordinator worked in the home two days each week. We were told that an additional activities coordinator was going through the recruitment process.

People and relatives raised no concerns regarding complaints management. A person said, "Oh I'm not afraid to speak up to whoever will listen." A relative said, "The complaints procedure is well advertised. If I've ever encountered anything like a problem it's been resolved."

We saw that a written complaint had been responded to appropriately. Staff were able to explain how they would respond to complaints. A complaints policy and procedure was in place.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received; however it was not fully effective as it had not identified and addressed the issues we identified at this inspection.

The operations director told us that representatives of the provider attended the home regularly. However, we did not see any reports completed following visits that had taken place since our last inspection. This issue had also been identified at our last inspection. We did see a provider audit that had taken place in December 2015 which identified a number of areas where substantial work was required. These areas included care plans and activities which remained an issue at this inspection.

We saw that the home's management team completed audits in the areas of medication, falls, pressure sores, care plans, kitchen and infection control. Action plans were mostly in place where required, however an action plan was not in place in response to the findings of the care plan audit. The care plan audit found that improvement was needed regarding the adequacy of care records which we also found at our inspection. The medication audit completed in September 2016 had identified that liquid medicines were not always labelled with the date of opening and this remained an issue at this inspection.

Improvements to the service had not been made and sustained following inspections by external organisations. The CQC inspection in July 2014 identified a breach in regulations and the service was rated, 'Requires Improvement'. The subsequent inspection in January 2016 found that the regulation had been complied with; however, the service remained rated, 'Requires Improvement'. At the inspection in January 2016 not all areas identified as requiring improvement had been fully addressed by the time of this inspection. This included medicines management, involving people in decisions about their care and the level of activities offered by the service. We also saw that areas identified by commissioners at more recent visits had also not been fully addressed. This meant that effective processes were not in place to ensure that improvements were made and sustained when required. We have been informed that Commissioners have suspended placements at the service until improvements have been made.

Most people and relatives we spoke with could not recall receiving any surveys or attending any meetings to discuss their views of the quality of the service provided for them. However, a relative said, "There was a meeting back in July. I've also been to a meeting to discuss the food at the home." Meetings for people who used the service and their relatives took place. Surveys were also sent to people who used the service and their relatives. Feedback was generally positive, however, comments had been made about activities and staffing levels which we also identified as concerns at our inspection. There was no documentation to show that people's comments in these areas had been considered and acted upon.

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

We saw that conditions of registration with the CQC were being met and statutory notifications had mostly

been sent to the CQC when required. However, notifications had not been sent to the CQC regarding the outcome of DoLS applications. In addition, the current CQC rating was not clearly displayed in the home which meant that the provider was not meeting their regulatory responsibilities.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be prepared to raise issues using the processes set out in the policy if necessary. The provider's values and philosophy of care were displayed on the wall and were in the guide provided for people who used the service. However, during our inspection we observed that staff did not always act in line with those values.

A relative said, "It's a friendly home. It's not sombre, people have a sense of humour and the staff are happy." A visiting healthcare professional said, "The home has a relaxed atmosphere." Staff told us that the home had a friendly atmosphere.

The registered manager was no longer working at the home. They had left the previous month and the deputy manager was working as the acting manager. They were available during the inspection. The acting manager told us that they felt well supported by the provider and that resources were available to support them to provide a good quality of care at the service.

Most people and relatives raised no concerns regarding the availability or approachability of the acting manager. A relative said, "I've seen [the acting manager] around the home and she has always known my [family member] in a level of detail which I find quite heartening." Most staff were positive about the acting manager. A staff member said, "She's great. Approachable and really friendly." Another staff member said, "She'll always help." Staff told us that staff meetings took place where the management team clearly set out their expectations of staff.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs. Regulation 18 (1)