Mrs Anne Going & Mr Kenneth Going & Mr Raymond Galbraith & Mrs Marian Galbraith

St Michaels House

Inspection report

1-3 St Michaels Avenue
Northampton
Northamptonshire
NN1 4JQ

Tel: 01604250046

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 5, 6 and 12 March 2018.

St Michaels House 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.

St Michaels House can accommodate 13 people in one adapted building. At the time of inspection, 10 people were living at the service.

There was a registered manager in post who was also the 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.

St Michaels House was inspected in April 2017 and rated as inadequate and placed into special measures. In August 2017 we inspected again, and whilst some improvements had been made, we found ongoing breaches of regulation. The service was rated as requires improvement, and remained in special measures. During this inspection in March 2018, we found that the provider had implemented improvements in some areas however; they remained in ongoing breach of regulation . There remained a poor quality of cleanliness within the home, lack of oversight to monitor and improve the quality and cleanliness. This meant there was a risk of harm posed to people due to the lack of cleanliness of the home. We found that there was not enough improvement to take the provider out of special measures. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The home was dirty and had continued to not be adequately cleaned. There were numerous areas throughout the home that posed a direct risk of harm through the allergens present in mould and the increased risk of infection associated with the ingrained dirt and general lack of cleanliness. This included the kitchen area and people's bedrooms. The kitchen had many areas of ingrained mould and dirt, and food was being prepared in these areas. We found mould around several people's basins, and serious damp and mould issues in one person's bedroom. This was a risk to people's health, including one person at a higher risk of developing respiratory infections due to a diagnosis of COPD.

We found that fire doors within the service had been propped open by chairs, thus creating a fire risk as the doors would not close in the event of a fire. People using the service smoked within their rooms. Risk assessments were in place to identify the potential risks of this behaviour, and people had signed agreements not to smoke in rooms. This did not stop people from smoking in their rooms, and no further actions had been taken by the service to address this.

The environment continued to be poorly maintained. A redecoration plan was in place, but this had failed to take prompt action in improving the environment.

A robust and detailed system of quality assurance to monitor the environment and key aspects of people's care and support had not been implemented. This had resulted in the shortfalls that we identified during this inspection failing to be identified or addressed by the provider. As a result of the last inspection, we were receiving monthly updates from the provider regarding the cleaning that was taking place and the environmental audits. We found that these were ineffective and did not reflect the state of poor cleanliness within the home. The registered manager had not taken prompt action to identify and address the problems with the environment.

Staff supported people in a positive manner and were caring in their day-to-day interactions with people. However, the overall ethos within the service required improvement in this area, due to lack of action taken to make sure people felt safe, comfortable and dignified in their environment.

At our last inspection, there was no evidence that people had been involved in capacity assessments and best interest checklists had not been completed. At this inspection, the service had begun to evidence people's involvement in their own care plans, and best interest decisions were being carried out around specific areas of people's lives. Where required, the use of advocacy services had been applied for to support people with their decision making.

A programme of activities had been introduced to increase people's sense of well-being. Improvements had been made in this area and detailed records were kept to evidence the different opportunities people were offered and when, and an evaluation of how successful this was.

People received their prescribed medicines safely. Staff had been recruited safely and received the training, support and supervision that they required to provide people's care and support.

People were supported to have enough to eat and drink and to access healthcare professionals when they needed to.

Care planning documents had improved since our last inspection. Person centred care plans were newly in place that included people's likes, dislikes, skills and preferences.

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.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Improvements had not been made regarding the cleanliness of the service. The service continued to be dirty and areas were covered in mould posing a risk of harm to people.

Staffing levels were sufficient and staff were safely recruited.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always met by the design and decoration of the premises. Areas within the service were not properly maintained, and required improvement works to be carried out.

The service had improved their work around the principles of the MCA and people were being involved in their plans of care.

Staff had received the support, supervision and training that they required to work effectively in their role.

People were supported to have enough to eat and drink and to access healthcare services when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

Individual staff members interacted with people in a caring way, but the ethos within the service did not ensure that standards were always high for people, and that they were provided dignified , and comfortable care

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were not being met in a person centred way.

The environment was not personalised to people's own preferences.

Activity schedules and evaluation of activity had improved since our last inspection.

Care planning had improved to include person centred information.

Is the service well-led?

Inadequate

The service was not well-led.

There has been an ongoing lack of effective governance.

A sustained lack of improvement had left people at risk of harm

Systems to monitor the quality of care that people received had failed.

Shortfalls that we found in relation to the cleanliness and suitability of the environment had not been identified or acted upon by the provider.

Appropriate strategies to address previous breaches of regulation had not been deployed by the provider.

St Michaels House

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 checked 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 5, 6 and 12 March 2018 and was unannounced. The inspection was completed by one inspector and an inspection manager on 5 March, one inspector on 6 March 2018, and two inspectors on 12 March 2018.

Before the inspection we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted and met the health and social care commissioners who monitor the care and support of people living in the home.

During the inspection we spoke with four people living at St Michaels House, three care staff and the registered manager who was also one of the providers.

We reviewed the care records of four people who used the service. We also reviewed records relating to the management and quality assurance of the service.

Inadequate

Is the service safe?

Our findings

During our last inspection in August 2017, we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of the failure to ensure that the home was kept sufficiently clean and that action was taken to protect people from the risk of harm through the spread of infection.

During this inspection, we found the service had continued to fail to ensure the home was kept sufficiently clean and that action was taken to protect people from the risk of harm through the spread of infection.

The kitchen area within the home was dirty and poorly maintained. The worktops, skirting boards, cupboards, doors, walls, radiator, tiled areas and the ceiling had ingrained dirt and grease, and had not been sufficiently cleaned. We saw black mould was on the ceiling and wall near the back door in the kitchen and dust and cobwebs were attached to the ceiling above the cooker hob, and in the corner of doorways. The plug socket on the tiled area next to the hob was stained and ingrained with dirt. We found that the hand-washing sink was dirty, and the sealant around it was mouldy. The kitchen window had a build-up of dirt around the edges and around the fly screen. The areas around the kitchen sink were dirty and mouldy. The strips used to join the kitchen worktops together, had a build-up of dirt and grease stuck in them. Ingrained dirt and dust was found on the kitchen door. We found a sponge and dishcloth that were being kept in a plastic tub on the window-sill in the kitchen. There was a significant build-up of mould and dirt inside this tub, which could contaminate the cloth and sponge. There was a build-up of dirt on the inside of the kitchen cupboards next to where food preparation chopping boards were being kept. Food and beverages were stored uncovered within the fridge and cupboards. We saw that half an onion was in the fridge door uncovered, and a container of squash was uncovered on the fridge shelf. We also saw a bottle of squash cordial was being kept in the cupboard without any lid on it. All the food within the service was being prepared in this kitchen, which meant that there was serious risk of harm to people, as the risk of the spread of infection was not being managed adequately.

We found that the floor and wall in the dining area was dirty, with a build-up of dirt around the skirting boards. We saw a section of lower wall in the dining area which had a visible damp and mould issue around the plug socket. This presented a risk to service users within the home through the allergens present in mould. One person in particular was at direct risk of harm through the allergens present in mould and the increased risk of infection associated with the ingrained dirt and general lack of cleanliness within the home. We saw that within care planning records, this person had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and was therefore at higher risk of developing respiratory infections.

In two people's bedrooms, we saw nail-brushes placed on their wash hand basins. The brushes were ingrained with dirt and lime-scale. The use of these brushes posed a risk of the spread of infection and placed people using them at risk of infection. There was the potential for people to use them and get dirt from the brushes under their nail and into cuts or wounds on their hands. Several people had wash hand basins within their rooms which had mouldy sealant around them.

In one person's room, we found a cup that was being used to store a toothbrush and toothpaste on their wash hand basin. The cup, toothbrush and toothpaste tube were ingrained with dirt and mould. This toothbrush and toothpaste was used by this person to clean their teeth. The use of these items created a risk of infection due to the bacteria and mould and put the person at risk of infection.

We saw that one person's bedroom was severely affected by damp and mould. There was a strong damp odour within this room, and black mould was growing in large areas across one wall. Mould was also growing along the edges of the window. The registered manager told us that a builder had been asked to come and fix the problem, but no date had been set. The registered manager was aware of the problem, but had taken no action to move the person to a room that was dry and mould free. During our inspection, we suggested to the registered manager that the room was not fit for anyone to inhabit, and that a different room should be used for the person. On the second day of our inspection, the registered manager had supported the person to move to a different room until the issue had been resolved. Action had failed to be taken without being prompted by our inspection, which meant the person was at risk of harm and the service failed to adequately maintain the environment that they lived and slept in.

In one person's room, a carpet strip in the doorway was broken and bent, thus creating a trip hazard. In the same person's room, we saw that the window had a large build-up of dirt, mould and cigarette burn marks along the bottom edge.

Several people living within the service, smoked cigarettes in their bedrooms. We saw that people had signed agreements not to smoke in rooms, and that risk assessments were in place to identify the risks this may cause people. This did not stop people from smoking in their bedrooms, and the registered manager said that no further action had been taken to address this. We saw that one person had a television in their bedroom, which had melted and burnt plastic on top, next to an ash tray. The registered manager told us this was caused by the service user's cigarette. The service had failed to manage this risk appropriately which put all of the people at the service at risk.

At our last inspection, we found that fire doors were wedged open, and the provider had not identified this practice nor considered that the failure of a fire door to close would pose a significant risk of harm to people living in the home in the event of a fire. At this inspection, we saw that fire doors continued to be held open. We saw that two people's bedroom doors were being propped open with chairs, thus creating a fire risk as the doors would not close in the event of a fire. The provider continued to fail to take action to make people safe.

These issues constituted a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that one person was bed bound. The registered manager told us that the person had a history of pressure sores and had in the past, received care from tissue viability nurses. The person was using a pressure mattress. The person did not currently have pressure sores, and the registered manager told us that no records were being kept to evidence that the person was being regularly checked, and make sure that pressure sores were not forming, in known vulnerable areas of the person's body. This placed the person at risk of pressure sores forming as no adequate checks were in place .

Action was not always taken when areas were identified that needed improvement. We saw that staff meetings were used as a method to discuss when mistakes were made and to create actions. For example, team meeting minutes showed that after our last inspection, issues were discussed within the team to raise

the standard of cleanliness. At this inspection we saw that action had not been taken by staff.

Staff were aware of how to report safeguarding concerns if they identified that an individual may be at risk. All the staff we spoke with told us they would report concerns to management or the local authority safeguarding team if required . However, no staff had identified any of the environmental issues as potential safeguarding concerns. Following our inspection we made a safeguarding referral to the local authority due to the environmental issues putting people at risk of harm.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). There was a sufficient amount of staff working at the service to keep people safe. One person told us, "Yes there is always someone about to help if I need it."

The service safely supported people with the administration of medicines. The staff completed medication administration records (MAR). We checked the MAR and saw that they were filled out accurately, and signed for every time. Appropriate storage and disposal methods were being used. We looked at stock levels of several medicines, and saw they were accurate. Appropriate training was in place for staff to safely administer medicines.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in August 2017, we found that the provider continued to be in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the environment continued to require redecoration and that the furniture both in people's bedrooms and in the communal areas of the home continued to require replacement because they were damaged.

During this inspection, we found the service had continued to be in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The physical environment was not decorated or adapted to a consistent standard to meet people's needs. The service had not carried out risk assessments where the environment may have had an impact on people using the service.

During our inspection we found the environment had not been adequately maintained. Throughout the home, paintwork was chipped and had ingrained dirt on it. The hand rails going up the stairs to the first and second floors were chipped and scraped. We found that the bath panel in the first floor bathroom was detached from the bath, and the towel rail was coming loose from the wall.

We found that although audits had been created and signed by staff, rooms were not being adequately maintained. The registered manager told us that a redecoration plan was in place at the service, and some rooms had already been painted. One room had been painted, but tobacco staining and damp staining had come back through the paint and was visible in large patches across the walls. We saw that throughout the service, Light switches, call bells and plug sockets in people's rooms and communal areas were stained yellow by both historical and on-going tobacco smoke. This meant people were living in an environment that was not pleasant, homely or suitable.

We saw that the garden area directly outside the conservatory/dining room was used by people to smoke. It had a significant build-up of cigarette ends across the ground. It was clear that this area had not been cleaned or maintained for some time.

These failures to adequately maintain the environment and equipment was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Premises and equipment.
During our last inspection we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent. This was because the provider had not followed the principles of the Mental Capacity Act 2005 (MCA) when developing people's plans of care, and people had not been involved in the assessments of their capacity. During this inspection, we found that improvements had been made in this area, and the service was no longer in breach of this regulation. Capacity assessments were specific to each decision, and people were being involved in their own plans of care. Signed documents were seen to show that where possible, people had agreed to decisions about their care. The service had understood that people would benefit from the use of advocacy services, so had been working with people to be introduced to advocates to support their decision making.

The service had sought advice and support from the local authority to enable people to become as empowered as possible with their own decision making and care.

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 found that the registered manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking capacity to be able to consent to their care.

People had received pre-assessments of their needs before using the service. On-going assessments and reviews of people's needs were carried out as required. Staff had a good understanding of each person's specific needs, wishes and lifestyle choices, and people were not discriminated against.

Staff were supported to access on-going training and development that was relevant to their role. One member of staff told us, "The training is very good, we have regular top up training to refresh knowledge." The registered manager told us, "I like the training to be done face to face, so we book people to come in and run sessions for us." We spoke with a professional from the local authority who told us they had been supporting the service with person centred planning training, and that the staff had engaged well with this. We saw a training matrix which showed training was up to date.

Staff had the opportunity for regular supervision and support from the registered manager and senior staff. One staff member said, "I have lots of support from the registered manager, I can approach them for anything." We saw that supervisions were recorded and areas for improvement were discussed with staff members.

People were supported to maintain a healthy and balanced diet. One person told us, "The food is lovely, I can't complain at all." The staff all had a good knowledge on what people liked to eat, and were motivated to encourage people to eat healthily as much as possible to increase their overall wellbeing. Care plans documented people's preferences and any requirements they had with food and drink.

Health and medical information was recorded for each person. The people we spoke with confirmed they were able to see health professionals as and when they needed to. Staff were vigilant to any changes in people's health and took action to enable people to access relevant healthcare professionals. Care planning documented any health conditions that people had, and kept an up to date log of recent appointments and medical input.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring. During our inspection we saw that individual staff members were interacting with people in a caring way, but the ethos within the service did not ensure that standards were always high for people, and that they were provided a dignified, comfortable and safe environment.

The service did not ensure that the quality and standards of the home were suitable, and people were therefore made to live within a poor environment. The staff and the management had not recognised or taken action against the fact that the standard of living was poor, which showed a lack of respect and dignity to people using the service. On the first day of our inspection 5 March 2018, we saw that one person had stained sheets on their bed, and a duvet and pillow case that had holes in them. We raised this with the registered manager. On the third day of inspection 12 March 2018, we found that the person was still using sheets that were stained. The registered manager told us that due to a busy weekend, new sheets and bedding had not yet been bought. The service did not have suitable bedding to replace the stained ones immediately, and did not purchase new bedding promptly. This showed a lack of respect, dignity and care towards the person using the bedding.

During our last inspection in August 2017, we saw that interaction between staff and residents was impacted by the availability of staff. We found that improvements had been made in this area, and that staffing levels were sufficient to enable positive interactions between staff and people. We looked at rotas which confirmed this was consistent.

People told us they felt involved in their own care. One person said, "Yes I definitely feel in control. I choose what I do and they (staff) listen to me." We saw that staff understood people's preferences and communication, and supported people to do the things they wanted to do. Care plans we looked at reflected this.

People confirmed that the staff respected their privacy when providing care. One staff member said, "I feel that all the staff are on the same page. Any of us would say something if we thought someone's privacy was not being respected." We were shown around the service on a number of occasions and we saw that staff always knocked on doors before entering to show us around. People had keys to their own rooms, and could secure their belongings if they wanted to. All the staff we spoke with understood the importance of confidentiality, and keeping people's information private and secure as required.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. The service was not meeting people's individual needs in relation to maintaining an environment where personalised care could take place. Personalisation of the environment was limited , and people were living in poor conditions that did not reflect their preferences. The service did not evidence any belief that people deserved to live in a clean and homely environment, which catered to their own tastes and preferences. The poor quality of the environment was not considered by the service to be a potential negative influence people's mental health and emotional wellbeing.

During our last inspection, we found that some further improvement was required to ensure a consistent approach was taken to deploy and encourage meaningful activity. We also found that activities based outside of the service and in the community were limited, and could be improved upon. At this inspection, we found that some improvements had been made.

A daily log of activities was being kept which evidenced the suggestions staff had made with people, who had taken part and any reasons given by people who did not wish to take part. One staff member told us, "I love to dance, so I am always encouraging people to have a dance and stay active." People we spoke with told us that there was usually activities on offer, although several people chose not to engage. We saw that there had been some activities offered to people to enable them to go into the community. This included trips to a local coffee shop to socialise, and trips to other shops. During our inspection, we saw that a staff member was researching and planning another community venue for people to be able to experience, and was planning to create a risk assessment specifically for this venue. We saw that some people chose not to take part in community based activity as they did not want to leave the service.

Care planning documents had been created to include person centred plans. We saw that the staff had received support from a local authority social care professional in creating plans for each person. These plans included section on 'Who is important to me', 'Things I like and dislike' and 'When I am feeling unwell'. Preferences, likes, dislikes and skills were listed for each person.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. No examples of accessible information had been created by the service, but the registered manager told us that they were able to create easy read or large print versions of documents if required.

People knew how to make a complaint if they needed and were confident that their concerns would be listened to and acted upon as required. The people we spoke with said they had not had to make any formal complaints but would do so if needed. We saw that if complaints were made, the service followed a complaints policy and could record and respond to each complaint. The registered manager Information from complaints could be fed-back to staff when required, so that learning and development could take

place.

No end of life care was currently being delivered at the service, but systems were in place to support people with decisions in this area should they need to. Advanced decision planning documents were being developed by the service.

Inadequate

Is the service well-led?

Our findings

The service was not well led. During our last inspection we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not deployed appropriate systems or processes to assess, monitor and improve the quality and safety of the care that people received.

During this inspection we found that the provider had continued to fail to deploy a system of audits to sufficiently assess the cleanliness and suitability of the premises and environment.

St Michaels House was inspected by CQC in May 2016 and we found that the provider was in breach of regulation 17, we inspected the service again in April 2017 and found that the provider remained in breach of regulation 17. We inspected again in August 2017 and found the provider again remained in breach of regulation 17. During this inspection the provider, for the fourth time, remains in breach of regulation 17 because systems to monitor and improve the quality of care and support that people received had not been implemented consistently, systematically or appropriately. This consistent failure in the leadership and governance of the home has contributed towards the rating of inadequate in the well-led domain.

Following our last inspection, the provider was required to submit information to us on a monthly basis. This included action plans and written evidence in relation to the cleanliness of the service, quality assurance systems and staffing levels. The provider sent in information to us as requested, but this information was not detailed and did not reflect the actual condition of the service.

The service failed to deploy a system of audits to sufficiently assess the cleanliness and suitability of the environment. Audits in place to measure and drive improvement were not detailed, effective and required improvement. Environmental audits did not reflect the actual condition of the service. An environmental audit carried out on 26 February 2018 stated that a person's bedroom was in 'good' condition, but needed new blinds. Upon inspection, we found this room to have large areas of tobacco and damp staining on the walls, and the basin in the room was dirty, had a dirty nail brush on it, and had broken and mouldy sealant around it. This was not mentioned on the audit.

An environmental audit dated 26 February 2018 stated that a person's room was in 'poor' condition, but no detail was given. The actions to be taken were listed as 'needs painting'. During our inspection we found this room to be severely affected by damp. The odour was strong and large amounts of damp patches were seen across the wall and window. The person's wash hand basin was dirty and they were storing their toothbrush and toothpaste in a dirty and mouldy cup. We went in to this room with the registered manager who told us the room just needed to be painted. The staff completing the audit, and the registered manager, failed to recognise the severity of the poor condition of the room and failed to take action until we inspected the service and pointed out the concerns. These failings posed a potentially serious risk to the person's health.

A cleaning record dated 19 February 2018 documented that the kitchen area had been cleaned. We found that the kitchen was in a very poor state of cleanliness, and had ingrained dirt and grease throughout. The

registered manager told us the kitchen was due to be replaced in their refurbishment plan. We asked why the kitchen had not been cleaned as per the cleaning records, and the registered manager did not know why the staff had not done this. Sufficient checks were not in place to monitor the environment and mitigate risks to people's health, safety and welfare.

We found that a complete and contemporaneous record of each service user was not always kept. One person had a history of pressure sores and did not have any documentation to show this was being monitored appropriately. The registered manager told us that staff made regular checks to the person's skin condition when performing personal care, but this was not recorded anywhere or mentioned in care planning documents.
This failure to address on-going breaches of regulation, implement a system of quality assurance or to identify and address the shortfalls in the cleanliness and suitability of the premises constitute an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

The service was being managed by a registered manager who was aware of their legal responsibilities to notify CQC about certain important events that occurred at the service. The registered manager had submitted the appropriate statutory notifications to CQC such as DoLS authorisations, accidents and incidents and other events that affected the running of the service.

People and staff we spoke with told us that they felt supported by the registered manager. Staff told us that they could approach the registered manager or senior staff members whenever they needed something, and they got the support they required.

Staff told us they had the opportunity to feedback and discuss any concerns as a team, and said they were listened to by management. We saw that team meetings were held which covered a range of subjects, and offered a forum for discussion. Staff told us that they were able to feedback through a variety of forums including team meetings, supervisions, and observations, as well as informally should they wish. We saw minutes of meetings held, and staff we spoke with confirmed they took place.

People had the opportunity to feedback on the quality of the service. We saw that quality questionnaires had been sent out to people and their families to comment on the quality of care they received. Results were collated and looked at to identify any areas of improvement.

The service worked openly with the local authority and other professionals involved in people's care. We spoke with a social care professional who had been supporting the provider with some improvements in care planning and other documentation that was required. The feedback was positive, and we were told the provider was receptive to the help offered to change and improve some of the care planning documentation in place.