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Angel Court Residential Care Home

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was unannounced and took place on 22 and 29 November 2017.

We had previously carried out an unannounced comprehensive inspection of this service on 20 and 21 June 2017. The service was rated as inadequate overall and was placed into special measures. A number of breaches of legal requirements were found at the inspection. On the 18 July 2017 we served the provider with two warning notices.

The first warning notice was served for a failure to comply with Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We found the provider had an inconsistent approach to the assessment and recording of risk, failed to ensure the safe management of medicines and did not have sufficient care workers available to keep people safe. The provider was given until the 18 August 2017 to demonstrate compliance with the regulation. The second warning notice was served for a failure to comply with Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. We found the provider had ineffective systems to improve the quality of the service and ineffective audits. The provider was given until the 01 September 2017 to demonstrate compliance with the regulation.

On 11 September 2017 we undertook an unannounced focused inspection of the service to check the progress that had been made by the provider to meet the legal requirements in respect of the key questions of Safe and Well-Led. At this inspection, we found that the provider had made improvements. We concluded that the legal requirements in respect of the breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as referred to in the warning notice, had been met. We were however unable to conclude that the provider had improved sufficiently to meet the legal requirements in respect of the breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection we requested details from the provider about how they planned to meet the requirements of Regulation 17.

At this, most recent inspection we found the provider had continued to make improvements in some areas. However, we were again unable to conclude that the provider had made sufficient improvement to demonstrate they had met the legal requirements of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Angel Court Residential Care Home is registered to provide accommodation for up to 25 older people, who require personal care and support, some of whom are living with dementia. On the day of the inspection there were 22 people living at the home. There was a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found risks to people were not always dealt with consistently by the staff team. Staff did not always follow the guidance in people's care records. People told us they felt safe living at Angel Court. Staff were aware of how to raise concerns for people's safety and wellbeing. There were sufficient numbers of staff to meet people's care and support needs and people received their medicines as prescribed. The provider was working towards an improvement action plan in relation to infection control and standards at the home had improved since the last inspection, although further improvements were still required.

We found staff did not always have the appropriate skills, knowledge and experience to meet people's needs. The provider had not assessed the competency and knowledge of staff to ensure they could provide effective care and support. Although people received sufficient amounts to eat and drink people's mealtime experience was not always positive as staff did not provide care that was consistent with people's care plan. Staff at Angel Court worked in partnership with other agencies to ensure people's health needs were met. Where people required support from external healthcare professionals visits were arranged by staff. Although some improvements had been made to the home's environment, further action was required to ensure people's bedroom were decorated and furnished to a high standard. People were asked for their consent before care and support was provided and where restrictions were in place the provider had acted lawfully to ensure people's rights were protected.

Although we found that individual staff were kind towards people, the provider's systems and processes did not always ensure that people's overall experience was caring. Language used by staff towards people was not always age appropriate or dignified. People were supported to make day to day decisions about their care and support. People's privacy was respected by staff and their friend and family members were made welcome when they visited the home.

Although a programme of activities was available people did not always receive support to follow their own individual interests and pastimes. People and their relatives were involved in the planning and review of their care and support. Staff understood people's individual needs and preferences. People knew how to raise a concern if they were unhappy about the service they received however the provider needed to ensure their complaints procedure was available in an accessible format.

While some improvements had been made the provider had failed to established systems to offer assurances about the effective oversight of the service. As a result people were placed at potential risk of harm. The provider had failed to ensure staff were appropriately trained and their competency to work effectively in their roles had not been assessed. The provider did not have clear strategy in place to ensure people received a high quality service and instead reacted to feedback given by other external agencies. People and staff felt they had the opportunity to give feedback to the provider, although it was not clear how this feedback had been used to drive improvements.

The overall rating for this service is 'Requires improvement'. However, the service remains 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.

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 always safe.

Risks were not always managed consistently by staff.

People felt safe and were supported by staff who knew how to raise concerns for people's safety and wellbeing.

There were sufficient numbers of staff available to meet people's care and support needs.

People received their medicines as prescribed and improvements had been made to the environmental standards of the home, although further improvements were still required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have the skills and knowledge to meet people's care and support needs. The provider had not assessed staff's competency and knowledge.

People were supported to eat and drink sufficient amounts to maintain their health however staff support at mealtimes was not always consistent.

Staff worked with other agencies to ensure people's health needs were met and people were asked for their consent before care and support was provided.

Some improvements had been made to the home environment, however further actions were required to ensure people's bedrooms were furnished and decorated to a high standard.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider systems and process meant that people did not always experience a caring service.

Language used by staff was not always age appropriate or dignified.

People were supported to make their own decisions about their day to day care and support.

People were supported to maintain their independence where possible and staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive support to take part in activities and pastimes that interested them.

People and their relatives were involved in the planning and review of their care.

Staff were aware of people's individual needs and preferences.

People knew how to raise a complaint if they were not happy with the care and support they received.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Although some improvements had been made since the last inspection the provider did not have systems in place to ensure effective oversight of the service. The potentially placed people at risk of harm.

The provider had responded to some of the concerns expressed by external agencies but had not developed their own strategy of improvement to ensure continuous learning and sustainability.

People and relatives had been invited to give feedback about the service; however there was no clear strategy about how this feedback would be used to drive improvement.

People and staff told us they felt able to give feedback about the service and staff felt supported in their roles.

Angel Court Residential Care Home

Detailed findings

Background to this inspection

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

This inspection was prompted in part by notification of concerns raised by the local authority. The inspection took place on 22 and 29 November 2017 and was unannounced on both days.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who use this type of service. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted the local authority and commissioners for information they held about the service. This helped us to plan the inspection.

During the inspection we carried out observations of the care and support people received. We used the Short Observational Framework for Inspection (SOFI) to observe how care was provided for people who were unable to speak with us. We spoke with eight people who lived at the home, five staff members and the registered manager who was also the provider. We looked at five records about people's care and support, three staff files, medicine records and systems used for monitoring the quality of care provided including health and safety checks.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection in June 2017 we found the provider had an inconsistent approach to the assessment and recording of risk, had failed to ensure the safe management of medicines and did not have sufficient care workers available to keep people safe. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in September 2017 we found that the provider had made improvements to meet the requirements of Regulation 12(1) described above, however improvements were still needed. At this most recent inspection we found further improvements were still required.

We reviewed how the provider assessed and managed risk. On the first day of the inspection visit we were made aware of a safeguarding concern. The concern was ongoing and as a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the lack of provider oversight and risk management. This inspection examined those risks.

We observed one person whose behaviours posed a potential risk to other people living at the home. While staff were aware of the risks they did not manage the person in a consistent way, with lots of different staff making attempts to prevent the person's behaviours from affecting other people. This inconsistent approach did at times result in the person's behaviour escalating, although not to the extent that a serious risk was posed. We discussed our concerns about how this person was being supported by staff with the provider. They told us they would meet with the person and also hold a staff meeting, to discuss strategies for supporting the person. On the second day of the inspection visit we found that that staff were now keeping more detailed records of the person's behaviours and the person appeared calmer. The provider told us they hoped this would enable them to monitor the level of support the person required and also offer additional support to staff in managing the person's behaviours.

We reviewed a further four people's care records and found risks to people had been assessed and accidents and incidents were recorded with actions taken to reduce the risks of similar incidents occurring again. For example, where people were at risk from refusing their medicines, which may make them unwell, staff had reported this to the person's GP so they could conduct a review and advise on the most appropriate course of action.

People told us they felt safe at Angel Court. One person told us, "I like living here. I feel very safe." We saw people were confident to approach staff if they needed assistance. Staff understood their responsibilities in recognising and reporting suspected abuse and knew how to raise concerns with both the provider and other external agencies if necessary. One staff member told us, "If I thought someone was being harmed I would report it to the manager and the police. I am confident [name of provider] would respond to this." Another staff member said, "I would certainly report any concerns to the manager." We reviewed information we received from the provider about incidents or concerns for people's safety since the last inspection and found they had notified us of specific events as required by law.

People told us there were enough staff to meet their care and support needs. One person told us, "I do use the call buzzer and staff come quite quickly." Another person, who spent much of their time in their room said, "The carers are very good, nothing is too much trouble for them. If I have any problems in my room I just ring down and staff will come up and fix it quite quickly." Staff members we spoke with told us they felt they were enough staff available on each shift to support people. One staff member said, "There are definitely enough staff during the day. At night it can be difficult if someone has to go to hospital urgently, but we have a process that we follow if that happens. I think the staffing levels are reasonable." We observed staffing levels throughout both days of the inspection visit and saw there were sufficient numbers of staff to respond to people's care and support needs. Where people required assistance with their personal care, mobility, or to eat their meals, staff were available to support them. However, we observed that there was very little support available from staff for people to take part in activities and pastimes. Staffing was not sufficient to ensure people always received support to take part in activities that interested them.

People received their medicines on time and as prescribed by their GP. People we spoke with told us they were happy with the way their received their medicines. One person said, "I have medication twice a day and always on time." Care plans provided staff with guidance to ensure people took their medicines safely and as prescribed. Staff told us they had been trained to support people safely with their medicines. Senior staff were responsible for supporting people with their medicines and staff we spoke with demonstrated a good knowledge of people's individual health needs. There were systems in place to ensure people received their medicines as prescribed which included audits carried out by senior staff. We identified an issue with the most recently completed medicines audits where stock balances had been incorrectly calculated. We brought this to the attention of the provider and senior staff member who advised they would conduct a further stock check without delay.

People we spoke with did not express any concerns about infection control. We saw personal protective equipment (PPE) was available throughout home and we observed staff using them. We reviewed audits carried out by the provider in relation to infection control, including mattress audits and saw these were being completed within best practice guidelines. The provider had instructed an external agency to test for legionella within the water system and the latest report we reviewed showed the water system was safe. The provider told us they were working towards an improvement action plan following a recent infection control visit, and we saw that the standards at the home were improving.

Requires Improvement

Is the service effective?

Our findings

We found staff did not always have the appropriate skills, knowledge and experience to meet people's needs. We spoke with five staff in total and found they had varying degrees of knowledge and understanding. Although staff told us they received an induction when they began working at the home and further training since, this had not always been sufficient to ensure staff had the skills and knowledge required to support people effectively. Two staff members we spoke with were unclear about the action they should take in the event of a fire and another staff member was unable to tell us about people's health needs. For example, what the risks might be for a person living with diabetes. We found that although staff had received training in these areas, their competency had not been assessed by the provider to ensure they were able to apply their learning sufficiently. We reviewed staff records and found regular supervisions had not been carried out. This meant the provider had no way of assuring themselves of the competence of staff.

Other staff we spoke with were knowledgeable about people's individual needs and knew what action they would take. However this knowledge and understanding was not consistent across the staff team meaning people could be placed at risk of not receiving appropriate support.

We discussed our concerns about staff training and competencies with the provider who advised that supervision and support sessions had supposed to have been undertaken by the previous manager; however since their departure they had discovered this was not the case. The provider told us they had started the process of meeting with all staff on an individual basis to review their knowledge and identify any further training that may be required. The provider also held a staff meeting after we shared concerns about staff knowledge in the event of a fire, to ensure staff had received clear guidance about what action they should take.

We observed some inconsistencies with the way in which staff supported people with their meals. For example, we saw a number of staff prompting one person to eat their lunch. Four different staff approached the person and tried to prompt them to eat, which resulted in the person becoming agitated. The person's care plan offered guidance to staff about how to support the person; however staff were not consistently following this guidance. Senior staff explained to us and records confirmed that advice had been sought from a healthcare professional about the person's dietary intake. However in continually approaching the person while their meal was in front of them staff caused the person to become anxious. We reviewed the person's records and found staff had carried out risk assessments in relation to their dietary intake and the person's weight was maintained. However, guidance on how to support the person was not being followed by staff.

We shared our concerns about the support this person received with the provider and senior staff who advised they address these concerns with staff without delay. They further advised they would make a referral to the Speech and Language Therapy service and request specialist advice about how best to support the person.

Most of the people we spoke with told us they were happy with the food and meals provided at Angel Court. One person said, "The food is nice and I get enough to eat. I have two choices for lunch." Another person told us, "The food is very good. I am never hungry and always have enough to eat. In the evenings you can have salad, eggs on toast, whatever you want really." However, two of the eight people we spoke with expressed concerns about the food. One person told us they were offered choices, but did not like the items on the menu. A second person felt that although they were offered a culturally appropriate meal, this was not always cooked to their liking. We reviewed the menu and found culturally appropriate foods were available at each meal time. We observed lunchtime on both days of the inspection visits and found it was relaxed with some people chatting amongst themselves and with staff. People were offered menu choices approximately one hour before lunch was served. Staff told us this was to ensure people who might have difficulty remembering their preferred choice could be given another opportunity to choose their meal.

People we spoke with were unable to tell us about the initial assessment of their needs carried out by the provider, because of their communication needs. However, we saw from people's files there was an initial assessment of people's needs carried out prior to people moving in to the home. Where people had been unable to communicate their needs and preferences information had been gathered from close relatives to enable staff to plan their care accordingly. We observed that a number of people living at Angel Court at the time of the inspection visit did not appear to be appropriately accommodated at the home. The provider explained to us that they were working with people, their families and other external agencies to try and identify more suitable accommodation.

Staff at Angel Court worked with other organisations to ensure people received effective care, support and treatment. Records we reviewed demonstrated staff contacted relevant healthcare agencies and professionals in response to people's changing needs. For example, one person had been supported to attend an appointment with the dietician after their eating habits had changed. Senior staff took responsibility for contacting people's GP when required and liaised with other healthcare professionals such as district nurses. We spoke with a visiting healthcare professional who told us, "I have no problems here. The staff are good. No problems with their knowledge of people and they seem to follow the advice I give them."

People told us staff supported them to manage their healthcare needs. One person said, "When I had a poorly foot carers got me to the hospital really quickly. It was good." Another person told us, "I have had the GP out very quickly when my health has not been good." People told us and records confirmed, they had been visited by chiropodists, opticians and a dentist.

Prior to our previous inspection in September 2017 they provider had begun a refurbishment programme in order to improve the quality of the home environment and better meet the needs of people living with dementia. At this inspection we found although some aspects of the communal areas of the home had been improved, further work was required to ensure people's individual rooms were decorated to a high standard. There was still a lack of dementia friendly signage in some areas of the home and the decoration of the upstairs corridor offered little orientation support to people who were living with dementia. We discussed this with the provider who advised that a recent audit had been undertaken by a local organisation who had made recommendations about how the provider could improve the home for people living with dementia. We reviewed this report which highlighted some good established practice at the home as well as areas for improvement.

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 people lack mental capacity

to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw people were asked for their consent before care and support was provided. Staff were observed to ask people if they were happy to receive support, or if they would prefer to wait until later.

Staff told us they had received training in the MCA and most staff were aware of the principles of the Act and how this should apply to people's care and support. Staff shared with us examples of how they involved people in making choices, for example asking people what time they wanted to get up and asking people about their personal care preferences. Information about people's capacity to make specific decisions was recorded in their care records and there was evidence of best interest's discussions and decisions being made which involved external professionals and family members. However, we found these decisions were not always documented clearly in people's care plans, which may mean staff were not aware of why certain decisions have been made. This could place people at risk of receiving inconsistent care. We discussed this with the provider who advised they would review documents relating to best interests decisions and ensure more details were included to support staff's understanding of the reasons why the decision had been made.

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). DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection four people living at the home were subject to an authorisation to deprive them of their liberty. The provider explained that a further eight applications to deprive people of their liberty had recently been submitted and were awaiting review by the relevant authorities. The provider shared with us how the decisions had been reached to ensure that people's rights and freedoms were lawfully protected.

Requires Improvement

Is the service caring?

Our findings

Although we found that individual staff were kind and caring towards people, the provider's systems and processes did not always ensure that people's overall experience of life at Angel Court was caring. For example, people did not always receive consistent support from a knowledgeable, skilled staff team. The oversight and governance of the care people received was not always effective in ensuring people were protected from the risk of harm.

We observed most staff interacted with people in a calm and friendly way and spoke about people with warmth and compassion. However we observed a number of interactions where people were not spoken to in a dignified way and language used towards people was not age appropriate. Although people did not react negatively to the way they had been spoken to, the language used towards them was not respectful. For example, when one person had become distressed staff said, "Stop being a silly fella, with your fake crying." We discussed our observations with the provider who told us they would address these concerns without delay.

People told us they felt they were supported by staff who were caring and respectful. One person told us, "The carers look after me well." Another person said, "The staff have been really good to me, they have helped me through some difficult times." Staff we spoke with shared examples with us of how they supported people in a compassionate and empathetic way. One staff member said, "It's all about seeing each person as an individual and letting them do things at their own pace. For example, with [person's name] you just have to give them time and a lot of encouragement."

Most of the people we spoke with told us they felt listened to by staff and were involved in day to day decisions about their care and support. One person told us, "I like to watch TV until about midnight, so I ask the staff to support me to me to bed last." Another person said, "It's fine here, I prefer to spend time in my room rather than be downstairs so staff come and talk to me when they can." We saw people were offered choices about when they spent their time and whether or not they wanted support with personal care. We found that staffing levels gave staff time to listen and engage with people.

Other than the examples of inappropriate language previously mentioned, we found staff supported people in a way that respected their privacy, dignity and independence. Staff member's shared examples with us of how they ensured people felt valued and respected. One staff member said, "I spend a lot of time talking to [person's name]. I try and talk to them like I'm a visitor and not a member of staff. I found if I'm not in my uniform they are much more receptive, they see me as a friend and not someone coming to support them. I talk to them like a friend." We observed staff knocked on people's bedroom doors before entering and quietly prompted people who required support with personal care. One staff member told us, "We treat people with dignity by looking after them. When visitors come we give people privacy and support them to spend time in their own room."

People's care records contained details of their culture and religion, so staff were aware of what was important for each person. We observed staff speaking to people in their first language which enabled

people to make their own decisions and be clear about any questions they were asked. Where staff did not speak the person's first language they requested support from a colleague to ensure the person was able to communicate their needs or requests clearly.

People told us their visitors and family members were able to visit at any time. One person said, "My visitors can come any time they want." Another person said, "My daughter can visit me every day and she can come when she wants as there is no time limit."

Requires Improvement

Is the service responsive?

Our findings

At the inspection in June 2017 we rated the provider as 'requires improvement' under the key question of "Is the service responsive?" We found people were not always supported to take part in activities that interested them. We also found there were some people living at Angel Court whose needs could not be consistently met by the skills, knowledge and experience of the staff team. We did not review this key question at the inspection in September 2017. However, at this most recent inspection we found although some improvements had been made, further actions were required to ensure people received a personalised service that was responsive to their individual needs.

Some people told us they were happy with the support they received to follow their interests and take part in activities or pastimes that they enjoyed. One person said, "I like playing cards and scrabble which I enjoy. Last week we had a dancing activity which was good." However, we found although improvements had been made since June 2017 to offer people activities to take part in, these were not always appropriate for people living at the home. We spoke with a number of people who spent time in their own rooms and found they had limited opportunities to engage in hobbies or interests. One person shared with us their disappointment about the lack of appropriate activities available to them. They said, "[Because of my disability] I can't join in with most activities. I do sing a few songs now and again when we have a sing a long, but that's not often." Another person told us they felt staff did not always have time to spend supporting them with their interests. They told us, "I love dominoes and play most days, but it depends on whether the carers have time to play with me."

Our observations confirmed that although there was a general programme of activities, which some people did take part in, personalised activities which were designed to meet people's individual needs were not available. This meant that some people spent lengths of time with little to engage them, particularly people who preferred to stay in their own rooms. This could place people at risk of isolation and also have a negative impact on their well-being. We discussed our concerns with the provider who acknowledged more needed to be done to support people's individual interests. They told us they had recently introduced more activities in the communal area of the home, but recognised they needed to improve further to ensure people's needs were met.

Due to their communication needs and understanding, people we spoke with were not able to share with us their experiences of how they were involved in planning their care. However, we saw from people's care records that they and their relatives had been involved in the assessment, planning and review of their care. One person told us, "Staff know what I can do, they are very good. I am able to take care of myself but staff support me when I need them to." People's care records contained some information about their life histories and individual needs and preferences. Another person said, "I am fairly mobile and use the lift to come downstairs when I feel like it. One of the male carers gives me a shave, which I like." Staff we spoke with were able to share examples of how they ensured people received personalised care which met their individual needs and preferences. One staff member said, "It's about knowing people well and understanding how they feel. There are naturally going to be some staff that people get on with better than others. We have to be aware of that and be sensitive to people's choices."

People told us they felt confident to raise concerns if they were unhappy about the care they received. One person said, "If I had any problems I would be happy raising them, but I have never had to." We observed that people were confident to approach staff if they had any queries or concerns. People also approached the provider on a number of occasions throughout the inspection visit and chatted to them about their experiences and family members. The provider had not received any recent complaints however we saw the complaints process was displayed in the entrance to the home, and complaint forms were also available. However, we found that while it offered appropriate guidance on how to complain, the format of the policy was not accessible to those people who may have communication difficulties or were living with dementia.

Inadequate

Is the service well-led?

Our findings

At the inspection in June 2017 we gave the service an overall rating of inadequate and placed it into special measures. Amongst other issues of concern we found the provider had ineffective systems to improve the quality of the service and conducted ineffective audits. This was a breach of the Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection in September 2017 we found that the provider had not been able to demonstrate it had improved sufficiently to ensure on-going consistency to meet the requirements of Regulation 17(1) described above. We wrote to the provider following the inspection and asked them to take action to improve the governance of the home. The response we received did not assure us the required improvements had been made.

During this most recent inspection we tested the changes and improvements the provider told us they had made. We found although some improvements had been made, further action was required to ensure people were protected by effective systems to monitor the quality of care provided and the home's environment.

Systems and processes including regular audits had been introduced following the last inspection. For example we found the quality of information recorded about cleaning, infection control and health and safety matters had improved. Equipment used to lift and support people with their mobility had been serviced in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Although improvements had been made to the communal areas of the home some people's individual bedrooms required redecoration or minor repairs in order to make them more pleasant for people to live in. We observed one person's room where parts of the wall had been damaged by the movement of furniture, but had not been repaired. The room also required redecoration. On the first day of the inspection we observed repairs were being carried out in some areas of the home, however there was no planned schedule for maintenance and actions taken to improve the environment had been in response to visits carried out by external agencies.

We found there was a lack of provider oversight in relation to the support staff had received and staff's competency to carry out their roles effectively had not been assessed. Staff we spoke with told us they had not had the opportunity to meet on a one to one basis with the provider or manager since the last inspection. Records we looked at confirmed this. The provider told us staff supervisions had been the responsibility of the previous manager, however they had not conducted checks to ensure these were carried out. We identified some areas where staff knowledge was lacking and asked the provider how they had assured themselves that staff were competent in their roles. The provider told us they were not aware staff supervision had not been taking place until recently and in the days preceding the inspection had begun to meet with staff to check their knowledge and understanding of their roles. We asked to see records of these meetings, but were told they had not been documented.

The provider told us they were working to an improvement action plan implemented by external agencies. This meant the provider relied on other agencies to identify areas where improvements were required and did not have their own clear vision or strategy to promote a positive culture which resulted in positive

outcomes for people.

We found oversight of safeguarding matters had not been effective to ensure people were appropriately protected from the risk of harm. The provider told us they had, "Left the (previous) manager to get on with running the home" and as a result had not conducted their own checks to assure themselves of the quality of the service being provided. This left people at risk of potential harm.

The provider had failed to operate effective systems and processes to make sure they assessed and monitored their service. This was a continuing breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that the manager had left their post in the days prior to the inspection. They advised that as an interim arrangement they would be based at the home on a daily basis and a senior carer would be responsible for the leadership of the home in their absence, until a new manager had been recruited. We reviewed information submitted to us by the provider and found they had notified us of incident and events as required by law.

People told us they had the opportunity to give feedback about the service provided at Angel Court. We reviewed minutes from a recent resident's and relatives meeting and saw the provider had shared the outcome of the inspection undertaken in September 2017. Information had also been given to people about the planned refurbishment of the home and the changes made to the company who provided meals. However, while feedback had been received from people and relatives the provider did not have clear processes in place about how to use this feedback to drive improvements and make any suggested changes.

Staff told us they felt the provider was approachable and felt supported by senior staff. One staff member said, "I feel supported. There is always someone I can go to, whether it's the seniors or [name of provider]. There is always someone." Another staff member told us, "I am supported; I have spent some time with [name of provider] today."

Prior to the inspection we were aware of the involvement of other external agencies at Angel Court, some of which had required the provider to make improvements. Specialists in developing a more dementia friendly environment had also visited the home and the provider was working towards improvements in this area. We found the provider was receptive to feedback offered by other external agencies and welcomed them in to the home. However, we found the provider had a tendency to react to feedback given by others rather than developing their own clear strategy for improvement and sustainability. The provider told us they kept their knowledge up to date by participating in local provider forums, where information about best practice was shared. They told us they and senior staff had also attended training offered by local agencies which aimed to support providers to raise standards in care homes. However, at the time of the inspection visit it was not clear how learning from these events had been implemented by the provider at the home.

Most people we spoke with were happy with life at Angel Court. One person told us, "I get good care here; [the provider] is very good." Another person said, "It's a nice place, I have got to know everyone here."

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 had failed to operate effective systems and processes to make sure they assessed and monitored their service.