Cherry Garden Properties Limited

Angelus

Inspection report

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Date of inspection visit: 1 December 2014, 2 December 2014
Date of publication: 15/04/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 1 and 2 December 2014 and was unannounced. The service provides accommodation for up to 31 people who have nursing or dementia care needs. There were 12 people living at the service when we visited.

There has been a history of non–compliance with this service since September 2013. Following an inspection on 13 May 2014, we served two warning notices and asked the provider to take action to make improvements for a further four regulations. During an inspection in July 2014 we found the provider had not taken steps to meet the requirements of the warning notices and found a breach of a further three regulations. We are currently deciding on the action we will be taking due to the level of non-compliance within the home. The provider sent us an action plan telling us the action they would take to ensure they met the requirements of the law. They told us they would achieve compliance with the regulations by the end of November 2014. At this inspection we found the provider had improved the cleanliness of the home and the management of medicines. However, they had not made the necessary improvements to the other areas of concern and were not meeting the requirements of the regulations.

At the time of our inspection the home had not had a registered manager since September 2013. A registered

Summary of findings

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. The provider had appointed a manager who had been in post since the end of September 2014 who was not registered with CQC. This meant CQC had not had the opportunity to assess this person's suitability and competence to manage the service.

People's safety was being compromised in a number of areas. The arrangements that were in place to safeguard people from the risk of abuse were not adequate as not all incidents which should be reported to the local authority and CQC had been. The management of risks relating to people choking, personal emergency evacuation and people's health conditions were inadequate. This put people at risk of serious harm.

The provider did not have a system to assess the number of staff needed and there were not enough staff at all times to meet people's needs. Recruitment procedures did not ensure that staff employed had the necessary skills and were suitable to work with vulnerable people. Not all staff had received the necessary training and some training was out of date. There were no systems in place to support staff appropriately, identify their development needs or to check they had learnt from the training.

Mental capacity assessments were not carried out and people who knew the person well were not involved in making decisions or helping to plan the person's care. People were not supported to eat and drink to ensure good health. People's weight was not monitored effectively and action was not always taken when they lost weight. This put them at risk of malnutrition and dehydration.

Staff demonstrated kindness and compassion however, people's privacy and dignity was not always maintained when receiving support in communal areas.

Care plans lacked information about people's interests and preferences. They were not maintained and did not always reflect the needs of people. People could not rely on care being delivered in a consistent and appropriate way. Where assessments of people's needs were required they had not always been undertaken. Activity provision was inadequate and those people who remained in their rooms had very little engagement and mental stimulation.

There was a complaints policy and a system to record and investigate complaints which we saw was being used. People were asked to confirm they were satisfied with the outcome of complaints.

The provider carried out some audits however these were not used to drive improvement. The provider had given CQC an action plan stating what they would do to meet the requirements of the law. However, this was not being followed or monitored to reach compliance with the essential standards of safety and quality. A lack of opportunities for nursing staff to meet meant there was no process to ensure any clinical issues could be discussed in a structured way to look at practice and improve standards of care being received by people. Opportunities to discuss issues relating to the home and identify areas of improvement or development were not available for people or staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Due to the level of concerns we served a notice of proposal to vary a condition of the providers registration and remove the location. The provider submitted representations and following the inspection in December 2014 took the decision to close the home. The providers representations were not upheld and we served a notice of decision, which the provider did not appeal against. The notice of decision came into effect on 18 March 2015.

Summary of findings

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. The provider did not notify the safeguarding authority of relevant incidents. Risks to people were not managed to ensure their safety.

There were not always enough staff to provide safe and effective care. Pre-employment checks and processes were not robust to ensure suitable staff were employed.

Appropriate arrangements were in place for the safe handling, storage and disposal of medicines, but the obtaining, administering and recording of medicines were not always safe.

The home was clean and tidy. Protective equipment was readily available and staff understood their responsibility for infection control.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive an induction or supervision. Significant gaps were identified in training staff received. There was no system in place to support staff and identify their training and development needs.

The requirements of the Mental Capacity Act 2005 were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation.

Care staff did not have an understanding of Deprivation of Liberty Safeguards and did not know which people they applied to.

People did not receive appropriate support to eat and drink enough. Food and drinks were not always prepared to the right consistency to meet people's needs. Food and fluid charts were not always accurate or fully completed. Action was not always taken when people lost weight.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring. Interactions between people and staff were generally positive and staff showed kindness and compassion.

People's privacy was protected when they were receiving support in their rooms; however when this was in communal areas, privacy and dignity was not always maintained.

People or their relatives were not always involved in decisions about their care and treatment.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive. Care plans did not always contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way. Where assessments were needed they were not always conducted.

There was a lack of activity provision to meet people's individual needs. People who remained in their rooms received very little mental stimulation or interaction.

Is the service well-led?

Inadequate 

The service was not well-led. Action had not been taken to address previous breaches of regulations we had identified. A range of audits were in place, however these were not used to make improvements to the service people received. The system used to assess and monitor quality was not effective.

There was a lack of continuity in the management of the service, which had had an impact on staff and the service provided.

People and staff were not actively involved in the service. Staff views were not sought by the provider and there was no evidence people were consulted about the home.

The provider was not notifying the Care Quality Commission of significant incidents.

Angelus

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 1 and 2 December 2014 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor in the care of older people and an expert by experience in dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

It was not always possible to establish people's views due to the nature of their conditions. We spoke with two people and a relative. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We also spoke with the provider, the manager, two nurses, four care staff, the activity coordinator, two housekeeping staff, the home's administrator, the cook and a social care professional. We looked at care plans and associated records for eight people, staff duty records, five recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

In May 2014 the provider could not demonstrate they applied safe recruitment processes and could not show that appropriate recruitment checks were undertaken before staff commenced work. Staffing levels and skill mix were inconsistently applied and we observed that staff did not respond to people's needs when needed. Staff did not have the skills and knowledge to support people appropriately. The service was in breach of regulation 21 and 22. We asked the provider to take action to address these concerns.

During our inspections in July 2014 care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required. This was a breach of regulation 9. People were at risk because medicines management was not effective and this was a breach of regulation 13. People had not been provided with a clean and hygienic home to live in. The provider had not followed appropriate guidance for the management and prevention of infection control. The policy was not reflective of current legislation. This was a breach of regulation 12.

The provider told us they would ensure all appropriate recruitment checks were undertaken and they would ensure a list of nurses' registration numbers were maintained and up to date. We found they had not done this. There was no list which detailed all nurses' registration numbers. It was not possible to establish all nurses had in date registration and were able to be working as the qualified nurse on duty. One person had been employed since our last inspection and the records showed all necessary pre-employment checks had not been undertaken. No photographic identification was available and there was no proof of address. This made it difficult to establish the person was who they said they were. Where the recruitment process had identified an area that may require further follow up for one staff member, this had not been done. There was no evidence this had been considered by the provider over a period of three years. Robust recruitment processes were not in place. People were at risk of receiving care from staff that did not have the appropriate skills to provide this.

This is a continued breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was not enough staff on duty to meet the needs of people. No assessment tool was in place or used to calculate how many staff were needed on each shift. The manager told us told us what the staffing level in the home should be however the duty roster did not reflect this was consistently applied. Staff described how the lack of staffing impacted around mealtimes and when providing personal care. The layout of the building meant sometimes one care staff member could not locate the other staff member to provide personal care and people were kept waiting. Eleven of 12 people required support to eat their meals and people had to wait until staff were available. We observed people being left without support to eat their meals while staff supported others. People did not always receive the support they required in a timely manner. Staff had reported their concerns to the manager who had reported the concerns to the provider about low staffing levels. The provider would not fund any extra staff and had looked and suggested staffing levels should be reduced.

This is a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider told us they would be implementing a new system for their care records by the end November. They said all risk assessments had been reviewed and updated. The implementation of the new care record system had only been completed for two people. For 10 people they were still using this old system which was not up to date and did not reflect people's current needs.

Risks were not managed effectively. One person who had been assessed by specialists as being at risk of choking on their food or drinks had refused to follow advice. Whilst their decision was respected by staff the increased risk of choking for this person had not been assessed. Observations of this person eating and drinking did not take place and there was no plan in place to monitor this risk. Staff said now the person had moved rooms they could hear any signs of potential choking and respond. We heard this person coughing regularly and did not observe that staff immediately responded to ensure they were not choking. This person was not observed by staff while eating their meals. This person was at risk of choking because staff did not understand how to ensure the safety of people when they were eating.

Two people had recently moved rooms however their Personal Emergency Evacuation Plans (PEEPS) had not

Is the service safe?

been updated to reflect this. Three people's PEEP plans did not record their immobility or increased frailty. People's emergency evacuation plans were not appropriate to people's current needs and placed them and others at risk should an emergency evacuation be required.

For two people who had a diagnosed health condition there was no risk assessments in place to support the care plan. There was no guidance about the risks associated with the health condition and how these should be monitored or managed.

The above issues are a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe but when we asked what made them feel safe, they didn't give us any examples. Staff had an understanding of safeguarding and said they would report any concerns about people's safety to the manager. Staff were confident the newly appointed manager would take appropriate action to address any safeguarding concerns. The provider had a policy in place which provided guidance to staff about how to recognise and report suspected abuse. This gave contact details for the local authority safeguarding team. Staff knew the home had a policy but had not read this. They said they would report concerns to CQC if they did not feel the manager acted appropriately or if their concerns were about the manager. Staff did not know how or who to report concerns to at the local authority. Training had been provided to staff, however we noted that five of 32 had not received any training and 12 were recorded by the provider as out of date. The manager showed us evidence of a safeguarding concern which they had reported to the local authority and investigated. We saw the report stated that follow up action had been completed including a review and update of the person's falls risk assessment, care plan and moving and handling profile.

Whilst we found this incident had been reported we could not be sure that all matters that might constitute a safeguarding issue had been appropriately reported. We discussed our concerns with the local authority. There was a risk appropriate investigations might not be undertaken and safeguards put in place to protect people. There were ongoing safeguarding issues within the home but no records of these could be found. Without information about safeguarding concerns the manager was not able to ensure that appropriate actions to safeguard people had been implemented. The lack of information meant people were at risk because information about safeguarding incidents was not available to learn from and inform future practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements had been made in relation to medicines management. The controlled drugs safe was compliant with the legislation and had been securely fitted. Tablet crushers were now clean and staff told us how they maintained the cleanliness of these to prevent cross contamination. Records of the refrigerator and room temperature were maintained daily and these indicated that they remained within the recommended temperature ranges. Guidance was available to staff about the action they should take should the temperature be out of range. Protocols were in place for as required (PRN) medicines and these matched the Medicines Administration Record sheets (MARS), however we found these lacked detail. For those people who were prescribed paracetamol on a PRN basis, the protocol detailed the dose and maximum dose in 24 hours but just stated it was for pain. There was no reference to the signs people might display that they had pain, no associated care plans for pain and no pain assessments for staff to be able to monitor and assess pain.

Where people were receiving variable doses of medicines the amount administered was recorded. For one person who was prescribed medicines that required regular monitoring to ensure their medicines were effective, we saw appointments were booked in advance and records were maintained. People were receiving appropriate monitoring to ensure the safe administration of their medicines.

Improvements had been made to the cleanliness of the home. The home had recruited a new cleaner and the home was clean, with no offensive smells. Domestic staff were able to describe to us how they ensured good infection control practices and we observed these being carried out. Daily cleaning records had been introduced and these were completed once they had completed the work. These were signed for on most occasions. However there were 11 days since October 2014 that had not been signed as the cleaning being done. Their policy had been updated and reflected the relevant guidance. Infection

Inadequate

Is the service safe?

control training had been completed on two days in August 2014. People were supported in a clean and hygienic environment by staff who understood their responsibilities in relation to infection control practices.

Inadequate

Is the service effective?

Our findings

At our last inspection in July 2014, we found the provider had not made suitable arrangements for obtaining and acting in accordance with the consent of people. The Policy for consent provided inappropriate guidance to staff. Staff had not received training in the Mental Capacity Act 2005 and demonstrated they had very little knowledge and understanding of this. This was a breach of regulation 18. The provider action plan said they would be compliant with this regulation by end of November 2014, however we found the necessary improvements had not been made.

The policy for consent had been updated and 15 staff had received up to date training in the Mental Capacity Act 2005 (MCA). When describing what this meant staff showed very limited understanding of the Mental Capacity Act and how they need to apply this to their practice. They were unable to demonstrate that the MCA should be used to assess people's capacity to make certain decisions, at a certain time.

Staff showed some understanding of the need to ask people for their consent. We heard examples of people being asked for their consent before care or treatment was given. One person had signed a disclaimer stating they knew the risk of not following specialist advice and were making that decision. The decision was respected by staff which increased the risks of harm to the person as they were known to be at risk of choking. A Deprivation of Liberty Safeguards (DoLS) application form reflected this person may not have the capacity to understand this risk however their decision had not been reviewed and best interests considered. We could not be assured the person had capacity to make this decision and understand the implications. They might be placing themselves at risk without now knowing this was what they were doing, as staff had not reviewed this decision.

Other decisions had been recorded by relatives. Consent forms had been signed by relatives. The provider could not demonstrate these relatives had the legal right to make to make such decisions. Decisions might not have been taken in accordance with people's wishes or best interests.

Staff had a basic understanding of Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely. The provider had told us at our previous inspection they had submitted applications for 11 people who lived in the home. The newly appointed manager said they were trying to find this information and any evidence these had been approved. They showed us evidence that four people in the home had authorised DoLS. However, the care records for people subject to DoLS contained no information about this or how staff should support the people if they tried to leave the building.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not receive an induction. The records held for staff and the manager had no details of an induction. There was no system in place to demonstrate the provider used the Common Induction Standards to introduce new staff to the home or care setting.

A training matrix had been completed and this listed 28 areas of training and identified which staff had completed the training. There were a number of essential areas that staff were out of date in such as training in moving and handling. Another example was that no staff had in date training in challenging behaviour. Essential training for staff, the chef and kitchen assistant had been cancelled by the provider. Staff did not have the training to ensure they could care for people effectively. The provider did not assess staff knowledge after training and could not be assured staff had understood the training and were confident and competent to carry out their roles effectively.

The provider had no systems in place to support staff development through the use of supervision or staff appraisal. There was no evidence of staff supervision or annual appraisals in staff member's files and staff confirmed they had not received any. The provider was unable to confirm staff were working to an appropriate standard or competent to carry out their roles effectively.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person and a relative told us the food was ok. The chef was aware of people's dietary needs and was provided this information daily by nursing and care staff. They had completed training in diet and nutrition. There was guidance available on display to show how to puree food to the correct consistency.

Inadequate

Is the service effective?

People were not always supported to eat and drink enough to meet their needs. Throughout our visits during the lunch period the care staff supporting people to eat their meals often had to leave them to get the next person's meal or a drink. They then returned to supporting the person with their meal. People did not receive the support they needed in a timely manner.

Four people's records showed they were at high risk of poor nutrition. While risk assessments were in place the related care plans lacked information regarding how people's nutritional needs should be met. Care plans provided no information or guidance to staff to ensure they knew what a person should be eating over the course of 24 hours. However, for another person their food had been changed to liquid form as they were refusing to take this from cutlery. This was provided and they were also receiving regular supplements to support their nutritional intake.

Where people had been consistently losing weight, care plans did not always reflect evidence of other specialist health care professionals had been sought. Where one referral had been made to a GP, it had not been followed up until we discussed this with nursing staff. We were concerned that had we not spoken to the nurse about this, contact with the GP might not have happened promptly and subsequently the person would not have received the supplements they required to support with adequate nutritional intake. For a second person we found in addition to the lack of external input, there was no evidence that supplements had been considered and alternatives had been offered. Assessment tools were not always kept up to date and did not reflect peoples changing needs. One was last updated in September 2014 and the person had been assessed as a low risk of malnutrition, however this person had consistently lost weight over a period of a few months and was refusing to eat and drink. This person was a high risk of malnutrition however care records did not identify this and no action was being taken to ensure the person was receiving adequate nutritional intake. This placed the person at risk of developing further health complications.

This is a breach Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

One person told us staff treated them well and were kind and respectful. They said their privacy was respected because the carers closed the door when they provided personal care and they felt listened to. A relative said staff had a kind and caring approach and that their relative's dignity and privacy were maintained.

Due to the nature of people's conditions most people were unable to tell us their views and opinions. We spent time observing interaction between staff and people to understand their experiences. Interactions were relaxed and staff engaged with people in patient and friendly ways. We saw many examples when they interacted with people in a caring manner. For example, the nurses sat down or knelt next to people explaining carefully what the medicine was for and how it should be taken. They engaged warmly with people and people responded in a like manner.

Some choices were offered to people. On one occasion a staff member had seen a person appear tired. They approached the person and asked if they would like to go to their room for a sleep. They also asked the person if they were happy for the hoist to be used. People were verbally offered choice of meals and drinks. However we observed staff doing this through discussion with them. Some people in the home were unable to communicate verbally and it was difficult to establish their understanding. Pictures to support them to make choices were not available.

There was no evidence to demonstrate people or their relatives had been involved in the development of their care and treatment plans. One person who was able to tell us did not recall being involved in developing their care plan. A visiting relative told us their relative had not been involved but staff told them when things changed. Resident and relative meetings had not taken place since April 2014. A relative said they had never been asked for their views on the service. People were not always supported to express their views and were not actively involved in making decisions about their care.

Staff understood the principles of privacy and dignity. We saw staff knocking on doors and ensuring these were closed when providing personal care. Staff placed signs on people's doors telling others not to enter as personal care was being delivered. However, when people were hoisted into chairs in the communal area screens were not used as the layout and size of the lounge did not support this. They were hoisted very close to other people and staff did not always use covers to preserve people's privacy. On one occasion a person's legs and incontinence aid were exposed whilst using the hoist. This was in very close proximity of others. This did not preserve the person's dignity.

This is a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

At our last inspection in July 2014, care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required. This was a breach of regulation 9. At this inspection the provider had not completed their action plan which told us all care plans had been reviewed and updated and that they would be in a new format by the end of November 2014. Care plans lacked appropriate guidance to ensure people's welfare needs were met and there was a lack of activity provision to meet people's individual needs.

One person said they didn't "have enough to do and there weren't any activities". A second said "No respect for the elderly" and shook their head when asked if there was enough to do. The activities coordinator said they had weekly activities which suited all residents; however we did not find this. An activity plan was in place for people however, they were not supported to engage in this. The first day of our visit the planned activity was to decorate the Christmas tree. Throughout the morning the activities coordinator was seen to be decorating the tree in the lounge area that was not in use. They did this alone with no involvement of people who were either in their rooms or in the other lounge in the home. On the second day of our visit one person was sat next to the tree holding decorations and for a 20 minute period we observed no engagement from staff with this person. The TV was turned over without consulting all people in the room and records for the day of our visit showed people who remained in their rooms did not participate in any activity. Activities had not been designed to provide appropriate mental stimulation. The provision of activities was not sufficient to engage people in the home and consequently, people's welfare needs were not met.

Staff were able to describe people well and showed a good understanding of people. Where people were living with dementia and were unable to communicate their needs well, staff would have to rely on people's care plans to guide them. Care plans for people living with dementia, contained little information about their backgrounds, preferences and personal history. Detail about people's daily routines, how they preferred to be supported and what actions staff should take to meet their individual needs were lacking. Care plans were not up to date.

People who had a diagnosis of diabetes had inadequate care plans to ensure this need was met. Care plans lacked guidance about how to monitor complications associated with this health condition. Where people had other health conditions that may have been as a direct result of this condition, nursing staff had not identified this and plans had not been developed to meet all of people's needs. For example one person's record identified increasing weight which could have caused additional complications for them. When we asked the nurse on duty about a potential link between the person's health condition and weight increase they said "I have only been trained a year and have not come across this before". Whilst we saw monitoring was taking place, there was no evidence the cause of weight gain had been explored and no plan in place to look at their diet to determine if any changes could have been made to support them with their health condition more effectively. There was no care plan in place related to their diabetes. The lack of planning and guidance meant the person was at risk of not receiving the appropriate care and treatment.

Pain assessments were not in place. One person who was reported as complaining of pain and refusing care was receiving pain relief medicines; however there was no pain assessment in place to establish if this medicine was working for them. There had been no consideration by staff that pain for this person may be impacting on their wellbeing. There was no care plan regarding pain to provide the guidance for staff to enable them to monitor pain effectively. For a second person one care plan stated pain relief medicines could be reviewed if they showed signs of increased pain. There was no pain assessment in place and no indication as to how staff would recognise an increase in pain. A lack of structured assessment and planning left this area of need open to staff interpretation and personal opinion. This meant pain might not be readily identified so appropriate action could be taken promptly.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home had a written complaints policy on display by the reception area. Staff said they were confident the manager would take action to address any concerns. The provider had received one complaint in the last 12 months which had been dealt with by the previous manager. A record was kept of the investigation and outcome, this

Inadequate

Is the service responsive?

recorded the person was satisfied with the response. People we spoke with and a relative told us if they had a complaint they would speak to the manager. The manager said it had been difficult to establish any previous learning opportunities as records were sparse, but they were able to describe how they would ensure a reflective learning approach would be taken with complaints.

Inadequate

Is the service well-led?

Our findings

At a previous inspection in May 2014, we identified breaches of six regulations. We issued warning notices requiring the provider to make improvements to the care and welfare of people and the monitoring of the quality of service provision. We also asked the provider to take action to make improvements to four other areas of concern. In July 2014 we found the provider had not taken steps to meet the requirements of the warning notice and identified a breach in a further three regulations. The provider sent us an action plan stating how they would address the areas of concern and meet the requirements of the regulations. They told us they would meet the requirements by the end of November 2014.

At this inspection, we found the provider had addressed two of the areas of concern, but had not met the requirements in relation to the other nine regulations. In addition we found a breach of two further regulations. This demonstrated that the service was not well led. Concerns which had been highlighted to the management were not addressed adequately and the impact this had on people living at Angelus had not been considered placing them at risk of receiving inadequate and poor standards of care.

The nursing staff conducted a range of audits including daily medicine stock checks and daily pressure mattress spot checks. These were not completed on a daily basis and we could not see what action had been taken by the manager or provider to address this. There were weekly pressure area audits and nutrition audits. We could not see how information was used to make changes or improvements. For example, for one person the nutrition audit reflected regular weight loss over a period of months, however no action had been taken to investigate this or review the plan of care. Care plan audits had been completed on 15 October 2014 but the majority of actions from these had not been completed. No further care plans audits had been done at the time of our visit to track progress.

The provider had a policy which stated unannounced visits by the registered provider would take place monthly and would involve interviewing people, staff, reviewing records and providing a report. The operations manager used to do this however they had since left and no further monthly audits being conducted by the provider. An external consultant had visited twice since September 2014. No specific actions plans to address recommendations had been developed but we had been told these had been incorporated into the overarching action plan for the home. Whilst some recommendations from the consultant had been incorporated, these had not been completed. Other recommendations we could not see had been considered. For example, a recommendation from the visit in 21 November 2014 was to consider staffing as there were times when people did not have staff readily available to them. No actions had been taken to look at this. We had also been told other audits and spot checks had been implemented and we found no evidence of these.

The failure to address concerns identified at our previous inspections showed there was no effective system in place to assess and monitor the quality of care people received. Consequently, people were not protected from the risk of receiving unsafe or inappropriate care and treatment.

The service had a manager in place who was not registered with CQC. They had been in place since September 2014. The management of the service had not been stable in recent years due to repeated changes of manager. We were aware of three previous managers since September 2013. The frequent change in management meant it was difficult for staff to know their role and what was expected of them. Staff felt supported by the new manager but did not feel supported by the provider. They said the provider did not respect them, did not listen to them and did not seek their opinions. We asked the provider what they saw their role and responsibility as and they said “to provide capital budget”. This meant people were not cared for by staff who were motivated and led by a stable, consistent management team.

The provider stated they shared their vision and values through staff meetings, which they did not attend. However, there had been no staff meetings since September 2014. Staff had their own values but did not know the values of the home. The instability of management and lack of support from the provider meant an appropriate culture and shared values by the staff team had not been developed for the benefit of people using the service.

We were told staff meetings could not be arranged without the provider’s approval. The action plan stated weekly clinical review meetings would take place from 11 November 2014 and these had not happened. The manager told us they were not able to arrange meetings

Inadequate

Is the service well-led?

where all clinical staff could attend due to finances. We were told resident meetings were used to actively involve people in the service; however these had not happened since April 2014. Opportunities to discuss issues relating to the home and identify areas of improvement or development were not available for people or staff.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Registered providers are required to notify the CQC of a range of significant incidents, which occur within the home. The provider continued not to notify CQC of incidents within the home. Four people had authorised deprivation of liberty safeguards in October 2014 which we had not been informed of. The manager made us aware of a safeguarding matter which we had not been notified of. Injuries that required reporting to CQC had not been. An incident in the home which caused damage to the property and impacted on the emergency alarm system had not been reported. The provider was still not fulfilling their obligation to notify CQC of significant incidents in their service.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2008, Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs.

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures in order to ensure that people employed for the purposes of carrying on a regulated activity were registered with the relevant professional body. The registered person did not ensure that all information specified in Schedule 3 was available.

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse. Allegations of abuse were not responded to appropriately.

The enforcement action we took:
We varied a condition of the providers registration and removed a location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided. We consent could not be provided best interests decision making had not been done.

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that persons employed for the purpose of carrying out the regulated activity were appropriately supported by receiving appropriate professional development, supervision and appraisal.

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration.**

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure people were treated with dignity and respect and involved in making decisions about their care.**

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person had not protected service users, and others, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided and identifying, assessing and monitoring risks relating to the health, welfare and safety of service users and others.**

The enforcement action we took:
We varied a condition of the providers registration and removed the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

The registered persons had failed to notify the Care Quality Commission of incidents which were reportable under the Health and Social Care Act (2008) Care Quality Commission (Registration) Regulations 2009. Regulation 18 (2)(b)(i)(c)(d)(g)(iii)(iv)(e)

The enforcement action we took:

We varied a condition of the providers registration and removed the location.