Care Quality Commission

Lincs Healthcare Ltd

Bank House Care Home

Inspection report

Gosberton Bank
Gosberton
Spalding
Lincolnshire
PE11 4PB
Tel: 01775 840297
Website: www.bankhouseresidentialhome.co.uk

Date of inspection visit: 21 October 2015
Date of publication: 27/11/2015

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 21 October 2015. This was an unannounced inspection.

The last inspection took place on 13 April 2015 and there was also an inspection on 3 September 2014.

The home provides residential care for up to 30 people. The care provided is mainly for older people, some of whom experience memory loss and have needs associated with conditions such as dementia. At the time of our inspection there were 12 people living at the home.

At our previous inspections we found the provider was failing to ensure that people's care was planned and delivered to meet their individual needs. They had failed to maintain appropriate standards of cleanliness and hygiene and did not have appropriate arrangements for the management of medicines. The provider did not ensure staff were appropriately supported with training and supervision and did not have effective systems to asses and monitor the quality of service provided to

Summary of findings

people. The provider was not aware of their responsibilities under the Mental Capacity Act 2005 and the environment had not been maintained to an acceptable standard.

At our inspection on 21 October 2015 we found the provider had made improvements in the cleanliness of the home and the number of staff available to provide care to people. In addition we saw the induction provided to new staff helped them provide safe care for people. However, we saw little improvement in the other areas of concern we identified at our previous inspections.

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

The provider had not complied with laws which protect people when they were unable to make decisions for themselves. The provider had not fully understood their responsibilities under the Mental Capacity Act 2005 and consequently had not ensured people's human rights were protected. Care plans did not record if people were able to make decisions for themselves. For people who were unable to make decisions for themselves there was no recording if best interest meetings were needed or if a Power of Attorney existed. No applications for Deprivation of Liberty Safeguards authorisations had been made.

The provider had not effectively addressed our concerns in relation to storing, recording and administering medicines. Some medicines could not be accounted for and there were numerous inaccuracies between records and medicines prescribed and available to administer. Therefore, we could not be assured people's medicines were being administered as intended by their prescribers.

Risks to people had been identified in their care plans. However, care was not always delivered in line with the care plans. Therefore, people were not fully protected from the risks of receiving unsafe care. In addition, the provider had not ensured accidents were reviewed to see if changes in care were needed to keep people safe.

New staff had received an induction into the home which supported them in their roles. However, training for existing staff had not supported them to have the skills needed to care for people and they did not understand the importance of some information in the care plan. Staff were unable to demonstrate competencies in key areas. A supervision and appraisal programme had been developed and was in the process of being implemented.

People's malnutrition risk was not always calculated accurately and we could not be sure people received fortified supplements appropriately. In addition guidance from healthcare professionals regarding people's ability to eat and drink safely was not available to support staff. Systems in place to record people's food and fluid intake were not effective and staff were unable to tell us when they would raise concerns around nutrition and dehydration.

There has been some improvements to the environment with dementia friendly signage in place and minor improvements to the fixtures, the quality of linen had improved. However, people were still living in rooms where the standard of decoration and furniture was not of an acceptable quality and did not support people's well-being.

Staff were individually caring to people and ensured people's dignity was maintained. Staff were aware of how people communicated their care needs. However, the provider and staff did not understand how people living with a dementia communicated their emotional needs.

The provider had taken action in some areas to improve the standard of care people received and had started to gather the views of people living at the home and their relatives. However, in other areas the provider had failed to take suitable action to make care safer for people. In addition, audit systems to identify shortfalls in care were not properly implemented and so areas for improvement were not being routinely identified.

The home was clean and tidy and the staff worked to reduce the risk of infection. However, the provider had not engaged with the local authority to help identify and implement best practice in this area. New domestic staff ensured care staff could concentrate on supporting to people. In addition. new care staff meant that there were always enough care workers to care for people. Staff

Summary of findings

knew how to raise concerns if they were worried about that a person was at risk of harm. People had been support to access healthcare from their doctors and community nurses.

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?
The service was not safe.

Inadequate

People's medicines were not managed safely.

Risks to people's health and safety were not always robustly managed and there was a risk that accidents and incidents could reoccur.

The cleanliness of the home had improved and staff worked to reduce the risk of infection. The provider had not engaged with external agencies to identify and implement best practice.

The staffing levels in the home had increased and there were enough staff to meet people's care needs.

Is the service effective?
The service was not effective.

Inadequate

The environment was not maintained to an acceptable standard.

The provider did not ensure people's rights were protected as people's ability to make decisions was not assessed.

New staff received an induction which supported them to provide safe care to people. However, existing staff lacked the knowledge needed to provide safe care and had not been supported adequate training.

People at risk of malnutrition and dehydration did not have their needs properly assessed and care did not always support them to maintain a healthy weight and stay hydrated.

People received support from visiting healthcare professionals.

Is the service caring?
The service was not always caring.

Requires improvement

People had not been involved in planning their care.

The provider and staff did not always understand how people communicated their needs when they were distressed.

Individual staff were kind and caring to people living at the service.

Is the service responsive?
The service was not responsive.

Inadequate

Although care plans recorded the care people needed, staff did not always understand the importance of the information in the care plans.

Summary of findings

The provider and staff did not fully understand how to provide care for people with dementia when they were distressed.

There was a lack of activities to keep people engaged.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor the quality of care were ineffective and did not identify shortfalls in the care provided.

The provider had started to engage with people who lived at the home and their relatives to gather their views on the care they received.

Bank House 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 took place on 21 October 2015 and was unannounced. The inspection team consisted of two inspectors and a medicines management inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, the provider did not return a PIR and we took this into account when we made the judgements in this report. We also spoke to the local authority infection control team and contracting team to gather their views on the service provided.

As part of the inspection we spent time observing how care and support was provided for people who lived at the service. This was because some people had difficulties with their memory and were unable to tell us about their experiences of living at the home. In order to do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not speak with us.

As part of the inspection we spoke with the provider, a senior care worker, two care workers, a housekeeper and seven people who lived at the service. We looked at the care plans for four people living at the home. We also looked at medicine administration records, staff training and supervision records and management paperwork related to the running of the home.

Inadequate

Is the service safe?

Our findings

At our inspection on 3 September 2014 and 13 April 2015 we identified that people were not adequately protected against the risks associated with the unsafe use and management of medicine. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 management of medicines.

At our inspection on 21 October 2015 we found that there had been no improvement in the way medicines were managed and the provider was not meeting the requirements of this regulation. People were still at risk of not receiving their medicine safely.

Record keeping about medicines was poor. For some medicines there were no records of them being received at the home, so we could not identify how much medicine should be available for people. Where we were able to audit medicines there were discrepancies between the records and actual medicine available in the medicines trolley.

Errors had been made in medicine names when completing the medicine records and these had been identified at our previous inspection. Staff were therefore unable to definitively check they were giving the correct medicine to people. There were gaps in records of medicine administration. For example, there were no records of medicines administered the evening before our inspection. There were record charts for the administration of medicines prescribed for external application but these were incomplete with numerous gaps. Records did not confirm that people living at the service were receiving their medicines as intended by prescribers.

There were some medicines available for which records were not being kept. These included medicines that had been discontinued by the prescriber but which had not been removed from the trolley. We found one medicine was available for a person in the monitored dosage systems and in a box in the trolley and there was a risk of the medicine being incorrectly administered twice. This was unsafe practice.

We saw that the member of staff who was completing the morning medicine round did not do so in a methodical manner to reduce the risk of medicine errors. In addition, we found that the medicines which should have been given to a person on the morning of our inspection were still in the packaging. Records showed the medicine as being administered. For another person medicine prescribed for an eye infection had not been administered as prescribed and not at all for the three days before our inspection. There were also no recorded explanations of why it was not administered.

Some supporting information was available to assist staff when administering medicines to individual people. However, there was limited information about how medicines should be administered to individual people. For people prescribed medicines to be taken as required there was limited or no guidance available to support staff to know when the medicine was needed.

At our inspections on 3 September 2014 and 13 April 2015 we identified that care plans did not contain accurate or up to date risk assessments. This meant people were at risk of receiving care which did not fully protect them from harm. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 21 October 2015 we found that care plans contained more information on how to keep people safe. For example, a person had bed wedges to prevent them rolling out of bed. There was a risk assessment for these and it was completed in appropriate detail.

However, we could not be assured that care was always delivered in line with people's care plan and therefore people were still at risk of harm from poor care. For example, one person had recently fallen, there was no recording in the care plan or accident book on how to prevent the accident re-occurring. The provider told us that staff now kept a more careful eye on the person and encouraged them to use the wheelchair for longer distances. However, not all staff were aware of this as two care workers told us that the person was safe walking and did not need particular assistance when using their frame and needed to be encouraged to do so to keep their mobility up.

In three of the four care plans we looked at people required creams to be applied to reduce the risk of them developing pressure sores. However, in all three care plans there were gaps in recording that the creams had been administered. The provider and staff told us they could not be certain that creams had been applied.

Inadequate

Is the service safe?

Accidents were not properly assessed and care was not planned to prevent accidents re-occurring in the future. There was an accident book and this recorded that there had been 10 events since the last inspection. There was a section that said, 'provide full recommendations to avoid similar accidents happening again.' None of these sections had been completed. There was an entry dated 1 June 2015 where a person had fallen out of bed and had cut their lip and bruised their face. There was no recorded action and the provider could not recall if anything had been done.

At our inspections on 3 September 2014 and 13 April 2015 we identified that the provider was not maintaining an acceptable level of cleanliness and hygiene. This meant people's risk of infection was increased. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 cleanliness and infection control.

At our inspection on 21 October 2015 we saw that there had been significant improvements in the cleanliness of the home. There were now two housekeepers on duty each day and cleaning recording sheets showed that cleaning was being completed in line with the cleaning plan. All the rooms had been deep cleaned in August 2015 and were due another deep clean in November 2015. While the standard of cleanliness had improved urine odours were still present in three rooms.

Hand wash and paper towels were available at all sinks. However, in people's bedrooms paper towels were not stored in a container but left on the side and this was an infection control risk. Both sluices were working, had dedicated hand wash sinks and hand wash and towels in holders on the wall were available.

The general environment had been tidied up and we saw the clutter in cupboards had been removed and this supported general cleaning and infection control. The laundry had been tidied up and systems put in place to reduce the risk of cross infection. For example, the sink was clearly labelled as a non hand washing sink.

The domestic's store room had been tidied and now only contained the equipment needed to clean. Appropriate colour coding was displayed to help reduce the risk of cross infection. We spoke with a new member of the domestic staff. They confirmed that they had been shown how to complete cleaning when they started at the home and they could describe the correct use of different coloured cloths and cleaning solutions to reduce the risk of infection. They told us that there were always equipment and cleaning products available and that they could raise any concerns with the senior carer, assistant manager of the provider.

Records showed most staff had completed infection control training on 19 October 2015. However, the provider had not engaged with the local authority infection control team and had not attended their quarterly meetings where any changes in best practice were discussed.

At our inspection on 13 April 2015 we found through observations and discussions with people that there were not enough staff to meet the needs of the people living in the home. We had concerns that there was only one waking member of staff available at night.

At our inspection on 21 October 2015 we found the provider had employed more staff and this had improved the staffing levels in the home. The provider confirmed that they were now working as manager full time and were not covering care shifts. In addition, a member of domestic staff said that they had enough time in which to complete the cleaning rota and they were never removed from cleaning to care for people.

The provider told us that they had reviewed staffing levels for the home in August 2015. They had calculated the care hours needed to meet people's needs. Records showed that for the two weeks preceding our inspection, more care hours than needed had been provided. We reviewed the staffing rotas for the two weeks prior to our inspection and could see two members of staff were available at night at all times.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the service.

At our inspection on 13 April 2015 we found the provider did not have effective systems in place to keep people safe from harm.

At our inspection on 21 October 2015 people told us they felt safe. One person said, "I do feel safe enough here because the staff are so kind." Another person told us, "I

Inadequate

Is the service safe?

have no problem with the staff because they're kind to me and they want to help." Staff knew how to raise concerns if they were worried about people. They were also aware of how to raise concerns with external agencies.

Inadequate

Is the service effective?

Our findings

At our inspections on 3 September 2014 and 13 April 2015 we found that the provider had not managed the environment to ensure it had been maintained to an appropriate standard. Rooms were in need of decoration and furniture was also old and worn hence was unable to be cleaned effectively. This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision

At our inspection on 21 October 2015 we found that there had been some small improvements in the environment. However, no decoration had been completed and no furniture replaced. The provider acknowledged that little action had taken place in regard to this area.

We walked around the environment and could see that some remedial work had been completed. Taps in some toilets and bedrooms had been replaced. Some toilets had new grab rails and the one toilet had a new clean rust free frame. New door strips had been fitted in bedroom doors so the trip hazard had been eliminated. In addition we saw dementia friendly signage around the home, to help people identify their bedroom and the toilets. All the bed linen and towels were of an acceptable standard with no holes, stains or frayed edges and the curtains in bedrooms had been fitted and hung properly.

However, some of the remedial work had not improved the environment. The hole in the wall in the ladies toilet number two had been filled but this had not been done neatly. A sheet of plastic had been stuck over the broken tiles in the gentlemen's toilet number one. It had come unstuck.

Rooms were in need of decoration, with water stains near the windows and paint peeling of the windowsill. Where equipment had been replaced decoration had not been made good with open raw plug hole in walls. In some of the rooms paint work was marked and in need of decoration, in others the wallpaper was old and discoloured. Damage to walls and ceilings in bedrooms and toilets had not been made good. In addition some furniture was old and worn. One set of drawers had missing handles and another had all the varnish worn away on the top.

At our inspection on 13 April 2015 we found that the provider did not ensure people's human rights were protected. We identified two people who had their freedom restricted as they needed constant supervision to ensure their safety which may be a deprivation of their liberty. No applications to the Deprivation of Liberty Safeguards (DoLS) authority had been completed to determine whether this level of supervision was lawful and in their best interests.

At our inspection on the 21 October 2015 we found the provider had made no improvements to ensure people's rights were protected. Care workers were not aware of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. These are laws which ensure people's rights are protected when they are no longer able to make decisions for themselves.

The provider told us some people lacked the capacity to make decisions for themselves. However, the provider had not assessed their ability to make decisions for themselves and there was no recording if best interest meetings were needed or if a Power of Attorney existed. The provider also confirmed that there were four people who lacked capacity and who would be stopped if they attempted to leave the building because they would not be safe on their own outside. The provider had not considered the need to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation for these people.

At our inspections on 3 September 2014 and 13 April 2015 we identified that staff had not received adequate monitoring or support to ensure the care they provided to people was safe and effective. This was a breach of regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 supporting workers.

At our inspection on 21 October 2015 we found the provider had made some improvements in relation to staff induction. However, limited training had been provided to existing staff and they were unable to demonstrate appropriate levels of knowledge.

Staff new to the home had been given a training booklet to complete. We saw two training booklets and could see that they had been completed. The provider confirmed that they still needed to complete some observations on these staff to check if they were competent in their role. In addition, the provider explained that all existing staff had also been asked to complete the induction book as a refresher to their knowledge.

Staff were asked about their knowledge in key care areas such as continence promotion, the management of falls,

Is the service effective?

skin care, mental capacity and Deprivation of Liberty Safeguards and Safeguarding. The three staff we spoke with were knowledgeable about safeguarding and promoting continence. However, they lacked knowledge about pressure care, mental capacity and the Deprivation of Liberty Safeguards.

We saw that only two training sessions had taken place in 2015, one for infection control and one for medicines management. The provider explained that further training was planned but no firm dates were scheduled. The provider confirmed that mental capacity training would take place sometime in November 2015.

Records showed that staff were starting to receive supervisions and appraisals. The process had begun in September 2015. Supervision forms seen were well completed and discussed people's performance and training needs.

At our inspection on 21 October 2015 we identified concerns about the provider meeting people's nutritional needs. Care workers did not always follow guidance in care plans to keep people safe and were unable to identify concerns relating to nutrition and hydration.

The provider confirmed that people were weighed monthly and had their body Mass Index (BMI) calculated and a Malnutrition Universal Screen Tool (MUST) completed. A BMI defines if the person is the correct weight for their height and the MUST looks at how well a person is maintaining a healthy weight. However, we saw the MUST was not always accurately completed. For example, we saw one person had their weight recorded but there was no height recorded. The MUST rating for this person had reduced from three to two indicating that they were at less risk of malnutrition. The provider could not say how the tool had been completed without the height. In addition records only contained people's weights for September 2015 and October 2015 so we were unable to determine whether people received nutrition that support them to maintain a stable weight.

Some people at the home were on a soft diet and had their drinks thickened to reduce the risk of them choking. We looked at the care plan for one person on a soft diet and the provider told us that a healthcare professional had assessed their ability to eat and drink safely. However, there was no evidence of this in the care plan so it was not possible to see what advice had been given. In addition, a care worker explained that some staff did not use thickeners in the person's fluids if they appeared to be well on a particular day. For another person on a soft diet the provider confirmed there had been no assessment by an appropriate healthcare professional.

Where people were at risk of dehydration a record was kept of their fluid intake. However, these records showed low intakes for some people. There was no guidance available in the care plans to identify what amount of fluids was an appropriate level to keep people safe and healthy.

Charts to monitor people's food intake were also not fully completed. We saw one person who was at risk of being unable to maintain a healthy weight was prescribed a fortified supplement from the doctor. This was prescribed to be given at least once a day but a second one could be given if needed. However, the care plan did not contain information on when it was appropriate to give a second supplement. There was no record kept of how often the person received their supplements.

None of the staff we spoke with had received training on diet and nutrition and they all said that they needed it. Staff did not know what an acceptable level of fluid intake was for a person and while one member of staff identified the link between dehydration and urinary tract infections none of them could tell us about the main signs of malnutrition and dehydration. Staff were unable to tell us about the Malnutrition Universal Screening Tool and how it was used in the home. This lack of knowledge impacted on staffs ability to identify concerns.

Requires improvement

Is the service caring?

Our findings

At our inspection on the 13 April 2015 we found that people received an inconsistent level of compassionate care.

At our inspection on 21 October 2015 people told us they were happy with the care they received. One person told us, “The staff are very kind and always ask me what I want, I’ve no worries about that.” Another person said, “The staff are wonderful and kind and can’t do enough for you. I wouldn’t want to be anywhere else.” Staff we spoke with could tell us about the needs of the people using the service. Records showed the provider and staff had engaged with relatives to keep them update if there were any concerns about people’s care and health.

We observed care being given and saw that individually staff were kind and caring with people. Care was provided in a quiet manner which ensured people’s dignity was maintained. For example, we observed two members of staff hoisting a person. This was done calmly and staff spoke reassuringly with the person telling them what was happening throughout the process. However, we saw that staff did not proactivity engage with people outside of giving care. For example, we saw two people in the lounge were quiet and withdrawn when the provider was sitting talking to a member of staff. Neither the provider or the staff member went see the people could be encouraged to be more engaged with their surroundings or other people.

The four care plans we reviewed contained no information on how the person receiving care had been involved in planning their care. In addition where people were unable to make decisions about their care, there was no information to show who should be consulted on their behalf. We discussed this with the provider who explained that the assistant manager was in the process of reviewing care plans and had just started to look at including the views of people living at the home.

The provider and staff knew how to interpret people’s individual communication when they were providing care. For example, while one person could not say if they did not want something they were offered they could push it away and staff understood this meant they did not want it. However, staff were not able to recognise how behaviour could indicate a person was feeling upset or frustrated. They did not take time to comfort a person who appeared to be trying to communicate by singing loudly.

We saw there were a lot of clocks around the home, however they were not all working or telling the correct time. This would confuse people living with dementia as they may be unable to know what time of day it was. This could result in them becoming disoriented and in turn confused or distressed.

People’s spiritual needs were catered for with a religious service in the home on a weekly basis.

Inadequate

Is the service responsive?

Our findings

At our inspections on 3 September 2014 and 13 April 2015 we identified that people's care plans did not accurately record each person's care needs or how those needs could be met in a person centred way. Care plans had not been reviewed routinely or after any incidents which may indicate a change in care was needed. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 21 October 2015 we found care plans had been reviewed and updated as there were reviews for September 2015 and October 2015. However, while the care plans had improved, they did not always contain enough information to support staff to be responsive to people's needs. For example, there was no information recorded on what level of food and fluid intake was enough to keep people safe and when to raise concerns. There was also a lack of information to support staff to recognise when medicines prescribed to be given as required were needed. Staff were able to describe people's basic care needs but were unable to tell us when they would raise concerns.

Care plans did not show how to support people's specific needs related to challenges around dementia For example, one person had been removed from the communal lounge to their bedroom as they were singing loudly. The provider told us that the person spent time in the lounge but when loud and animated was encouraged to move to their bedroom where the provider told us they had frequent one to one attention to help them become more settled.

However, we saw the person did not receive any attention and continued to be distressed in their bedroom. A staff member told us, "They are like that some days you get used to it." They added, "Staff don't know what to do with person but they quietened down after a while on their own." Their care plan noted the use of their bedroom when they became animated but did not give staff any details about the support to be provided in that locale. Records showed the regular use of their bedroom in this way but did not indicate that once there the person had received any supportive care.

People told us that there were not enough activities to keep them happy and settled. One person told us, "It can be a long day here with just the television to watch. There are some activities but most days are the television and looking about." Another person said, "I would like to have more things to do during the day because time hangs a bit when you're older."

The activities for the week were listed on the notice board in the entrance hall. People living at the home did not go into this area of the home on a daily basis and so may not have been aware of the list. The list had activities recorded on four mornings, two afternoons and one evening a week. For example, we saw that Monday morning was listed as a pamper session and Wednesday morning as a walk in the garden. However, the provider told us that they had a member of staff dedicated to providing activities, who worked all day Thursday on activities and would come in 1:30pm to 3pm on a couple of days a week. Therefore there were no dedicated staff to support the morning activities. No record of activities undertaken had been completed and no information was included in the care plan to show how people were supported to maintain their interests.

During the course of the inspection no activities were observed to be held. In the afternoon we saw most people were sat in the communal area. Four people were reading, however, two people were passive and withdrawn. No attempt was made by staff to interact with them apart from offering one a drink. Staff could not describe the characteristics of social activities that were likely to engage older people living with dementia.

The provider had a formal procedure for receiving and handling concerns which was on display in the main foyer of the home. Complaints could be made to the provider. There had not been any formal complaints since our last inspection in April 2015.

Inadequate

Is the service well-led?

Our findings

At our inspections on 3 September 2014 and 13 April 2015 we identified that the quality assurance processes in the home were inadequate and the provider was not aware of the changes needed to provide an adequate service to people. This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision.

At our inspection on 21 October 2015 we found the provider had failed to make the required improvements to monitor and improve the quality of service people received. We found that the provider had not responded to all the concerns we had identified in our previous reports. In addition we found that the provider had still not sent us information about the service which we had requested before our last inspection.

At our previous inspection the provider had worked as a member of care staff on shift. However, due to the increase in staffing they were now able to work full time as the manager of the home. In addition there was a new assistant manager in place to support the manager and on some shifts there was a senior carer in place.

However, job roles were unclear to some staff and the provider had not clarified with staff their roles and responsibilities. For example, it was not clear to staff whose responsibility it was to record the administration of creams, food and fluid. This lack of clarity meant at times it was not clear if records were incomplete or if care had not been given.

The provider told us that they were now completing an audit which covered all the quality assurance areas needed on a two monthly basis. We saw this audit had last been completed in September 2015. It showed action was needed in a number of areas including maintenance, health and safety and privacy and dignity. An action plan with person responsible and dates for completion had been developed.

The provider did not have effective systems to review and improve the care that people received. There was no analysis of incidents or any attempts to learn from them which meant that people were at risk of accidents or harm happening again. We saw for key areas such as medicines and care plans the relevant section of the audit had not been completed despite the provider being made aware by our previous reports that there were concerns in these areas. In addition, although the provider had completed the audit section for falls and pressure sores they did not demonstrate that they understood how to deliver a high quality of care. Issues such as inconsistent recording of creams to prevent pressure sores were not identified by the provider. Furthermore, while the provider was responding to some concerns made by external agencies such as the CQC and the local authority. Their own systems were failing to highlight areas for improvement and they were reliant on the reports of outside agencies.

The provider had started to engage with people's living at the home and their relatives. For example, records showed that two residents' meetings had been held since our last inspection. At the resident's meeting on 30 September 2015 staff had helped people to complete a questionnaire. We saw most of these identified that a lack of activities was an issue. However our findings showed this had not been addressed. In addition, the provider told us that individual issues that had been raised had been actioned. For example, one person had commented that they had no hot water in their bedroom and this had been resoved.

On the day of our inspection there was a meeting for relatives and they told us they were happy to see recent improvements and hoped that the service would continue to improve. The provider confirmed this was the first relatives' meeting held since Care Quality Commission and the local authority met with relatives in May 2015.

The provider had also started to engage with staff and staff meetings had been held in June 2015 and September 2015. Records showed staff were aware of the concerns around infection control, the quality of linen used and the Care Quality Commissions inspections. Staff were now supported to engage with how the quality of service could be improved.

At our inspection on 13 April 2015 we identified that there had been three expected deaths which the provider was required to notify us of. However, they had not submitted any notifications, these are incidents that the provider is required to tell us about by law. We discussed this with the provider at this inspection and they were able to tell us what incidents were notifiable. They confirmed no notifiable incidents had occurred since our last inspection.

Before our inspection we were aware that the provider had worked with a management consultancy to improve the

Inadequate

Is the service well-led?

quality of care they delivered to people. We saw improvements were in place in regard to staffing levels, supervision and appraisal, cleanliness and engaging with people. However, the provider was no longer working with the management consultants and while the changes were positive we had no assurance that the improvements would be sustained.