MAPS Properties Limited

The Limes

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 July 2017, it was unannounced.

The Limes provides accommodation and support to a maximum of 46 older people some of whom were living with dementia. It is not registered to provide nursing care. At the time of our inspection there were 44 people living in the home.

At the time of our inspection visit there was registered manager in post. 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.

We last inspected this service on 13 and 14 June 2016 and found the provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices in respect of these breaches. Following our inspection in June 2016, the provider sent us an action plan to tell us about the actions they were going to take to meet these regulations. They told us they would be compliant with two of the regulations by September 2016 and with a further regulation by November 2016.

We carried out this inspection to check if the improvements had been made in order to achieve compliance with the regulations. At this inspection we found insufficient improvements had been made and governance arrangements in the home were not effective enough to rectify the breaches found at the previous inspection. The provider was still in breach of regulations for: safe care and treatment, safeguarding service users from abuse and improper treatment, and good governance. We found that there had been a deterioration in the quality of care in other areas, which meant the provider was in breach of a further five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that risks to people had increased.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found people were not being provided with safe care. Risks to people's health and safety were not always identified. We found in cases where risks had been identified, that insufficient action had been taken to manage and mitigate the risk of any further harm. The systems in place had also not identified risks to people from the premises. The service remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from improper treatment and had been subject to inappropriate restraint. Systems and processes in place were not effective to ensure people living in the home were adequately protected from improper treatment. The service remained in breach of Regulation 13 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes were not robust and did not fully mitigate the risks of employing staff unsuitable to their role. The registered manager had not taken action to fully assure themselves that staff employed were fit and proper. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always understand the importance of seeking consent from people living in the home. The service did not fully adhere to the mental capacity act which meant people's rights to provide consent were not always fully protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional and hydration needs were not always met. People did not always receive adequate support with their meals or access to suitable foods. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported in a caring manner that promoted their dignity and independence. People's privacy was not always respected. Their independence and ability to choose for themselves was not always promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care provided did not to take in to account people's individual needs and preferences. Staff did not always support people to make their preferences known. Where preferences where known these were not always acknowledged or provided for. Care plans did not always contain sufficient information or guidance, including on how people wanted to be cared for. The activities on offer did not always meet people's individual needs which meant they were not always inclusive. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. Necessary improvements to the service had not been made. The culture in the home was not always person centred or respectful. This had not been identified by the provider or management in the service and consequently improvements in this area were required. The service remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required in the safe management of medicines. We found systems in place were not always effective at ensuring people received medicines that were appropriate to their needs. Guidance for 'as required' medicines did not provide adequate guidance for staff regarding when this should be administered.

Staffing levels appeared adequate in the home, although we observed that staff could be better deployed to help ensure people's needs were fully met.

There was varied feedback regarding the competency and expertise of the staff. Staff training was in place although not all staff had attended this training, and training rates for some individual staff members were very low.

People could access their local GP however we found staff did not always advocate on behalf of people to

access other health care services.

There was mixed feedback regarding how the service responded to complaints, although where complaints were recorded we saw the manager had investigated and responded.

The overall rating for this service is 'Inadequate' and the service is therefore 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?

Inadequate

The service was not safe.

Risks to people's wellbeing and safety were not always identified and actions to minimise risks were not always taken.

People were not always protected from improper treatment and had been subject to inappropriate restraint.

Recruitment processes were not robust and did not fully mitigate the risks of employing staff unsuitable to their role.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had not received sufficient training to ensure they could meet the needs of people living in the home.

The home was not working within the requirements of the MCA. Staff did not always seek people's consent.

People were not adequately supported with their nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always interact with people in a caring manner. People's dignity and privacy was not always promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care provided did not always meet people's individual needs and preferences, including the provision of activities.

Care records did not provide sufficient guidance to staff to help ensure the care provided was person centred.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread and significant shortfalls in the way that the service
was being managed.

Whilst there were some systems in place to monitor the quality of the service, these were not effective.

The culture in the home was not always person centred or respectful.

The Limes

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 July 2017 and was unannounced. The inspection was carried out by 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 uses this type of care service.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority adult safeguarding team and the quality assurance team for their views on the service. We looked at the action plan the provider had sent us after their last inspection.

During our inspection we spoke with five people using the service and eight relatives of people using the service. We spoke with seven members of staff. This included the registered manager, deputy manager, two care staff, two senior members of care staff, and a kitchen assistant.

Not everyone living at The Limes was able to speak with us and tell us about their experiences of living in the home. We observed how care and support was provided to people and how people were supported to eat their lunch time meal.

We looked at nine people's care records, three staff recruitment files and staff training records. We checked the medicines records for eight people. We looked at quality monitoring documents, accident and incident records, and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 13 and 14 June 2016 we identified a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always identified and action was not always taken to keep people safe. At this inspection on 25 and 26 July 2017 we found sufficient improvements had not been made and additional concerns were identified.

Risks to people had not always been identified and managed appropriately. Two people living in the home required specialised diets because they were at risk of choking. Food records for one person showed that staff had failed to provide foods that were suitable for their needs and meant there was an increased risk of harm to the person. For another person on the first day of our inspection visit we saw they were given a dessert that was not suitable and they started to experience difficulties while eating this. We intervened to ensure the person did not eat any more of this dessert and asked the registered manager to respond urgently to this risk. For a third person we found they had been experiencing unstable diabetes and sufficient actions had not been taken to assess and manage this risk. For a fourth person, we found they had been consistently refusing their medicines over a three week period and sufficient actions had not been taken to assess and manage this risk.

At this inspection we also found sufficient and timely actions were not taken to ensure people who were nutritionally at risk were safe. For one person, records showed they had lost 2.8kg between 31 March 2017 and 30 June 2017. Food charts were completed between 29 June and 1 July 2017 which showed the person was eating very little. No additional actions to assess or manage this risk, such as an increased monitoring of this person's weight loss, food intake, or referral to a dietician had taken place. For a second person we saw they had lost 4.2kg between the 16 June 2017 and 24 July 2017. Whilst the service had taken some action to respond to this risk, such as requesting referrals to a dietician. We found that their three day food chart from 6 July 2017 to 8 July 2017 showed they were eating small amounts and this was discontinued despite the person being assessed at a high risk of malnutrition. This meant staff could not sufficiently monitor and respond to this risk.

Risks to people from deterioration of their skin conditions were not adequately monitored or managed. We found that for two people at high risk of pressure sores, regular repositioning as detailed in their associated risk assessments was not taking place as frequently as required. We observed one of these people sitting in the lounge for long periods of time without the required repositioning taking place. A third person's risk assessment stated they required support with repositioning every three hours at night. The registered manager was unable to provide us with any documentation showing this was taking place. This meant no monitoring of the person's repositioning was taking place so that the level of risk could be adequately assessed. Staff we spoke with did not always demonstrate full understanding of this risk and how to manage it.

Risk assessments did not always identify risks or provide staff with sufficient guidance. For example, in relation to the management of people's diabetes, required specialist diets and the risks of choking, and non-compliance with medicines.

There was a system in place for the reporting and analysis of accidents and incidents that occurred in the service. However, we found this was not always effective and did not always ensure satisfactory actions had been taken in response to identified risks. For example, we saw one person had fallen three times in June 2017. The registered manager had recorded that in response to this risk a referral to a falls clinic and occupational therapy had been made. However, there was no evidence that these referrals had been made. We asked the registered manager and deputy manager about this who told us they had experienced difficulties making these referrals and were unable to confirm that these had been made. This meant we were concerned that the identified action to manage this risk had not been taken.

At our last inspection in June 2016 we found some risks to people from the premises were not adequately managed or risk assessed. Whilst we saw regular health and safety checks were now being carried out, we found there was a continued risk relating to the management of the premises. On the first day of our inspection visit we found people had access to the garden of the home where a shed had been left open with tools and paint, and other equipment that posed a risk to people's safety. Records showed that cold water temperatures in the home were above the recommended range which meant there was an increased risk of legionnaire bacteria growing. This risk had not been sufficiently identified and suitable action to address this risk had not been taken.

The above information meant the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection carried out in June 2016, we found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of systems and staff understanding to ensure safeguarding incidents were identified and reported to the local authority safeguarding team as required. At this inspection we found whilst improvements in reporting safeguarding incidents had been made, continued concerns remained.

During our inspection visit we witnessed two incidents where people living in the home were subject to improper treatment which included a disproportionate use of control and restraint. There was at least one other staff member present during this incident but they did not intervene. We reported this incident to the registered manager during the inspection and they were not aware this incident had taken place, or aware of any other concerns in the service regarding improper treatment or restraint. This meant we were concerned that the systems and processes in place were not effective and people living in the home were not adequately protected from improper treatment. Therefore the provider remained in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in July 2017 we identified a breach of Regulation 19 of (Regulated Activities) Regulations 2014. This was because the recruitment processes in place were not robust and did not fully mitigate the risks of employing staff unsuitable to their role.

We found where issues had been raised through recruitments checks no risk assessments had been carried out to ensure that staff employed were of fit and proper character.

We found improvements were required in the safe management of medicines. Records for one person showed staff had administered a medicine they were allergic to and this had impacted on their health. Whilst the registered manager had taken action in response to this we were concerned that staff practice in the home had allowed this to occur. For another person we saw they had been administered a medicine that they were unable to take due to swallowing difficulties. Whilst staff had subsequently taken action, we were concerned that the actions they had taken had not sufficiently explored the risk to the person and had

meant that the medicine was administered covertly with no thorough consideration and consultation in place.

People's medicine administration records showed medicines were administered as prescribed and were stored safely and securely. One of the medicine administration records we checked did not have available written information to show staff how and when to administer as required medication. We found for other people this information was in place but did not always contain sufficient guidance for staff on when to administer these medicines. We checked three medicines and saw the stock count was accurate.

People told us they received their medicines when required. One person said, "I get my tablets in the morning and the evening and they watch me take them." Another person told us, "They always make sure that I get my tablets in the morning and at night."

None of the people, relatives, or staff raised concerns about staffing levels in the home. One person said, "[Staff] are pretty good at turning up if I press my buzzer when I want something." This person gave a demonstration of this to us, pressing their call bell, with a member of staff responding promptly. A second person told us, "If [I] need any help then there is someone about to help me." However, during our inspection we observed that although there appeared to be sufficient staff they were not always deployed effectively to ensure people were adequately supported, for example over the lunchtime period.

A staffing dependency tool was used to help the registered manager establish how many staff were required to meet people's needs. We looked at this and saw it reviewed how many people had high dependency needs in the home and involved asking people's and staff member's opinions of staffing levels in the home. We reviewed the staffing rosters for the last two weeks and saw the home was staffed to the levels the provider had deemed as required to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called Deprivation of Liberty Safeguards (DoLS). 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 was being met.

People and relatives we spoke with told us not all the staff asked for their consent before providing support. One person said, "Not all of them ask if it's alright to do things for me. Some do. I eat whatever I'm given as I don't mind." A second person told us, "Some of the carers do ask if it's alright to do things for you, but not all of them. They have to do what they have got to do." A relative said, "Some of the staff ask [name's] consent and some don't but understanding of the question is very limited."

We saw that relatives were being asked to provide consent for people without staff checking that they had the legal authority to do so. For example, we saw relatives were signing for consent to the service sharing information about people. On another occasion we saw that family members had been advised that their consent would be sought before staff took people out of the home on trips.

People had risk assessments in place that stated people did not have full capacity to make decisions about their care, however there were no mental capacity assessments in place to support these risk assessments and provide clarity regarding what specific decisions they could not make. We found for one person a mental capacity assessment had been made that they lacked the capacity to make decisions regarding their diet. Records showed that actions had been taken to restrict the person's diet however we later received conflicting information from the provider that the person had capacity in regards to their diet. We spoke with this person who told us they understood why the restrictions had been put in place but had not felt involved or consulted about this decision. This meant we were not confident the home was fully adhering to the MCA.

The registered manager had made applications for authorisations under DoLS. However, we found in the home's development plan they had stated that all people with a diagnosis of dementia required an application to be made. Having a diagnosis of dementia does not automatically mean a person lacks capacity to consent and that an authorisation is required. Each person's circumstances must be assessed and considered individually, including the individual's ability to consent. We were concerned that this blanket approach to applications demonstrated that the registered manager did not fully understand their responsibilities under DoLS and applications for authorisations were being made without following the

proper legal processes and assessing if they were required.

The above information meant the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported with their nutritional and hydration needs. We observed during both days of our visit that people in the home did not always have drinks readily available to them and were not always supported to drink enough. We observed the support provided over lunch time and saw not all people were supported adequately with their meals; as a consequence we observed some people did not receive enough to eat. For one person we found they required nutritional supplements but their medicine administration records showed these had been out of stock and had not been given for eleven days. This meant the person had not received the right support to ensure their nutritional needs were met.

We also found that meals were not provided in a way that ensured people's nutritional needs or preferences were met. For example, one person's care plan stated they preferred to eat using their fingers and for staff to provide finger foods. We observed on the 25 July 2017 that the meal provided to the person was not finger food and although they attempted to try to eat this with their fingers this was not possible. We reviewed the food records for this person and saw they were consistently not provided with suitable finger foods. This meant that they were at risk of not eating their meals. For a second person we saw their care plan and associated risk assessment said to offer regular high calorie snacks. Their discharge letter from the local nutrition and dietetics department advised they should have a small and frequent meal pattern. During our inspection we observed regular high calorie snacks and a frequent meal pattern were not provided, which meant their nutritional needs were not being met.

The above information meant the service was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments about the food provided. One person told us, "I'm very happy with the food I get. I have no complaints about it." Whilst another person said, "The food could be much better, it's not terribly appetizing. It needs to be more like home cooking." Whilst some relatives we spoke with raised concerns about the support their relatives received with their nutrition and hydration. One relative said, "We have concerns about [name's] food and fluid intake which we don't think is monitored properly. We bring in more drinks." Another relative told us, "[Name] does not eat much or drink much. I try to help but they do not want that they want to do it themselves. I have asked for help from a dietician, but I have not had any feedback from them."

People and relatives provided us with varied feedback regarding the competency and expertise of the staff. One person told us, "I think they know what they are doing." Whilst another person said, "Some know what they are doing and some are not so well trained." A third person told us that a new member of staff had supported them with specific care task involving equipment which they had no experience of. They said the member of staff was able to undertake this task with instruction from themselves. A relative told us, "Some of the staff know what they are doing and some don't."

Staff we spoke with told us their training was up to date. One staff member told us it was, "Always good to refresh." Staff told us training provided was via online courses and that it provided them with the information they needed. However, from our conversations and findings from this inspection we were concerned about how effective the training and systems in place were in order to ensure all staff had the knowledge required to meet people's needs. For example, not all staff were able to tell us about the MCA and some showed poor knowledge of the prevention of pressure ulcers.

Staff training records showed training rates for each topic that staff had training in, for example first aid or fire safety, were over seventy percent in the majority of areas. However, it showed some individual staff members had poor training rates. For example one staff member only had a training attendance rate of five percent and another two staff were on seventeen percent. We reviewed the audits for training and found this issue did not appear to have been sufficiently identified and there was no clear plan in place to address this.

New staff told us they received an induction, which consisted of training and shadowing other experienced staff prior to working in the home. One staff member told us, "I was well prepared." We saw there was a staff induction checklist in place to ensure staff had been told about the care required and their responsibilities.

People told us they could access their local general practitioner. One person said, "If I need the doctor I can see one, but I very rarely require one." Another person told us, "I can see the doctor when I need to." Whilst records showed people were supported to access their local doctor we were not always confident that the service was sufficiently advocating on people's behalf for access to other health care professionals, such as speech and language therapists or falls specialists.

Requires Improvement

Is the service caring?

Our findings

People were not always supported in a caring manner that promoted their dignity and independence. During our visits we saw a number of incidents when staff did not act in a caring way. For example, we observed the support provided over lunch time and saw staff standing over people when supporting them to eat rather than sitting alongside them. We also observed staff assisting people with no acknowledgement or interaction. On another occasion one staff member was assisting two people to eat at the same time. On a fourth occasion we observed a staff member encouraging a person to drink a previously served hot drink that had gone cold. We observed that staff member had noted the drink was cold but continued to encourage the person to drink it, and did not offer a fresh drink.

One person was sitting in the communal lounge and we saw them sleeping on and off throughout the day. We observed that they were often doubled over and slumped on the table in front of them, at one point with their hair in their food, for long periods of time. Whilst staff were present in the communal lounge we noted staff did not consistently respond to this person in order to support them to sit upright or offer them assistance to their room so they could sleep comfortably. We noted that this compromised the person's dignity.

We found people's privacy was not always respected, for instance we observed a staff member pulling up a person's trousers and administering cream to their legs whilst in they were sitting in the communal lounge, in full view of other people during their lunch time meal. They did not offer the opportunity for privacy, compromising both privacy and dignity for the person.

People's independence and choices were not always promoted and respected. At lunchtime we noted that one person was wearing a coloured plastic apron around their neck to protect their clothing. They repeatedly tried to remove it during the meal. A staff member intervened and stopped the person from doing this several times, tucking the protector in. We found that whilst the staff member's intentions may have been to ensure the person kept clean this did not fully acknowledge or support their right to remove the protector.

The above information meant the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people and relatives regarding how caring staff were. One person told us, "They look after me well here and they are all very nice." Another person said, "The majority treat me with respect." A third person told us, "Some of the staff are caring and some are not so caring. The same applies to the way they speak to you. Some are more respectful than others." A relative said, "There are some caring staff here who work very hard, but there are not enough staff so they under a lot of pressure. Some of the agency staff are not so good. The same applies to the way they speak with [name]. It is the way in which things are missed." Whilst a second relative told us, "The care here is variable the permanent staff are more caring and thoughtful, whereas the contract staff are less so. I needed to chase them over [name's] personal care of their nails which were dirty. They said that was because [name] had had chocolate cake. They did

clean them, but even now [name's] nails are too long and need trimming. You do have to remind them to do things."

Requires Improvement

Is the service responsive?

Our findings

The care provided did not to take in to account people's individual needs and preferences. We found systems and staff did not fully support people to make their preferences known. For example, there was no additional support in place, such as picture menus, for people to help them make decisions regarding what they wanted to eat and to communicate this. We observed that without this support people struggled to understand staff member's questions and make their preferences known. We observed on another occasion a staff member provided a person with a hot drink without communicating with the person and asking them what they wanted.

We found actions were not always taken by staff or the management to ensure people's needs were met and reasonable adjustments made in order to promote people's independence. We found one person required additional support to regain their independence. There was no system in place to support this and records did not show this support was being given. We asked the registered manager what support was being provided by staff and were provided with conflicting answers regarding whose responsibility, staff or relatives, this was.

We also found that people's previous preferences were not being considered when people had lost the ability to recall and communicate what those preferences were. For example, foods that people had chosen not to eat or did not like, such as meat, were given to them despite the fact they had previously not wanted to eat such foods. People's pre admission assessment and care plans did not contain sufficient detail, including what foods they did not like, in order to ensure these preferences were met.

The care plans we looked at did not always contain sufficient information or guidance, including on how people wanted to be cared for. For example, in relation to refusals of medicines, diabetes, or behaviour that others may find challenging. This meant staff did not have sufficient written guidance to meet people's needs. It also meant that new or agency staff who did not have knowledge of people and their needs would not have sufficient written guidance to meet people's needs in the event that permanent staff were not available.

We observed that activities on offer during our inspection did not take in to account people's individual and specific needs. The majority of people in the home were seated in two lounge areas for most of the day. We saw most of the entertainment on offer was loud music being played whilst at the same time a television was switched on and put on mute with subtitles. In the afternoon of one of our visits the activity on offer was a quiz. We observed this quiz and saw only two people were able to fully participate in this. We noted for some people this had the potential to cause frustration and upset as some people were attempting to join in and answer the questions but were unable to do so due to the nature of their cognitive impairment.

The above information meant the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people and relatives we spoke with felt staff knew them well including their preferences,

although this was not consistently reported. One person said, "I think they do know what I like and what I don't like. I have been here a while and I think they know me by now." Another person told us, "They know what I like and what I don't like and make sure I get it." However, one person said, "The activities are a bit limited. The lady who does it tries her best but her time is limited and I don't think she fully understands the type of people here. The loud music here kills conversation in the lounge, that's if there were people to speak with." Two relatives told us, "We are not sure that they all know what [name] likes and does not like" and "I'm not sure they fully understand [name]. It's the little things that bother me like their nails and making sure they are well fed and can get what they want."

None of the people we spoke with were able to recall having recently been asked their opinion about their care and preferences. One person told us, "I think I filled a questionnaire in the past but I can't remember when." None of the relatives we spoke with could recall recent meetings to discuss and review their relatives care needs, where appropriate. It was not always clear from looking at people's care records how much input they and their relatives had in to formal care planning. However, most of the relatives we spoke with confirmed they felt informally consulted and involved in their relatives care. Although one relative told us, "We don't feel that we are fully consulted on all the detail of [name's] care."

Most people and relatives we spoke with told us they had no complaints and had not raised any. One person said, "If I have any complaints then they soon see to it." Although a relative we spoke with told us they did not feel their concerns were always taken seriously and responded to. They said, "We complain a number of times about a number of things, particularly about [name's] safety and wellbeing but we feel that we have not been listened to. We don't know if all our complaints are recorded and what response they say they have made to us." We looked at the complaint records and could not see that the concerns raised by this relative had been recorded and responded to. This meant we could not be certain that complaints were always being noted and reported to the management team. However, we saw where complaints had been recorded and reported to the registered manager they had responded appropriately in order to resolve them.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 13 and 14 June 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. At this inspection carried out on 25 and 26 July 2017, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

There were some systems in place to monitor the quality of the service provided via audits on areas such as health and safety, infection control, medicines, and care plans. However, we found these were not effective and had not identified the issues found at this inspection. For example, health and safety audits were not effective as they had not identified issues with water temperatures and water safety in the home and timely action had not been taken in response to this. The most recent infection control audit had not been completed properly as it provided no detail regarding what areas of the home or equipment had been checked. We saw one of the areas to be audited was the number of staff who had completed training in infection control, against this was written 'yes' without identifying the actual number and any actions needed.

We found further examples of poor ineffective quality control when looking at the service's quality monitoring report and home development plan. The quality monitoring report did not answer the questions set out in it. For example, it asked that the registered manager carry out observations of staff practice and of service users living in the home. The comments recorded showed that observations had not taken place which meant this audit was ineffective at identifying poor quality interactions and care which we had identified at our inspection on 25 and 26 July 2017. The home development plan did not provide a clear action plan regarding what actions are required to make improvements to the home and did not set out clear timescales and accountability. For example, the home development plan dated 30 May 2017 stated 'visual photos will benefit the resident in choosing their meal. It is in progress.' There was no further detail recorded on what actions were required for this to be put in to place and by what time scale. At the time of our inspection on 25 and 26 July 2017 this was still not in place. This meant the system in place was ineffective at monitoring and driving improvements required in the home.

Other systems to ensure the quality and safety of people in the home were also lacking.□For example, effective recruitment systems had not been established and operated effectively to ensure the risks of employing unsuitable staff were mitigated. Systems regarding incidents were also lacking. The registered manager was unable to provide us with an overview of safeguarding incidents that occurred in the home. The registered manager said safeguarding incidents reported to them were recorded on each person's care record. They went on to tell us there was no system in place that provided an overview of safeguarding incidents in the home and they were not analysed for any trends or themes.

Our findings during this inspection showed that the provider had failed to meet the regulations in respect to

safe care and treatment, safeguarding, the employment of fit and proper persons, nutritional and hydration needs, dignity and care, consent, person centred care, and good governance. In addition, the provider had consistently failed to sustain and make improvements where non-compliance and breaches of regulations had been identified during previous inspections. This meant the provider had failed to take sufficient action to maintain standards in the home and ensure the service was compliant with these regulations.

At our last inspection we found that the care records we looked at contained information about people's care needs but these were not always sufficient, accurate, and up to date. The care records we looked showed this continued to be a concern and action had not been taken to make sufficient improvements. This meant the home did not have in place accurate, complete, and contemporaneous records of people's care including guidance for staff on how to meet people's needs. This was of particular concern given some of the staff working in the home were agency staff.

During our inspection on 25 and 26 July 2017 we observed a number of incidents that did not uphold people's rights, dignity, and constituted improper treatment. We reported our concerns and observations to the registered manager and deputy manager during our inspection. They were not aware of such incidents, had not received reports from other staff, and felt this was not a normal occurrence. We were concerned about there being a culture in the home which was not person centred or respectful and had not been identified by management or staff working in the service.

We asked staff we spoke with how they knew what was expected of them on each shift and how they understood their responsibilities. The staff we spoke with told us that staff worked together to decide which tasks they completed. One staff member said, "Everybody kind of knows without being told." Our observations during the inspection indicated this was not always effective. For example, we observed during lunch times staff swapping and changing roles with each other which impacted on the support people received. This meant we were concerned there was a lack of leadership and direction in order to ensure staff understood their duties, carried these out, and were accountable for them.

Staff told us that the management team was supportive and approachable. One said, "It's the sort of place if I went to [deputy manager] and said I'm not confident, they would help." Another staff member said the management were, "Supportive, helpful." We saw there were regular staff meetings where staff had an opportunity to discuss the service. One staff member told us, "[Management] will always listen to what we've got to say."

We saw there were also regular meetings for people living in the home and their families, where people were asked their feedback about the service. A recent quality assurance survey had been conducted with people and their relatives to gain their views on the service. However, we were not sure how effective this model of feedback was given they had been conducted with some people living in the home who had limited ability to provide verbal feedback due to the nature of their cognitive impairments.