Ablegrange (Lincoln) Limited

The Limes Care Home

Inspection report

Main Street
Scopwick
Lincoln
Lincolnshire
LN4 3NW

Tel: 01526321748
Website: www.thelimescarehome.co.uk

Date of inspection visit:
08 November 2016

Date of publication:
08 December 2016

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8 November 2016 and was unannounced. The Limes Care Home provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 40 people who require personal and nursing care. At the time of our inspection there were 25 people living at the home.

There was not a registered manager in post. An application for the current manager to become the registered manager had been made to CQC. 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.

At this inspection we found that the provider had failed to ensure that previous improvements had been sustained. We found that there were five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. You can see what action we have taken at the back of the full version of this report.

On the day of our inspection people were not cared for safely. Staff knew how to safeguard people against abuse however staff did not have the appropriate competencies and skills to provide safe care. Staff did not respond appropriately and in good time to people's changing needs.

Medicines were not managed appropriately and safely. People did not always get their medicines as prescribed. The management of infection prevention and control did not mitigate the risk of cross infection.

Staff did not follow care plans when delivering care. Staff did not respond in an appropriate manner to people and did not always provide emotional support to people. Staff were not consistently kind to people when they were providing support. People did not have their privacy and dignity considered. Staff were able to tell us about people's needs but we did not see care being provided in a way that met their needs.

We found that people's health care needs were assessed however care was not planned and delivered to meet those needs. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals. However we observed medical assistance was not always provided in a timely manner.

Staff did not always provide care according to their training. Staff were provided with training on core areas but had not received training in areas specific to the needs of people who lived at the home such as care of people with dementia. The provider had a training plan in place and staff had received supervision.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make

certain decisions, at a certain time. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

People did not have their nutritional needs met. People had their nutritional needs assessed but were not always supported with their meals to keep them healthy. Where people had special dietary requirements we saw that these were not consistently provided for. People had choices at mealtimes.

People had access to limited activities. Signage in the home was poor and not provided in a manner which assisted people with dementia to orientate themselves.

Records were not accurate and did not include a record of the care and treatment provided to the service user and of decisions taken in relation to that care. Care plans were not updated consistently and did not reflect the care people required.

Systems were not in place to adequately assess, monitor and improve the quality and safety of the services. Audits were in place for areas such as medicines and infection control however they had not consistently improved the quality of care. Accidents and incidents were recorded and analysed.

Staff felt able to raise concerns and issues with management. Relatives were aware of the process for raising concerns.

The provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about. The current rating was not displayed on the provider's website as required by law by CQC.

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.

Risk assessments were not updated and consistent.

Medicines were not administered safely.

Care was not provided as detailed in the care records. People were at risk of developing pressure sores, choking and having falls.

There were sufficient staff to provide care but staff did not respond to people appropriately.

Staff were aware of how to keep people safe from abuse.

Is the service effective?

Inadequate

The service was not effective.

The provider did not act in accordance with the Mental Capacity Act 2005.

People did not have their nutritional needs met. People were not always supported with their meals.

Staff did not have the knowledge and skills to carry out their roles and responsibilities effectively.

Staff did not recognise the need for people to have access to urgent medical support.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff did not always respond to people's emotional needs.

Staff did not respond to people in a kind manner.

People did not have their dignity maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not reflect the care people required. People and relatives were unaware of their care plans.

People had access to activities.

The complaints procedure was on display and people knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well led.

The systems and processes in place to check the quality of care and improve the service were not always effective. The provider did not have adequate systems in place to ensure that the service was well-led.

A registered manager was not in post.

The provider had not acted as required by the CQC in displaying their rating on their website.

Staff felt able to raise concerns.

The Limes 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 8 October 2016 and was unannounced. The inspection was completed by an inspector, two pharmacy advisors, a specialist advisor 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. A specialist advisor is a professional who has expertise in relevant areas of care for example nursing care.

Before the inspection, the registered provider completed 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 what improvements they plan to make. We used this information to help plan our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection we observed care in the home and spoke with the manager, the acting deputy manager and two members of care staff. We spoke with four people who used the service and three relatives. We also spoke with three visiting professionals during our inspection and to another health professional by phone on the day of our inspection. We looked at seven people's care plans and records of staff training, recruitment, audits and medicines.

Inadequate

Is the service safe?

Our findings

People who lived at the service received care that was not safe. Individual risk assessments were completed for issues such as a risk of falls and skin care, however risk assessments were not consistently in place where equipment was used such as bed rails. Risk assessments had not been consistently updated. For example, one person's fall risk assessment was last completed on 11th May 2016 and had not been updated, despite the person having fallen and broken their arm in October 2016. There was a risk that the person would fall again because the risk was not being managed. Accidents and incidents were recorded and investigated to help prevent them happening again.

Other risks were not managed appropriately and placed people at risk of harm. For example, we found that people with swallowing difficulties were put at risk of choking. We saw that someone who had been assessed as needing thickened fluids to prevent choking had been left with a drink that had not been thickened. We took a drink away to show the manager because we were concerned about the risk. In the afternoon we returned and found that, despite this having been raised, fluids were still not thickened and there were only two entries for 200mls logged for the whole day. A carton of cranberry juice was on the person's side table opened but without a cup or thickener available. There was a risk this could have been given to the person without being thickened. We also observed that on one occasion the person had been given a drink in a cup with a spout despite the guidance stating this should not happen as the flow of the liquid was less easy to control.

We observed another person eating a bowl of pasta with their fingers, lying down in bed therefore there was a risk of choking. A risk assessment had not been completed. A nutrition care plan stated that they should have a soft diet when in bed however the kitchen sheet stated that they should have 'finger food'. When we asked the manager they told us that the person required a normal diet. This lack of clarity meant the person was at risk of receiving an inappropriate diet and there was a risk of choking. We saw the same person later drinking from a spouted beaker laid down in bed and struggling to get the spout in their mouth, on one occasion they pointed it towards their nose. There was a risk of the person inhaling fluids and choking.

Care was not provided as detailed in the care records as required. For example a person was recorded as needing to be weighed weekly. We looked at the weight records and saw they had only been weighed on a monthly basis until March 2016 and had lost weight on a consistent basis. Despite the weight loss they were not weighed after March 2016.

Staff did not ensure that people were kept warm. We walked around the home and spent time with people in their bedrooms. We found bedrooms were cold. We spoke with a person whose bedroom was cold and found them also to be cold to touch. We observed visiting relatives come into the lounge to pay a visit to their family member who was sitting in a chair. The person appeared to be cold and shivering, we observed the main doors were open. The relative commented that their family member was cold and that they would benefit from a blanket. We observed the staff member directed the relative, by pointing to where they could collect a blanket from, they did not assist the relative or check that the person had suffered any ill-effects from being so cold.

People were at risk of developing pressure sores and having falls. For example, we saw a person sitting at the breakfast table at 10 am although they had finished their breakfast and remained there until 11 30am. They were sitting in a hard chair and attempted to go to sleep however the chair was not appropriate for this and this could result in the person having skin damage due to being seated inappropriately. Two relatives told us, "We often have come and found that my family member's `crash` mat has not been plugged in. My sister comes too and finds the same. Our family member has lots of falls which we accept. But it's poor to find that the mat has been left unplugged, so they will never know if he has fallen or not until they go in and find him."

The manager told us they had implemented a plan for infection control. However when we walked around the building we found areas that were unclean. Three of the bedrooms we looked in had unpleasant smells despite being cleaned. We found in one bedroom a feeder cup with dried faeces on and spilt urine on the floor which was an infection risk. One person had a sandwich crust on their chest of drawers when we visited their room in the morning and it remained there in the afternoon. We saw the dining room floor required cleaning to remove debris such as paper and food. We also observed the dining room floor to be sticky underfoot. After lunch we noticed a member of staff attempted to clean the dining room floor underneath the tables with a small hand held dust pan and brush. We observed this was inadequate for the task and did not improve the state of the floor. One of the visiting professionals we spoke with told us that the home was always dirty and people often appeared unkempt. We saw in responses from the quality survey carried out with relatives and visitors the issue of cleanliness was raised as a concern. In the outside area we observed the general waste bins were overflowing and the garden was unkempt. Two relatives showed us bags of rubbish by the side of the building which they said had been there for at least three weeks. This was a hygiene risk.

We found there were shortfalls in the way the provider managed the administration of medicines and people were at risk of not receiving their prescribed medicines. We looked in detail at the medicines and records for 12 people living in the home. We found that people were receiving their medicines as prescribed providing that the medicine was available in the home and the medicine was prescribed to be given regularly. Records showed that one person had not had their regular pain relieving medicine for four consecutive days because it was unavailable. Staff described this person as having reduced mobility if they did not have this medicine and said that after two days it was particularly noticeable and they were seen rubbing their knees.

We could not be sure that two people, who had medicines prescribed for them with no specific directions as to how they should be given, were being given these medicines as their doctor intended. Staff could not show how they had come to a decision on how they were giving these medicines to these two people. Handwritten medication records produced in the home were found not always to be accurate one chart had no strength for one of the medicines recorded and so the record was not complete and accurate. Records were either not signed by the person writing the chart or those that were signed had not been checked by a second member of staff, in line with best practice guidelines. We found the front sheets in the medication administration records (MARs) folder had not been consistently completed with people's names, date of birth and allergies. This meant that they could not easily be used to check people's identities when administering medicines. Where people were prescribed 'as required' medicines such as paracetamol, protocols were not in place to indicate when to administer these medicines and whether or not people could request and consent to having their medicines.

This was a breach of Regulation 12(2) (b) (g) (f) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

More positively records were kept of medicines received into the home and given to people. There were no gaps on the MARs. Clear records were kept of when to give the next dose of medicines which were not given every day and people were getting these medicine at the right times. People were protected against being given medicines that they were allergic to. Their allergies were recorded on their administration records and on the information sheets kept with their medication records. These information sheets also recorded how people preferred to take their medicines. When people had patches applied we saw that records were kept to ensure that they were applied and to different parts of the body in line with the manufacture's guidance. We watched people being given their medicines by one of the care workers on duty. They followed best practice with regards to recording when people had taken their medicines. Medicines were stored in locked cupboards according to national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control.

People who used the service told us they felt safe living at the home. Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example to the local authority. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

People told us that there was usually enough staff to provide care to people but they told us that they felt staff had no time for them as individuals. We observed during the day of our inspection that although there appeared to be sufficient staff available to meet people's needs they did not always respond to people in a timely manner. We observed people were left without support and intervention for long periods of time during the day. However staff told us they felt there were sufficient staff to provide care to people. The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable people were employed by the provider.

Inadequate

Is the service effective?

Our findings

We found people were at risk of not receiving adequate nutrition. At 10.50am we entered a person's bedroom and found their breakfast on the bedside table uneaten and a cold mug of tea untouched. When we spoke with the person they said they didn't know it was there. We asked them if they required a drink to which they agreed and we asked a member of staff to provide a fresh drink. We observed at 11 am the breakfast and drink being cleared away uneaten. Another person had a drink which had gone cold and had not eaten lunch because they did not like the choices. They told us they wanted a drink. A staff member confirmed to us that they had asked for a drink but they had not yet got the person one. When we checked later the person had received another drink but had not drunk it because they wanted sugar in it. A relative told us their family member was supposed to have a yogurt mid-morning with their cup of tea because they couldn't eat biscuits. They said, very often, staff forgot to get it so the relative collected it from the kitchen when they were there to do so. We asked what happened when they were not visiting and they said they did not suppose the family member got the yogurt every day. We observed the person was not offered yoghurt on the day of the inspection. There was a risk people were not receiving sufficient fluid and nutrition because the drinks and food they were provided with were not according to their preference.

People had been assessed with regard to their nutritional needs however we observed they did not receive the nutritional support they required. Another person also had guidance from a SALT which stated they should have been on thickened fluids. However when we checked their drinks in the afternoon we found two full beakers of drink on their side table. One was a cold up of tea and the other a juice, neither were thickened. We saw the person's nutrition care plan did not include the need for a soft diet or thickened fluids but the kitchen guidance did. We also saw they were prone to urinary tract infections and therefore required regular fluids, but had not been encouraged to drink either of the drinks provided which placed them at risk of developing further infections. Nutritional supplements were prescribed for a person who was cared for in bed but this did not appear to be on the most recent care plan dated 24th June 2016 which meant that they may not receive these as appropriate.

Jugs of juice were in the lounge but cups were not available and a person told us they hadn't been refreshed that day so they wouldn't drink it. We observed that cups were not available in people's bedrooms for juice and jugs of fluid were also not consistently available in people's bedrooms. We looked at fluid charts for the day of inspection and the month previous and saw that they were not completed consistently. Two people's charts only recorded two occasions during the day of our inspection when fluids were offered and these were only small amounts. People were at risk of dehydration.

We observed lunchtime and saw many of the residents left their meals. We observed staff just took the plate away without questioning why they had left the food, or if they would prefer an alternative. One person appeared very drowsy and indeed was asleep at the table for most of the duration of the meal. We observed staff served the meal to them whilst asleep. 10 minutes after the meal had been placed in front of them a member of staff went to assist to the person with their meal. We saw they only assisted with one spoonful of food, then left and the person fell asleep again. Three minutes later the staff member who was administering medicines approached the resident and asked, "Do you want any paracetamol? Oh are you

having a sleepy day today. Come on eat your dinner and then you can go back to your bedroom." This sounded more of a threat than an encouragement and the member of staff did not attempt to assist this person to eat their meal or find out if there was a problem. People were at risk of not receiving sufficient nutrition or inappropriate nutrition which could result in harm such as choking.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were offered choices at lunchtime and that a menu in pictures was available in order to assist people to make choices. The food was well presented and freshly cooked. One person said, "The food is ok I think, the cook is good, he cooks home cooked meals and there's always plenty of it."

We observed people did not receive care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. During our inspection we asked a member of staff about covert medicines, these are medicines which are given in food without a person's knowledge. The member of staff who was responsible for administering medicines did not understand the meaning of this. It is important that staff who administer covert medicines understand what they are to ensure that people are administered their medicines in the correct manner. Staff should be aware of the risks when administering medicines in this way and also understand the issues in relation to people not being able to consent if their medicines are given covertly. When we explained they told us a person who they thought received medicines in this way but when we checked this was not the case. Staff did not have the knowledge to provide appropriate care to people. We spoke with three staff about our concerns regarding a person who was later admitted to hospital although two staff recognised the signs and symptoms and the implications of these they did not respond in a timely manner. The person was alone in their bedroom with a bowl. Inside the bowl appeared to be 'coffee ground' vomit which would indicate the presence of blood. We spoke with the acting deputy manager about this who said the person had been ill in the night. At lunchtime a member of staff shouted across the dining room to another member of staff that the person had been sick so hadn't wanted their meal or fluids. They said they had only had taken 18mls of fluid. A fluid chart had not been completed which meant the person's fluid intake could not be monitored to prevent dehydration. We spoke with the manager and advised them to obtain medical advice. The person was later admitted to hospital. When we spoke with a visiting professional they told us they felt that the home did not react in a timely manner to people when they were ill. Staff did not recognise the signs of someone requiring immediate medical assistance.

We found that although people who used the service had access to local and specialist healthcare services people did not get access to healthcare in a timely manner. A visiting health professional told us that they were not usually contacted until people's illnesses had progressed. They said that staff were not proactive in contacting them.

We observed that staff were not aware of the importance of providing care specific to people's needs for example thickened fluids because training had not been provided. A visiting professional told us they thought staff were not adequately trained in areas such as nutrition and moving and handling. A relative told us, "I think the staff could do with more training on dementia." We observed staff supporting a person to move into the dining room. We saw that they held the person under their arms and marched them at a pace which appeared to be beyond the person's capability. There was a risk that moving people in this manner would cause distress to them and injury. A visiting professional told us they thought staff did not have the skills to provide safe moving and handling support to people.

This was a breach of Regulation 12(2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff were in the process of receiving updates on core training on areas such as fire and health and safety. The manager also told us there were plans to provide more specialist training such as training about dementia care and nutrition. There was a system in place for monitoring training attendance and completion. Staff also had access to nationally recognised qualifications. New staff received an induction and when we spoke with staff they told us that they had received an induction and found this useful. The induction was in line with national standards. Staff were happy with the support they received from other staff and the manager of the service. They told us that they had received supervision and that supervision provided an opportunity to review their skills and experience.

The registered provider did not act consistently in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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. For example we saw a person was recorded as having capacity in their record however forms had been signed by a relative on their behalf and there was no record of the reason for this or if a discussion had taken place. We observed another person had a number of restraints in place such as bedrails and a pressure mat but a consent form had not been completed. There was also no evidence that a best interests decision had been made with regard to these items to ensure that staff were providing care in the person's best interest. It was not clear in any of the records we reviewed what decisions staff were taking on people's behalf in their best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the 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 were being met. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there were 9 people who were subject to DoLS. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. We are observed the appropriate paperwork and processes had been followed.

Requires Improvement

Is the service caring?

Our findings

People were not cared for in a caring environment. There were very few kind interactions that we observed. When tea was served mid-morning people were not offered a choice and in most occasions not spoken to. We observed two people were given biscuits in packets, one person took five minutes to struggle to open them and another person took 10 minutes. Despite staff being in the room they did not offer to assist or ask if they could manage. We observed staff supporting a person with their meal in their bedroom but saw they snatched the spoon from them. We observed two people were visibly distressed and staff did not provide any comfort to them.

A person whom we observed to be cold was covered with an uncovered quilt with the waterproof cover next to their skin. When we asked a member of staff why this was they said they didn't know, 'it must have been the night staff'.

We observed another person was laid in bed with a thin sheet as a cover. Throughout the day this sheet was invariably not covering them. The door to the room was left open and any visitors and people could see them in an undignified position. Staff did not treat people with dignity and respect. People were unkempt. We observed a person with faeces on their cardigan and another with significant dinner spills on their clothing. Another person was asleep and we observed a member of staff shouting their name loudly to wake them for lunch rather than gently speaking to them and waking them in a kind way. In the afternoon we saw a person still had their apron on from lunchtime and their used dishes from lunchtime had not been cleaned from their side table. Staff did not observe the need for confidentiality and we observed them speaking with people in a loud voice so that conversations could be overheard.

During the afternoon we observed three members of staff in the lounge area writing in files. During this time they spoke with each other but did not speak to people who were sitting in the lounge area.

This was a breach of Regulation 10(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that where people were unable to represent their needs and wishes and did not have appropriate people to support them professional advocacy had been provided in order to support them with specific decisions.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not accurately reflect the care people required. For example a person had recently been in hospital following a fall. The risk assessment stated that a wheelchair was required and that this should be reviewed in one month. There was no evidence of a review. However the moving and handling care plan stated that the person walked around the home and required one staff member with them at all times. It was not clear what care this person should be receiving so we asked the manager. The manager stated that previously the resident was mobile with the use of a frame but since breaking their arm was unable to use this and required a wheelchair. We asked why this detail was not in the care plan but the manager did not know. The person was at risk of being supported and supported to move inappropriately. Another person had a skin condition which required treatment. A care plan was not in place for this and a body map had not been completed. We observed the MARs detailed that a cream was prescribed however there was no detail of this in the care plan and how to use it appropriately. There was a risk the person would not receive appropriate and safe care.

The care records we looked at did not always detail people's past life experiences. Information such as this is important because it helps staff to understand what activities people have previously enjoyed so they can try to offer similar experiences. For example, a person had always liked a newspaper on a daily basis. We observed that they still received a daily newspaper however they were unable to read the paper without support. Their relatives told us they rarely received this support but they carried the paper with them. The person was not supported to maintain activities which were important to them.

We observed that daily records were maintained, however when we reviewed these we found the records did not relate to the care plans and it was not possible to understand what care had been provided. For example a record for one person stated, 17/10/16, "settled day sleepy", 18/10/16, "settled day, very sleepy" and 12/10/16, "sleepy." Daily records would usually detail what care had been provided such as support with washing, how the person felt on the day and if they required additional support with any care. This is so that a record of people's wellbeing and care is available for monitoring purposes. Relatives and people we spoke with were not aware of people's care plans.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection we observed some activities being provided. For example two people were being supported by a member of staff to complete jigsaw. Later in the day people were also encouraged to take part in a game. We observed that when supporting people to take part in activities the member of staff responsible for activities staff interacted with people and chatted about the activity. An activities programme was on display, however when we asked people and relatives about it they said it didn't happen. On the day of our inspection the activities on the plan did not take place. A relative told us, "It's (activities) not as good as it used to be."

Relatives we spoke with told us that they felt welcome at the home. However a comment from a relative in

the recent quality survey stated, "Last time I visited I felt I was a nuisance. My mother was promised a cup of tea and I stayed an hour but it never arrived." We observed that relatives were not offered a drink when they were visiting mid-morning, even though their family member was offered a drink. Another relative told us that when they did ring staff were usually unable to tell them how their family member was. They said, "I am not always kept well informed and if we telephone to ask how things are with my relative, it's difficult to get an accurate picture. We get told things like, 'Well I`ve been off for a couple of days so I don't know' or 'Well I have only just come on shift so I don't really know'. You would think they would have notes or something to pass onto one another so that when relatives ask how their loved one is, they could at least tell us. It's quite frustrating and worrying when you live a long way away and just want to know how your loved one is. After all if they don't know then who does?"

The environment in the home was not responsive to the needs of people with dementia or provided in a way that would assist people with their orientation. For example, bedroom doors had numbers on rather than pictures or names on to assist people to identify their bedrooms. During our inspection we found two people trying to locate their bedrooms as we observed them wandering about the corridors confused and asking for assistance.

A complaints policy and procedure was in place and on display in the foyer area. Relatives told us they would know how to complain. Where complaints had been made these had been resolved.The complaints procedure was only available in a written format. This could result in a lack of accessibility to people with poor reading skills. Complaints were monitored for themes and learning.

Inadequate

Is the service well-led?

Our findings

The provider did not have adequate systems in place to ensure that the service was well-led. Although we were told by the provider regular quality visits were carried out by the operational manager these had failed to ensure that standards of care were maintained. There had been a recent change in the manager, the current manager had been in post since March 2016. We found the provider had not ensured that arrangements were effective during the period of change and that previous improvements were sustained while the new manager became embedded in their role. As a result of this we found significant shortfalls in the care and treatment that people received throughout our inspection.

At our last comprehensive inspection in 2015 we also found breaches in the legal requirements. Although when we followed these up, improvements had been made, we found at this inspection this progress had not been sustained and the quality of the service had deteriorated owing to the lack of oversight and support from the provider. At the previous inspection we had identified areas of concern about the safety and management of the service. The provider had not taken sufficient action to ensure that any introduction of quality processes were carried out in a systematic manner and maintained.

A local process was in place for checking the quality of some areas of the service and making improvements to the quality of care. However we found that the system was not effective in improving the quality of care to people, for example, two external medicine audits had been completed. On both audits we saw the same issues were raised so hadn't been addressed. During our inspection we confirmed that one of these had still not been addressed. For example, the issue of handwritten MARs charts not being signed and checked for accuracy. Internal medicine audits did not have action plans to ensure that issues were addressed and hadn't been carried out since July 2016. We saw an action plan was in place to monitor the improvement of the service, however the action plan was not dated and it was not clear from the document who had responsibility for taking issues forward. We were unable to monitor the progress of this work due to the lack of detail in the document. We observed that audits on records had not identified the lack of consistency in care plans and completion of care records. Although infection control audits had been completed these had not resulted in prevention of the risk of cross infection due to poor hygiene and cleanliness.

This was a breach of Regulation 17 of (1) (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider was not displaying the current rating of the home on their website as required by CQC.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager did not have a good understanding of people's needs and personal circumstances. At the beginning of the day the manager advised there was only one resident who remained in bed during the day. However, we observed five people who remained in their beds throughout the duration of the inspection

visit. Visiting health professionals confirmed that this was usually the case.

There was not a registered manager in post. An application for the current manager to become the registered manager had been made to CQC. 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.

Staff said they felt supported in their role and that they worked as a team in order to meet people's needs. Staff and relatives told us that the manager and other senior staff were approachable and supportive. Staff said that they felt able to raise issues and felt valued by the manager. A meeting with team leaders had been held since the new manager commenced in March 2016. However meetings had not been held on a regular basis with staff. We looked at the minutes from the meeting and saw that issues such as medicines and record keeping were discussed. A resident and relatives' meeting had also been held. We saw from the minutes of a meeting held issues such as meals and activities had been discussed. Surveys had been distributed to people, their relatives and professionals and were in the process of being collated.

The service had a whistleblowing policy and contact numbers to report issues of concern, were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed and felt able to raise concerns and issues with the manager. The provider had notified the CQC about notifications as required by law. Notifications are events which the provider is required to inform the CQC about.