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Radiant Care Home

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

We inspected this home on 17 and 24 August 2017 and this inspection was unannounced. The provider had been directly involved in two substantiated safeguarding concerns as people did not always receive appropriate safe care and treatment when they needed it and medicines were not managed safely. We brought this inspection visit forward in response to those concerns.

The home is situated in the Bulwell area of Nottingham and offers accommodation for to up to 18 people who require personal care. On the day of our inspection, 13 people lived at the home, some of whom lived with dementia.

The home was last inspected on 10 January 2017 and was rated 'requires improvement' overall. We found two breaches of the regulations in relation to how people's consent was sought and how the home was run. Since the previous inspection, we received information of concern from the local authority safeguarding team regarding the management of risks to people. We undertook this inspection to check whether improvements had been made since our previous visit, and to check the concerns raised by the local authority. We found some little improvement had been made and there were still some significant improvement required.

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.

There was a registered manager in place at the time of our inspection who was also the registered provider.

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's governance arrangements were not effective in monitoring, assessing and improving the service for people who lived at the home to ensure they received safe, compassionate and high quality care. Where their systems had identified shortfalls in provision, these had often not been acted on, or not acted on in a timely way. Improvements made had often not been sustained and the provider has been in breach of the regulations in five of the six inspections we have undertaken at this home.

The provider did not always notify us of events they were legally obligated to do, therefore we were not always able to monitor the service provided at the home.

People were not protected from risks associated with the premises and equipment. Since our last visit the fire service found the provider had not kept the premises safe from the risk of fire and had required action from the provider to improve fire safety. Shortly following our inspection visit the fire service found that sufficient action had not been taken and people were placed at potential risk. We continued to have concerns about the provider's response to the risks of legionella in the home.

People were not supported by enough staff to ensure they received care and support when they needed it.

People, who were able to, were supported to make decisions, however the provider did not follow the Mental Capacity Act principles when people's decision making ability was in doubt.

People were supported to maintain their nutrition and staff monitored and responded to people's health conditions; however this was not always recorded in people's care plans. People were supported by individual staff members who had the knowledge and skills to provide safe and appropriate care and support.

People told us they lived in a home where they felt staff listened to them and knew how to complain if they were unhappy however the provider did not always take action when concerns were raised.

People's emotional needs were recognised and responded to. People were supported to enjoy activities. However activities for people who lived with dementia required improvement.

People's privacy was not always promoted by staff, as some staff did not knock on people's bedroom doors or seek permission before entering. However people felt staff treated them with respect.

People were supported to maintain relationships with people that were important to them. Visitors were made to feel welcomed and there were no restrictions on visiting times.

The provider had displayed the rating of our last inspection within the home for people and visitors to see. They had also displayed their rating on their website.
We found five breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 and one breach in relation to the Registration Regulations.

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.

People were not protected from risks associated with premises, equipment and environment. Medicines were not managed safely and we could not be assured people received their medicines are prescribed. People were not always protected from abuse or avoidable harm. People told us they thought there were not enough staff to assist them when needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not always act in line with the principles of the Mental Capacity Act when people's decision making ability was in doubt. People who were able to, were supported to make decisions about their care. People were supported to eat and drink enough and were supported with their day to day healthcare.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy was not always protected as staff did not always seek permission before entering people's bedrooms. People's dignity was promoted and respected by staff. Staff encouraged people to be as independent as possible and supported people when they needed it.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not involved in planning and reviewing their care. When people's needs changed, this was not always recorded in people's care plans. People were supported to take part in activities they enjoyed. People knew how to raise concerns and felt the provider listened to them.

Is the service well-led?

Inadequate

The service was not well-led.

Systems and processes to monitor, assess and improve the quality and safety of the care provided to people was not comprehensive or effective. Audits did not always identify shortfalls and when shortfalls were identified, it was not clear what action, if any, the provider had taken. The provider did not notify us of events in the home which they were obligated to do.

Radiant 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.

We inspected the home on 17 and 24 August 2017. The inspection was unannounced and the date of this was brought forward in response to concerns we had received. The inspection team consisted of two inspectors, a pharmacist specialist who is a member of our medicines team and an expert-by-experience. The expert-by-experience had personal experience of caring for someone who used this type of service.

Prior to our inspection visit we reviewed information we held about the service. This included previous inspection reports, information received from the provider and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the home and commissioners who fund the care for some people who use the service. The Local Authority shared information of concern with us.

During our visits we spoke with six people who lived at the home and two visiting relatives to understand their views of the service.

We also spoke with three members of staff, the deputy manager and the registered provider, who was also the registered manager. We looked at three people's care records, nine people's medicines records, staff training records, and a range of records relating to the running of the home including audits carried out by the registered provider.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017 we found the provider did not always undertake checks of the premises and equipment when they should, or take action when issues were identified. This meant people lived in an environment which may not protect them from harm. At this inspection, we found improvements were still required.

Since our last inspection the local fire service had inspected the home and found the provider had not ensured their premises were safe in the event of a fire. In April 2017 the fire service issued the provider with a 'deficiencies and remedies' notice which identified several concerns. Fire doors were not to the required standard; there was no evidence to confirm that the current fire alarm system was to the required standard and regular servicing was not undertaken; the emergency lighting system was not adequately maintained and there was inadequate fire detector coverage. Since receiving the notice, the provider had an action plan in place to address the issues, with some action already completed such as improvements to emergency lighting. We saw work was on going to the walls, floors and doors to ensure they were fire resistant and the provider was sourcing a contractor to service and install a new fire detection system; however no timescales for completion of the work were in place. The fire service undertook a follow up inspection to the 'deficiencies and remedies notice' on 21 September 2017 and found that there was no operational fire detection system in place as the provider had decommissioned the old system prior to the new one working and had no other system in place to keep people safe from fire. The provider notified the fire service at 01:00 on the 22 September that the new system was operational. However there was still no assurance from the provider that the fire detection system was to the required British Standards and they had yet to obtain certification to assure themselves it was fit for purpose. This meant people might be still be at risk if there was a fire within the home.

Following our visits, the provider sent us a copy of their fire detection and alarm systems certificate on 9 October 2017 confirming the installation is to the required standard. However we have not been able to check this.

At the last inspection health and safety checks such as water sampling for legionella was not completed. Legionella is known to cause respiratory diseases, and the bacteria for Legionella can be found in water systems. The provider told us at the last inspection, water checks were not undertaken because they had a new boiler system which they believed prevented legionella. They were unable to provide us with information to support this conclusion. Following the last inspection the provider told us they would undertake a risk assessment and take any action identified such as checking water samples for legionella.

Since our previous visit in May 2017, the provider employed a specialist contractor to assess the risk to the water system. The risk assessment identified a number of remedial actions to reduce conditions within the water system which may favour bacterial growth. We saw work was underway to address those issues. However the risk assessment did not identify whether water sampling to check for presence of legionella was required. As such, the provider still had not undertaken checks to see if legionella was present and within safe limits. As remedial action was required to make the water system safe, there was a risk legionella

could be present and might have affected people's health. Following this inspection visit, the provider had sent us proof of purchase for the legionella water sampling kits, and sent us the results on 15 September 2017 confirming that legionella was within safe limits.

During the previous inspection we found electrical equipment tests were last completed in May 2015, but further testing had not been completed in line with current guidance. The provider subsequently undertook a portable appliance test (PAT) in February 2017 and found there was a faulty plug on a seat scale. A seat scale is a piece of equipment that measures a person's weight when seated on a specialist chair. The assessment did not identify what action had been taken. A member of staff we spoke with told us they still used the seat scales to check people's weight and were unaware that the equipment should not be used. We looked at the piece of equipment and there was no sign to advise it had failed the PAT and should not be used. We brought this to the attention of the deputy manager who removed the power cable and plug so it could no longer be used and told us that they would inform the provider so that a new plug could be purchased.

At our last inspection we identified that water temperature from the taps in some of the bathrooms was running at above the recommended safety temperature of 43 degrees which posed a risk of scalds and burns to people. The provider told us that they would install a temperature control device to ensure the temperature of the water remained within a safe range. At this inspection we found three water outlets in one bathroom were still above 43 degrees. We discussed this with the provider who told us that they had installed a temperature control device and they were not aware that the water temperature was still too high, even though checks undertaken by staff recorded and stated that the issue had been reported. Following our visit, the provider told us that they had booked a professional to look at the issue.

The lift in the home was serviced regularly and the engineer had made several health and safety recommendations between June 2016 and July 2017. For example, poor emergency lighting within the cart, the top of the lift cart was not to the required standard; there were no rubber mat to reduce slips, trips and falls and the engineer had recommended that the lift was refurbished or replaced. We found no evidence the provider had taken any of the recommended actions as the issues continued to be identified by the engineer on subsequent visits. This meant that the lift might become unsafe in the future and people who were not able to use stairs would be unable to move safely between the floors within the home.

Following our inspection visit, the provider told us that they had put a rubber mat within the lift to prevent slips and they were sourcing a contractor to look at the remedial actions.

This was a breach of Regulation 15(1)(c-e) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Since our last inspection, the provider had been directly involved in two safeguarding allegations. The allegations were substantiated by the local authority safeguarding team following an investigation into both allegations. One person received inappropriate end of life care which was not in line with national guidance produced by NICE (National Institute of Clinical Excellence). This was because the provider had not sought medical advice in a timely manner when the person's health deteriorated, and anticipatory medicines (medicines prescribed 'just in case') were not given when the person required them. Another person was not given their prescribed medicine as the provider had made the decision not to administer this. This person's records were falsified to conceal the error.

At this inspection we saw that people had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. We found that balances of medicines recorded on three

people's medicine administration records (MARs) did not match the quantity we found within the home. In some cases this was attributed to the medicines administration chart not being signed when medicines had been given but in other cases the staff were unable to offer an explanation for the discrepancy.

Some people were prescribed topical medicines (prescribed creams applied to a particular place on the body). The records we checked did not indicate where these were to be applied on the person despite the provider's medicines policy requiring that body charts were in place for creams. When we spoke with staff there was no clear understanding of who may apply medicated creams and this was not clarified in the medicines policy. This meant that untrained staff might apply creams without having full information of where they were to be used or the quantities to apply. None of the creams we looked at had been dated on opening or had an expiry date recorded in accordance with the medicine policy. This meant that people may be receiving creams that were out of date and may be ineffective.

The temperature of the room where medicines were kept was recorded on a daily basis; however this was done at five am when temperatures are generally cooler. The checks showed the temperature was below the required 25 degrees, however on the day of our inspection, the weather was wet and overcast and we recorded the room was 24.5 degrees. This meant medicines might be stored at temperatures above 25 degrees on warmer days. Medicines stored above 25 degrees may lose their effectiveness. Some items were stored in a medicine fridge. The maximum and minimum temperatures were logged daily by night staff but from the readings recorded we could not be assured that the thermometer was being reset and the temperature readings were accurate.

The provider's medicines policy stated that monthly audits of medicines should be completed. We asked to see these and were told these had not been completed. The newly appointed deputy manager showed us an audit tool that they planned to introduce which was expected to identify issues going forward.

This was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
Medicines were stored securely and keys held by authorised members of staff.

People were not always protected from abuse and avoidable harm. Prior to our inspection visit we received concerns from the local authority safeguarding team. They shared information that they had investigated and substantiated concerns about the provider's practices in the safe management and administration of medicines. After our visit we received a further substantiated concern in relation to inappropriate care and treatment for a person who was at the end of their life. The local authority told us that the provider should have referred these issues to them but had failed to do so and a result of their concerns they had suspended further placements of people to Radiant Care Home. This meant that the provider had failed to protect people from improper treatment.

This was a breach of Regulation 13(4)(d)(6)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some of the people we spoke with told us they felt safe living at the home. One person said, "I think that I am safe living here." A relative told us, "I have no problems [my relation] is safe here." Whilst we had concerns about the provider's understanding of safeguarding processes, staff recognised the signs of potential abuse and how to protect people from harm. Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and how to escalate concerns to the provider or to external organisations such as the local authority or the police. One member of staff told us, "I have had safeguarding training. I would report concerns to the

provider or go straight to the local authority If I wasn't happy I would report to the CQC."

People did not always receive the care and support they needed in a timely way. One person told us when they spent time in their room; they could not call for help. We saw there was no call bell system in use. The person told us that they had been provided with a portable alarm however when we checked this, it was not working and the provider had failed to check to ensure it remained functional. The person described to us that they would have to push over their bedside table to make a 'thud' and if staff heard the noise, they would check on the person. Another person we spoke with told us they did not have a call bell and summoned assistance by shouting. There were signs around the home telling people to press the 'red buzzer' if they required help. These were in all communal rooms and bedrooms. However when we checked the communal areas and bedrooms for the buzzers, we could not locate them. The provider told us, that the call bell system was not in use as they planned to refurbish this in the future. However, they had checked the portable alarm that was not working and had replaced the batteries and reported it now worked. However other people did not have access to a call bell system to summon assistance when they required it. Following our visits, the provider informed us that a new call bell system was operational and people were able to summon help when they needed it.

Three of the people we spoke with told us there were not enough staff available if they needed support. One person said, "I do shout for help, the staff don't come." The deputy manager told us that three care staff were available to support people on each shift. * The provider had identified that three trained care workers should be on shift each day to meet the assessed needs of people living in the home. However we found that on the first day of our visit there were only two trained staff and a new member of staff who was shadowing (working alongside more experienced staff) as they had not completed their induction and training. The deputy manager was also included in staff numbers but they were new in post and also yet to undertake their induction and training. This meant there were not enough trained staff to support people as the provider identified there should be three trained care workers on each shift.

During our visit we saw some people sat in the lounge waiting for a film to start when one person sat on a table beside the TV and was seen to provoke the other people in the room. The people waiting for the film became irritated and began insulting the person. After approximately 10 minutes, staff were still unaware of the situation in the lounge and we brought this to attention of the deputy manager who requested a care worker diffuse the situation. Whilst the care worker handled the situation well, due to the number and deployment of staff available, people did not receive support when they required it.

The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed, the provider carried out checks to determine if staff were of good character and requested police checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

Other risks to people's health, safety and well-being had been assessed and staff had access to information about how to manage the risks. For example, there was information in people's care plans guiding staff in what to do to protect people if there was a fire, the information was also available in a central access point within the home near fire alarm system. Staff were able to tell us what aspects of care people required support with and what people could do for themselves. For example, one person's care plan said they walked with the use of a frame; however they were likely to forget to use the frame so staff should encourage the person to use it.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2017, there was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the provider did not understand or act in line with the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found improvement was still required.

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 is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at one person's care plan that showed a DoLS had been applied for. The person was under constant supervision and staff needed to assist them with their personal care as the person was unable to give their own consent. However there was no record of an assessment to determine whether the person did not have capacity to make an informed decision. It is also a requirement of the MCA that when decisions are made on behalf of people, these are in their best interests. We could not see that a 'best interests' meeting had been held to determine whether the constant supervision and delivery of the person's personal care was in their best interests. This would be required prior to the provider applying for a DoLS in order to demonstrate that a deprivation of the person's liberty had occurred.

We saw the provider had attempted to assess another person's capacity in relation to administering their medicine however it did not reflect the principles of the MCA for example it did not demonstrate that the provider had understood the two stages when they assessed capacity . The assessment concluded the person had no capacity to make this particular decision due to the person's 'confused condition' and staff were to administer the person their medicine. The assessment did not evidence that the provider had applied the principles of the MCA and there was no information to demonstrate that a best interests meeting had taken place.

Therefore we could not be assured that decisions made on behalf of people who lived at the home were in their best interests.

This is a continued breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However a care worker we spoke with was able to tell us how they supported people with decisions on a day to day basis and what action they would take if the person's decision making capability was in doubt. They

said, "Capacity can change. I help them make simple decisions like showing a choice of clothing. Major decisions would need to be made in a best interests meeting with the social worker and relevant family member. A urine infection can affect people's capacity so I would check if I thought someone was becoming confused and inform the GP."

People thought staff had received enough training to meet their needs. For example one person said, "The staff are trained and they are okay." Another person told us that they thought the staff were, "Trained well."

Staff told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support people. One staff member said, "We now have a lot of in- house training. We recently did a fire training day. I've have done moving and handling and also epilepsy." We saw records which showed that staff had undertaken training in various aspects of care delivery such as safe food handling, moving and handling people and infection control.

Staff were supported to have the skills and knowledge they needed when they first started working in the home. Induction training was provided when they first started working. The provider told us that new staff would complete the care certificate. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. Staff we spoke with were knowledgeable about aspects of safe and effective care delivery.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the provider and were given feedback on their performance. We saw records which confirmed this.

People were supported to eat and drink enough. We spoke with people about meals provided and they told us they had enough to eat. We saw people had access to food and drink when they wanted.

People who were at risk of malnutrition or dehydration had their food and fluid intake monitored. People's nutritional needs were assessed, and care plans contained this information. One care worker said, "We have to be accurate when filling out nutritional charts and record what people are eating and drinking." This assisted staff to identify whether people were at risk of not eating or drinking enough, so that referrals could be made to relevant healthcare professionals.

People were supported with their day to day healthcare. We saw people were supported to attend regular appointments to get their health checked. There were arrangements in place for healthcare professionals to visit people living at the home if they were unable to attend appointments in the community.

Requires Improvement

Is the service caring?

Our findings

People were not always supported to maintain their privacy. One person told us, "I can't say that the carers knock on my door all of the time when they come into my room, I think they sometimes forget to do that," but the person said they felt they were respected by staff. A member of staff told us, "To protect people's dignity, I close the curtains and shut doors; I always knock on the door before entering and cover intimate areas when supporting people to bathe."

People told us they made their own choices for example, about when and where they ate, how they spent their time and what activities they did. We saw that people's choices were not always respected on the day of our visit. For example, we saw that choice was not given at meal times. We observed at lunch time that everyone was given chicken breast and a fruit salad for dessert. The menu had said the option was chicken lattice pie. We spoke with the kitchen staff about this, they told us that they had sampled a few people earlier that morning and people only wanted chicken. We discussed about how people who lived with dementia were supported to make choices, and the cook told us that they knew people well and staff knew what people liked. We discussed the use of pictures to enable people who cannot communicate their preferences verbally, the cook told us this was a good idea and would develop this going forward.

People who could make decisions about their care had their choices respected. One person told us they had asked if they could come down for breakfast earlier and staff supported them to do this. We saw that people chose where and how they spent their time. Another person told us, "I could go out if I want to and I can go to bed whenever I want to." However we found that people were not always involved in planning and reviewing their on-going care.

We saw that overall, people were treated as individuals and staff respected people's preferred needs. One staff member said, "It is good we now have a male carer as people can have a preference. [Person's name] doesn't like to have personal care from the male member of staff but that's okay, as we have female staff to support them." Staff were mindful not to have discussions about people in front of other people and they spoke to people with respect.

People we spoke with told us they were happy living at the home. One person said, "The care is very good. The staff know me fairly well and they are kind and caring." A relative we spoke with was positive in their comments and said, "The staff know [my relation] well."

We saw staff interact with people and saw staff were kind and caring to people when they supported them. Staff told us they enjoyed working in the home and one member of staff said, "I love the people here. I know them so well and I get straight on to something if I feel they are not quite right." Through seeing how staff engaged with people and through talking with staff we found they clearly knew people's needs and preferences.

We saw activities and food menus were chosen by the people who lived at the home and records showed people were encouraged to speak up if they wanted any changes to be made. We saw people had bedrooms

which were personalised to their tastes. We saw that staff knew what choices people were able to make themselves and what they would need support with.

We asked the provider if anyone living in the home had an advocate, or if they used advocacy services. An advocate is a trained professional who supports, enables and empowers people to speak up. The provider told us no one in the home was using this service but information was still available for them should this be required. Following our visit the provider sent us some information confirming that an advocate would be visiting the home in the near future to gain the views of people so that improvements could be made if people were unhappy with any aspect of the care and support they received.

People were supported to be independent. One person said, "I like to be as independent as possible and do things myself. Staff we spoke with told us they tried to encourage people to do as much as they could for themselves and supported them with things they needed help with.
People were supported to develop and maintain relationships with those important to them. People told us visitors could visit anytime and were made to feel welcomed.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2017, we identified that some people's care records and documentation lacked up to date information and people were not involved in decisions about their care. This meant that people may have received care in a way that was not appropriate or how people wished to supported.

At this inspection we found that people and their relatives were not involved in planning and making choices about their care and support. We saw that care plans were written by the provider based on their knowledge of the person but the person and those close to them had not been consulted or given the opportunity to be involved in decisions about their care. We found that care plans did not provide specific instructions to staff on how to support people with their care. For example, at our last inspection we identified that care plans in relation to supporting people to manage their diabetes was poor. At this inspection we found little improvement had been made. One person's care plan did not contain information about how the person manages their diabetes and what signs or symptoms the person might display when their blood sugars were too high or too low and what action staff would need to take.

Two people told us they were not involved in making decisions about their care. The provider told us they were in the process of transferring care plans from a paper based system to an electronic system and they were using this as an opportunity to update people's care plans. The provider told us that once they had re-written the care plans they would ask the person and those close to them to read and sign or make amendments. However none of the electronic care plans we looked at had been comprehensively completed or reviewed by people. Staff we spoke with told us they did not have access to the electronic system and they used the paper care plans. This meant that staff may not have access to the most up to date information about how a person preferred to be cared for.

In addition to the care plans not being personalised to the individual's needs and preferences. We found in one care plan, the use of derogatory language, for example referring to the person being a, "Loner," instead of using social and personable language such as the person prefers to spend time alone. When we discussed this with the provider, they told us that it would be removed when they transferred their records to the new system.

The provider did not complete a full review of each person's care and support on a regular basis and care plans were not adjusted to meet people's changing support needs. For example, we were made of aware of one person who had a wound to their leg which was being managed by district nurses. The district nurses visited the home on a regular basis to treat and dress the wound and prescribed the person antibiotics to treat an infection. Staff we spoke with knew about the wound however this was not recorded anywhere in the person's care plan. This meant that staff new to the home may not know about it. We also saw the person had anxiety and their care plan said they sometimes shouted at other people who lived at the home. However there was no information to tell staff what signs the person might display or action to take to support the person to manage their anxiety.

People were supported to follow their interests and take part in activities. One person told us about the

activities they enjoyed and said that staff supported them with this. The person said, "I like the bowling and there is someone who comes in every other week to do motivational activities." Another person told us, "I like to read the newspaper and watch films on TV."

Staff told us they felt people were given enough opportunity to socialise. One member of staff told us, "We play dominoes, provide colouring books and play cards." However we found staff had little understanding about activities appropriate for people who lived with dementia.

People knew what to do if they had any concerns or complaints and a policy was in place. People and the relative we spoke with told us they would speak to the provider if they had a problem or concern. They told us they felt they would be listened to, however sometimes suggestions were not acted on. One person told us, "I don't have any complaints but if I did I would tell [the provider]. Another person we spoke with told us, "The provider always listens to me. I have made suggestions but I have been told that you can't chose how a place like this can be run. There are people here who are up at night and they disturb my sleep. They walk around and the floorboards are creaky. I have asked if something could be done about this and have been told no." When we discussed this with the provider, there was no record of this complaint and their response. They acknowledged they were aware of the issue but said nothing could be done as the home was an old building. However the provider did not consider other possible actions they could take, such as offering the person to move rooms if and when another came available. Staff were aware of how to respond to complaints.

Following our visits, the provider told us that the 'creaky' floorboards had been replaced. However we were unable to assess whether this improved the outcome people.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2017, there was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the provider's audit systems were not effective in identifying issues to make improvements. At this inspection we found the systems to monitor the quality and safety of the service provided were still ineffective.

There was a registered manager in post who was also the registered provider and people knew who the provider was. The provider was supported by a newly appointed deputy manager.

Since registration with the Care Quality Commission in October 2010, the provider had not consistently been compliant with regulations at this home. We have inspected the home six times. Five of the inspections found the provider non-compliant with either one or more of the regulations. There have been few signs of improvement or of improvement being sustained. This meant that people did not receive the minimum levels of care and support they should.

At this inspection we found systems and processes to monitor, assess and improve the quality and the safety of the service provided to people were not comprehensive or effective. Where shortcomings were identified; there was no clear action plan in place to demonstrate how the provider planned to address the short falls, and re-evaluate whether any action taken had resolved the issues. We could not be confident the service provided to people was monitored and assessed to ensure improvements were made for people who lived at the home and the provider had the capability to ensure people received safe, effective, and compassionate, high-quality care.

For example, at our last inspection we identified the provider had not undertaken the required safety checks in relation to the premises and equipment. Despite actions required, these had still not been effectively carried out, placing people at risk.

We found that the provider still was not working within the principles of the Mental Capacity Act when making decisions on a people's behalf in their best interests.

We found that medicine audits had failed to identify the concerns we found at this inspection. This included gaps in people's MAR charts, stock held in the home did not always match what was recorded as in stock; and staff did not follow the provider's medicine policy as 'cream charts' were not used to record when people had their cream applied. There had been two substantiated safeguarding reviews against the registered manager in relation to how medicines were managed and how care was delivered to people at the home.
This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found that the provider was not always clear about their responsibilities and they had not always notified us of significant events in the home. For example, they did not notify us of two recent safeguarding

allegations and we were only made aware of the concerns due to the local authority sharing the information with us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

People we spoke with told us they were happy living at the home and knew who the provider was. People told us that the provider was approachable. One person said, "I can speak to [the provider] anytime that I want to." A visiting relative told us, "I know [the provider] very well and I chat to them and all of the staff when I am here. I know some of the residents do too."

People who lived at the home, their relations and other visitors were given the opportunity to have a say about the quality of the service. The provider sent feedback forms to people who used the service, their relatives and health professionals annually. The results of these were analysed and shared with people and an action plan was put into place for any areas which needed addressing. Since our last inspection a further survey had not been undertaken as it was not due until November 2017 but the provider told us they planned to change the survey and undertake them on a quarterly basis.

Staff we spoke with told us they felt the service was well run and said that the provider was approachable. One staff member said, "[The provider] is fair and we can go to them, they are always there. Staff told us they would speak up if they had any concerns or suggestions and felt they would be listened to. Another staff member told us, "We have staff meetings, we can discuss problems and [the provider] tells us important things."
The provider had displayed the rating of their last inspection within the corridor of the home for people and visitors to see. Their rating had also been displayed on the provider's website.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not always notify us of events within the home that they are legally required to.

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not able to demonstrate that decisions made on people's behalf when their decision making ability was in doubt was done inline with the Principles of the Mental Capacity Act 2005.

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive their medicines as prescribed and stock of medicines within the home did not always match with what was recorded as in stock.

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse and avoidable harm as concerns were identified with the management of medicines within the home

and inappropriate end of life care.

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Risks to people's health, safety and well-being were not always protected from risks associated with premises, equipment and environment.

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to monitor and improvement the quality and safety of the service

The enforcement action we took:

We issued a notice of decision to cancel the provider's registration