Elmbank Residential Care Home Limited

Elmbank Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Elmbank Residential Care Home provides accommodation and personal care for up to 14 people. At the time of our visit there were 13 people living at the home, some of whom were living with dementia.

This inspection took place on 7 October 2016 and 7 November 2016. Both visits were unannounced.

The registered provider is also the registered manager of the home. 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.

.At our previous inspection in July 2015 we found breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found shortfalls in relation to the management of medicines and the governance of the home. Following our inspection, the provider sent us an action plan and provided timescales by which time the regulations would be met.

At this inspection we found the management of medicines and some aspects of governance had improved. However we found that the home was still not well-led and we identified further concerns and breaches of the regulations in other areas.

There were not always enough staff deployed to meet people's needs safely. People were at risk because there were not always enough staff in all parts of the home to provide the support they needed. People were not protected by the provider's recruitment procedures. The provider had not obtained all necessary information when prospective staff applied for work.

People were at risk of harm because the provider had not taken action to mitigate known risks. For example some people had been identified as at risk of poor nutrition. No referrals had been made to professionals, which meant there was no guidance in place for staff about how to meet these people's needs and keep them safe. Accidents were recorded but no action was taken following these events to reduce the risk of them happening again.

People were not adequately protected against the risk of infection as staff were not working within current guidelines on the prevention and control of infections. Some parts of the home were not adequately clean or well maintained. The environment was not designed or adapted to meet the needs of people living with dementia.

People's care was not being provided in line with the Mental Capacity Act (2005). Decisions had been taken on behalf of people without their consent or establishing whether or not they had the capacity to make decisions for themselves.

Care was not responsive to people's changing needs. Some people were consistently losing weight but no action had been taken to address this. Care records did not contain all the information necessary to ensure people received the support they needed. Where people had specific behavioural needs, there was no guidance for staff about how to manage this behaviour or provide appropriate support.

Some of the terminology used by staff to describe people and aspects of their care was inappropriate, which did not promote dignity or respect. People were not receiving a service or care that was responsive to their needs, wishes or preferences. Some aspects of care were institutionalised and did not take account of people's individual preferences. People did not always receive the support they wanted at the time they preferred.

People had access to activities but these did not always reflect their wishes and preferences, particularly in relation to going out. People who stayed in their room had little company apart form when staff delivered basic care and were at risk of social isolation.

The assessment of the quality of care was insufficient to identify shortfalls and make improvements. Accidents and incidents were recorded but there was no evidence of learning from these events or that action had been taken to prevent a recurrence. Records were not always maintained appropriately to demonstrate that people were receiving effective care.

People told us they felt safe at the home and with the staff who provided their care. Staff had attended safeguarding training and were clear about their role in keeping people safe.

The provider carried out health and safety checks and maintained appropriate standards of fire safety. There were plans in place to minimise the impact on people's care in the event of an emergency.

The provider had submitted applications for DoLS authorisations where restrictions were imposed upon people to keep them safe.

Staff had received appropriate training and attended an induction when they started work, which included shadowing an experienced colleague.

People were supported to access medical treatment when they needed it, although their health was not effectively monitored.

People were cared for by kind and friendly staff. People were supported to maintain relationships with their friends and families. Relatives were consulted about their family members' care and had opportunities to give their views.

The registered provider had a written complaints procedure and the one complaint received in the previous 12 months had been managed appropriately.

People told us they would feel comfortable raising a concern with the management team if necessary. Relatives told us the management team were approachable and available.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special

measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

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.

There were not always enough staff deployed to meet people's needs safely.

People were not protected by the provider's recruitment procedures.

People were not adequately protected against the risk of infection or other risks.

People felt safe at the home and with the staff who provided their care.

People received their medicines safely.

There were plans in place to minimise the impact on people's care in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

People did not always live in a clean, well maintained environment.

The environment was not designed or adapted to meet the needs of people living with dementia.

People's care was not always provided in accordance with the MCA.

Some people felt there was an insufficient choice of meals.

People's health was not appropriately monitored.

Applications for DoLS authorisations had been submitted where necessary.

Staff received appropriate training and support to perform their roles.

People were supported to access medical treatment when they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

Some of the terminology used by staff was inappropriate, which did not promote dignity or respect.

The care provided was not always respectful of people's choices and wishes.

People were cared for by kind and friendly staff.

People were supported to maintain relationships with their friends and families.

Relatives were consulted about their family members' care.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Some people were consistently losing weight but no action had been taken to address this.

Care records did not contain all the information necessary to ensure people received the support they needed.

Some aspects of care were institutionalised and did not take account of people's individual preferences.

People had access to activities but these did not always reflect their preferences. People who remained in their rooms were at risk of social isolation.

People knew how to make a complaint and felt comfortable raising concerns.

Is the service well-led?

Inadequate

The service was not well- led.

Quality assurance monitoring systems were not effective in identifying shortfalls.

The registered manager did not ensure that staff were working to best practice principles or current legislation.

There was no evidence of learning from accidents and incidents.

Records were not maintained to demonstrate that people were received the care they needed.

Elmbank Residential 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, to check the provider had taken action to address the concerns identified at our last inspection and to provide a rating for the service under the Care Act 2014.
We carried out this unannounced inspection across two visits. The first visit took place on 7 October 2016 and was carried out by two inspectors. The second visit took place on 7 November 2016 and was carried out by three inspectors.

Before the inspection we reviewed the action plan submitted by the provider, which set out how they planned to become compliant with the breaches of regulations identified at our last inspection. We also reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR) prior to our inspection in July 2015. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We did not ask for another PIR to be completed as we were following up on action taken in response to the concerns found at the last inspection.

During the inspection we spoke to six people, three relatives, the registered manager, the deputy manager, four care staff and the cook. Where people were unable to communicate their experience verbally, we observed the care and support they received. We checked four people's care records and other records related to the running of the home, including recruitment records, complaints and quality monitoring audits.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who provided their care. One person said, "I feel safe; the staff are helpful and friendly." Relatives told us they were confident their family members were safe. One relative told us, "I feel he is safe because it is a small home." Another relative told us, "They have 24 hour care here. I've never had the sense that [family member] is worried about anything." A third relative said, ""I've never had a concern about her safety or the way she is treated; I'm quite happy with the care she gets." Despite people's positive comments we found that people were not always protected from risks.

There were not always enough staff deployed to meet people's needs safely. People were at risk because there were not always enough staff available in all parts of the home to provide the support they needed. Many people required equipment such as walking frames to keep them safe when moving round. The walking frames were all kept in one area of the lounge or dining room away from people's reach. Staff were not available to assist people to reach the equipment or to support people to move safely. We observed one person attempt to cross the lounge independently to reach their walking frame. The person was at risk because they needed their frame to walk safely and there were no staff in the lounge to support them. Staff attended to support the person when we alerted them to this person's need.

One person confirmed that the absence of staff in the lounge sometimes put people at risk. The person told us, "There could be more staff in the lounge. They serve refreshments and disappear. Sometimes I feel like I'm an assistant carer. I get frames for people." The person told us they found it difficult to relax as they were spent their time trying to ensure people did not spill their drinks when staff were not present.

Two care staff were deployed on each shift during our inspection. The deputy manager and registered manager were also present but were not involved in the delivery of care. The deputy manager told us three people always required two staff to provide their care and one person sometimes required two staff to provide their care. We observed that, when two staff were required to support someone with personal care, there were no staff present in the lounge to supervise or support the people there. Care staff also carried out auxiliary tasks, such as laundry, which reduced the time they had available to provide the care people needed. We found that staff were not attending often enough and as required, to the two people who remained in bed for the majority of each week. They required regular checks and monitoring to ensure they did not develop pressure sores and had enough to eat and drink. The registered manager could not assure us that staff were attending to their needs as records showed gaps when staff should have been with those people.

Failure to deploy sufficient staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the provider's recruitment procedures. There was a checklist for recruiting new staff but people were at risk because this had not been followed. None of the five staff files we saw contained all the information required on the checklist. One file contained no references and two files contained one reference when the provider's recruitment procedures stated that two should be obtained.

The employment application forms submitted by some staff contained gaps in employment history. There was no evidence that these gaps had been explored by the provider to satisfy themselves of the applicant's previous conduct or experience. The registered manager was made aware of these shortfalls on the first day of our inspection but had not taken action to rectify them by the second day of our inspection. Staff files did contain proof of identity and a Disclosure and Barring System (DBS) certificate for each member of staff. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

Failure to ensure that staff employed were of good character and had the necessary qualifications, competence, skills and experience was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2015, the provider was breaching Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because safe medicines management procedures were not being followed. At this inspection we found the management of medicines had improved and the provider was meeting this part of regulation 12.

People received their medicines safely and as prescribed. All staff authorised to give medicines had attended relevant training. When staff administered medicines to people they sought their consent, explained what the medicine was for and why they needed to take it. Any changes to people's medicines were authorised by the person's GP.

Medicines were stored securely and in an appropriate environment. There were appropriate arrangements for the ordering and disposal of medicines. Each person had an individual medicines profile that contained information about the medicines they took, any medicines to which they were allergic and guidelines about any medicines they took 'as required'.

People were not adequately protected against the risk of infection as the provider was failing to adhere to current guidance on the prevention and control of infections in care homes issued by the Department of Health (DH). The home did not have a sluice and the small laundry room was not equipped to clean soiled bedding adequately. There was insufficient space to provide a soiled area for dirty items, no hand washing facilities, no disinfector for reusable items and a no clean storage area, well separated from the soiled area. The deputy manager said the absence of a sink in the laundry meant staff handling soiled bedding had to leave the room and go to the toilet next door to wash their hands.

Most of the communal bathrooms in the home contained neither soap nor hand towels. There was no soap in any of the bedrooms we checked. The deputy manager told us that commodes were emptied into toilets each day, rinsed with water, sprayed, wiped and returned to people's rooms. The deputy manager said that once a week the commodes were soaked in the bath with cleaning fluid. The registered manager acknowledged that it was not appropriate to soak commodes in the bath which people were expected to use and that the home did not have the facilities necessary to achieve acceptable standards of infection control.

People did not always receive the support they needed to have a diet that suited them but also was safe for them. Staff had carried out nutritional assessments but had not taken appropriate action where people had been identified as at risk. No referrals had been made to professionals such as speech and language therapists or dietitians and, as a consequence, there was no guidance in place for staff about how people's nutritional needs should be met or how they should mitigate the known risks for people. For example nutritional screening assessments carried out in July 2016 had identified three people as at risk of

malnutrition. No care plans had been developed to address this need and no referrals had been made.

Accidents had been recorded and there had been 15 since February 2016, mainly people falling. One person had fallen four times but there was no risk management plan in place and no action had been taken to mitigate the risk of harm for this person. Other people had experienced more than one fall but again there were no plans in place to investigate, take action or mitigate the risks.

Failure to implement appropriate measures to prevent, detect and control the spread of infections and the failure to identify and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were clear about their role in keeping people safe and were aware of safeguarding procedures. The provider had a safeguarding policy, which provided staff with guidance about the action they should take if they suspected abuse, and the local multi-agency safeguarding procedures were available in the home. Staff confirmed they had received safeguarding training within the last 12 months and that they felt able to report any concerns they had to the manager.

People had access to the equipment and adaptations they needed to meet their needs. These were inspected on a regular basis to ensure they were safe and in working order. The provider carried out regular checks on electrical and fire safety equipment. There was a fire risk assessment in place and each person had a personalised emergency evacuation plan. Staff carried out regular fire drills and had a clear understanding of what to do in the event of an emergency. The provider had put plans in place to minimise the impact on people's care in the event of an emergency.

Inadequate

Is the service effective?

Our findings

People did not always live in a clean, well maintained environment. Four of the five commodes we saw were dirty on, under and around the seats. The deputy manager said staff should clean them whenever they had been used, this had not happened and there were no checks in place to make sure the commodes were clean. Staff had removed a mattress from one bed and propped it against the wall. We saw that the mattress was badly stained. An electrical socket had come loose from the wall in another bedroom and television aerial wires were exposed. The bath panel was warped in one of the bathrooms and a toilet seat was broken. Some of the chairs in the dining room were stained. None of the bedside lights in people's rooms worked and there were areas of the home, particularly in people's rooms with poor decoration, missing paint and broken furniture.

The environment was not designed or adapted to meet the needs of people living with dementia. The carpets in the majority of rooms were strongly patterned, which caused some people to become confused. We saw one person attempting to pick up what they thought was an object on the floor but was part of the carpet's pattern. The person continued in their attempts until their relative explained that the carpet's pattern resembled an object. The colour scheme had not been designed to enable people living with dementia to orientate themselves easily, such as identifying different rooms through the use of colour.

Failure to ensure that premises and equipment were clean, properly maintained and suitable for the purpose for which they are being used was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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.

We found that people's care was not being provided in line with the principles of the MCA. Decisions had been taken on behalf of people without proper consent. The provider had not carried out assessments to determine whether people had the capacity to make decisions but had made assumptions that they lacked capacity based upon their dementia.

The deputy manager told us that all but one of the people currently living at the home lacked the capacity to make decisions. However the deputy manager confirmed that no assessments had been carried out to

establish whether people had the capacity to make decisions or whether they required support to ensure that decisions were made in their best interests.

The deputy manager told us all the people living at the home recently had a 'flu vaccination as the GP had stated this was in their best interests. However there was no evidence that people's consent had been obtained or that mental capacity assessments had been carried out to determine whether people had the capacity to give informed consent. No best interests meetings had been held to consider what action would represent the best decision for each person.

The deputy manager told us that applications for DoLS authorisations had been submitted to the local authority for all but one of the people currently living at the home. Applications for DoLS authorisations should only be submitted in respect of people who lack capacity. However no assessments had been carried out to establish whether people had the capacity to make decisions or whether they required support when decisions that affected them were being made.

People's care records contained consent forms in relation to medical and dental treatment, to taking their medicines and to the implementation of their care plans. None of these forms had been signed by the person receiving care but all contained the signatures of relatives. No checks had been carried out to ascertain that these relatives had power of attorney to make decisions on their behalf. There were 'Do Not Attempt Resuscitation' (DNAR) forms in place for two people, which represented instructions to medical staff not to attempt cardio-pulmonary resuscitation in the event of cardiac arrest. The first question on the DNAR form required the member of staff completing it to record whether the person to whom the DNAR order related had the capacity to make decisions. Staff completing the forms had recorded that neither person had capacity. However no mental capacity assessments had been carried out to establish whether the people could make decisions for themselves.

Providing care and treatment without appropriate consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives confirmed that staff arranged medical input promptly if their family members needed it. One relative told us, "She has been better since she has been here. The staff have called the district nurse and the GP today because they were concerned about her." Another relative said, "They are very good. [Family member's] leg was playing up so they sent for the doctor."

We saw that health care professionals had been called and consulted about people's health. However, people's health was not appropriately monitored. Charts to check people remained well were incomplete and the registered manager said this meant they could not assure people that staff would always notice if people's health deteriorated. This was particularly relevant for two people who remained in bed for most of the time. Although they were not currently unwell and had not developed pressure sores there is a risk their conditions could deteriorate without staff noticing in a timely way and seeking advice or treatment.

We recommend that the provider ensures people's health is monitored effectively to determine when they may require referrals to health care professionals.

Staff had received appropriate training for their roles. Staff confirmed they had attended an induction when they started work, which had included shadowing an experienced colleague until they were competent to carry out their role. The provider's records confirmed that staff had attended core training including moving and handling, fire safety, food hygiene and health and safety. Training was delivered in different formats such as online learning, training courses and certificated learning workbooks. Staff confirmed they had

regular meetings with their line manager to discuss their work and performance and records confirmed that staff had access to regular one-to-one supervision and annual appraisals.

Requires Improvement

Is the service caring?

Our findings

Some of the terminology used by staff to describe people and aspects of their care was inappropriate, which did not promote dignity or respect. People who required support to eat were referred to as 'feeds' and support guidelines referred to as 'feeding times.' We heard staff use the term 'feeds' to describe people who needed this support and a notice in the dining room set out the time at which lunch would be provided for 'feeds'.

The registered manager and deputy manager spent long periods of time in the empty dining room during the inspection. When we pointed out shortfalls in care or the environment the registered manager did not take action to see what was wrong but relied on the deputy manager. People were sitting around the edges of the lounge and spent time alone but the registered manager did not spend time engaging with them. One relative arrived and the deputy manager greeted them, they said 'hello' to the registered manager who was also in the hallway. The registered manager did not respond and turned to walk away.

People were not encouraged to be involved in making decisions about the home or their care. This was because the registered manager had made an assessment without proper guidance that people lacked capacity. Therefore decisions were taken away from them and made by staff, people's relatives or the registered manager. People were asked when they wanted to get up but there was little autonomy for people in their daily lives. People told us they wanted to go out but were unable to do so, even with staff.

There was a pervasive smell of urine in and around one person's bedroom during our inspection. We also smelt urine from one of the commodes. It is not dignified or respectful for people to live in an environment where there are unpleasant smells.

The failure to always treat people with respect and dignity was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by individual staff who were compassionate and caring. People told us that staff were kind, friendly and helpful. One person said, "The staff are very good, they do their best; some of them are amazing." Another person told us, "The staff are very kind; that makes all the difference." A third person said of the staff, "They are very good, they look after me." A fourth person told us, "Staff are caring and attentive. They look after me all right."

People were supported to maintain relationships with their friends and families. Relatives told us they could visit whenever they wished and that they were made welcome when they visited. Relatives told us staff had developed positive relationships with their family members and that staff genuinely cared about their welfare. They said staff were kind and helpful. One relative told us, "The staff are very kind and friendly. All Mum's friends and family have remarked on that when they have visited." Another relative said, "I feel staff know him well and meet his needs."

We observed examples of kind and caring interactions between people and staff. One member of staff

displayed skill and empathy when reassuring a person who had become anxious when trying to perform a task independently. The member of staff said, "Don't worry, I'm here. I'll help you; take your time." The member of staff then supported the person to perform the task at a pace comfortable to them and in a way that promoted their independence. The person clearly valued the support the member of staff had given them as they said, "Thank you so much for your help, you're very kind."

Staff were attentive to people's needs and supported them to maintain their appearance, for example ensuring their clothes were hanging correctly when they got up from a chair. Staff spoke to people in a friendly manner and ensured that personal care was provided in private. Staff provided support at a pace comfortable for the person receiving care. They ensured people were given the time they needed to consider information and make choices.

Relatives told us they were consulted about their family members' care plans and had opportunities to contribute their views. One relative said, "We are involved in any decisions about Mum's care. We can ring at any time and speak to someone. They are always well informed about what's going on with Mum."

Inadequate

Is the service responsive?

Our findings

Care was not responsive to people's preferences or changing needs. We found that three people were consistently losing weight but no action had been taken to address this. Staff had recorded these people's weights each month, which demonstrated that their weight was reducing significantly. None of these people had been referred to health care professionals, a speech and language therapist or dietitian to identify the cause of their weight loss or ways in which they could be supported to maintain adequate nutrition and a healthy weight. There was no care plan in place to guide staff about the support the people needed to maintain adequate nutrition.

The manner in which some aspects of people's care were provided was institutionalised and did not take account of people's individual preferences. There were instructions for staff about when people should receive their care, which meant people did not always receive the support they wanted at the time they preferred. For example the minutes of a staff meeting noted, "Toileting rounds for the residents should take place around 9.00, 11.00, 13.30, 15.30, 18.00." We saw a bathing rota, which gave instructions to staff about which two people should be supported to shower each day.

Some people told us they would prefer to have a bath rather than a shower but this was not made available to them. Staff said that people were supported to have one shower each week and confirmed there was a rota detailing which people would have a shower each day. This was displayed in a bathroom. One person told us, "We don't get offered a bath. The only time I was offered a bath was when the shower was not working. It would be nice ideally to have a bath but staff are really busy and we don't have time." Another person said, "I'm waiting for a shower but I'd prefer to have a bath." The person repeated this statement when a member of staff arrived to assist them but the member of staff did not comply with this request and supported the person to shower.

Some people said they enjoyed the range of food provided but others told us there was an insufficient choice of meals. One person said, "The food's not bad, they do pretty well. It's hard to please everyone." Another person told us, "We get good food here." People who were dissatisfied said there was only one hot meal option at mealtimes and this restricted their choice. One person told us, "There's not much of a choice. It's a hot meal or a salad and I don't like salad. Some of the hot meals I like, some are very good, but some I don't. I do my best to eat it if I don't like it." Another person said, "Supper is always sandwiches or soup. If it was possible I would like a hot meal in the evenings." The cook confirmed there was one hot meal option and a salad or sandwich option at mealtimes. We saw the cook asking people for their lunchtime preferences by showing them pictorial representations of the hot meal and a salad.

Care records did not always contain all the information necessary to ensure people received care that was responsive to their needs. People's needs had been assessed before they moved in to ensure that the staff could provide the care and support they needed. Following this assessment, a care plan was developed in the areas where people needed support.

We found that the information recorded in respect of some people was incomplete, which meant there was

insufficient information for staff to respond to their individual needs. For example some people's care records did not contain information about their medical history, physical and mental health needs and potential risks to their safety. Where people had needs arising as a result of their dementia, these needs had not been taken into account when planning their care or recording the support they needed. One person exhibited behaviour that challenged the service but there was no guidance for staff about how to manage this behaviour or provide appropriate support for the person.

People had access to activities but these did not always reflect their wishes and preferences, particularly in relation to going out. Some people told us they enjoyed the activities on offer in the home but others said they would like the opportunity to go out more. They said they did not have opportunities to go out unless their relatives visited and took them out. One person told us, "I would like to go out more and get my legs moving. I feel my walking is not as good as it was as when I first came in." another person said, "We play chess and a big snakes and ladders. There are no trips out, though. I would like to do trips that would be nice." When asked, the registered manager said they offered people trips out in the summer. We asked when the last trip had been and the registered manager said "Not this summer, yes there should be more for people to do."

Where people's ability to participate in communal activities was affected by their dementia, there was no evidence that their needs were considered. Staff recorded the activities in which people took part and we found that for one person with dementia, staff had recorded either 'missed activity' or 'unable to participate' each day. People who were cared for in bed were at risk of social isolation. They were unable to participate in group activities but there was no evidence that staff spent time with them in their rooms engaging them in activities or spending time with them on a one-to-one basis.

Failure to provide care and treatment in a person centred way that takes account of service users' preferences and needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had an activities co-ordinator who arranged a programme that included bingo, board games, arts and crafts and exercise sessions. One the second day of our inspection, one member of staff engaged people in a reminiscence exercise, which they clearly enjoyed. The activity generated animated conversation in which several people took part. The member of staff was skilled at involving people, asking follow up questions and expressing interest in people's recollections.

People knew how to make a complaint and told us they would feel comfortable raising concerns. One person said, "If I was unhappy about anything I would tell them [staff]." Staff had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the provider would take any complaint seriously. The provider had a written complaints procedure, which set out how complaints would be managed. The complaints procedure was displayed in the home and provided details of agencies people could contact if they were not satisfied with the provider's response. We checked the complaints record and found that one complaint had been received in the previous 12 months. This complaint had been investigated and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2015, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems in place to monitor the quality of care or drive improvement. Staff had not been well supported and shortfalls in staff training and care documentation had not been identified or addressed.

At this inspection we found the support provided to staff had improved. Staff had attended appropriate training and received regular one-to-one supervision and an annual appraisal. However other concerns regarding the management and leadership of the home remained.

Since mid-October 2016 the registered manager had been spending part of each day at another care home owned by them as it did not have a registered manager. This had had an impact on the management and monitoring of both homes. During feedback at the end of the inspection, the registered manager acknowledged they had failed to identify the shortfalls related to the environment, cleanliness, infection control, care plans and records. The registered manager agreed that they did not have all the knowledge required to ensure that staff were working to best practice principles or current legislation. For example the registered manager did not have an understanding of the MCA and DoLS, which meant people had not been supported in accordance with this legislation.

Risks to people's safety were not always addressed. Accidents and incidents were recorded but there was no evidence of learning from these events or that action had been taken to prevent a recurrence. The registered manager had introduced a form to record how many accidents happened each month. Since February 2016 15 accidents had been recorded, principally people falling. The registered manager told us they had drawn up an action plan to address any factors contributing to accidents but was unable to produce it when we asked to see it. The registered manager then said they had not yet drawn up the action plan but planned to do so.

Records were not always maintained appropriately to demonstrate that people were receiving effective care. Two people who were cared for in bed needed to be repositioned every two hours to prevent pressure ulcers. Staff had implemented charts to record when these people had been repositioned but we found gaps in recording, including whole nights where no repositioning had been recorded. There was no evidence that these people had developed pressure ulcers but their records failed to demonstrate they were receiving the care they needed to prevent them. The registered manager confirmed that these people should have been repositioned every two hours throughout the day and night and acknowledged that they could not be sure they had received the care they needed.

Where people were at risk of dehydration or malnutrition, staff had implemented food and fluid charts but we found these were not always completed accurately, which meant staff could not be sure the person had received the support they needed. One person's charts recorded no foods or fluids at all on two days in the previous month and there were gaps in recording on six other days that month. Some records were completed retrospectively, which meant staff could not be sure they were accurate. One member of staff

told us they often recorded what people had eaten several days later. The member of staff said they did not doubt the accuracy of the records as they had a good memory. The registered manager told us they were not aware that staff completed records retrospectively and agreed that this was not appropriate. Minutes of staff meetings held on 23 September 2016 and 27 October 2016 demonstrated that the registered manager was aware care documentation was not up to date.

Staff maintained daily records of the support provided to people but these were not sufficiently detailed to fully and accurately reflect people's experience of the care they received. Daily records detailed the care tasks staff had carried out but there was no information about people's mood, well-being or the interactions they had experienced with others. The registered manager did not have an effective system for checking records were accurate. There were some notes in care files where gaps had been identified and staff needed to update them. However, no action had been taken to check the amendments had been made or to recognise when staff were not completing monitoring forms, such as food and fluid charts.

Failure to assess, monitor and improve the quality and safety of the service and failing to maintain accurate, complete and contemporaneous records was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had opportunities to have their say at residents meetings. People told us they would feel comfortable speaking with a member of the management team if they had a concern. One said, "The manager is very good, she always makes sure that my wife and I are okay." Relatives told us the management team were approachable and that they could speak with them whenever they wished.

The registered provider was aware of the requirements in relation to the Care Quality Commission (CQC). The manager had notified CQC where necessary about important events the service is required to send us by law.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to provide care and treatment to people that was appropriate, met their needs and reflected their preferences.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that people were always treated as individuals and with respect and dignity.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure that appropriate consent had been obtained for care and treatment.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to do all that is reasonably practicable to mitigate risks to people or to implement appropriate measures to prevent, detect and control the spread of infections.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure that premises and equipment were clean, properly maintained and suitable for the purpose for which they are being used.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to adequately assess, monitor and improve the quality and safety of the services provided or to maintain an accurate, complete and contemporaneous record in respect of each person.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to ensure that staff employed were of good character and had the necessary qualifications, competence, skills and experience.

The enforcement action we took:

We have removed the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to deploy sufficient numbers of staff to meet people's needs.

The enforcement action we took:

We have removed the providers registration