Four Seasons 2000 Limited

Burgess Park

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

Burgess Park is a nursing home that provides accommodation and personal care for up to 60 people, some of whom are frail and live with dementia. At the time of the inspection there were 31 people living at the service.

We carried out a comprehensive inspection at this service on 17 December 2015, and rated it as requires improvement. At that time we found two breaches in regulations for safe care and treatment and good governance. We asked the registered provider to send us a plan to tell us what they would do to meet legal requirements. We did not receive the action plan.

We carried out a focussed inspection on the 13 September 2016. We did not look at all of the Key Lines of Enquiry under each key question. We followed up on the breaches of regulations to see if the registered provider had made improvements to the service. At the last inspection on December 2015 we asked the provider to take action to make improvements for safe care and treatment and good governance. We found for safe care and treatment this action has been completed. However, we found the provider was in continued breach of good governance. We also found new breaches of staffing and person centred care. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. You can read the report from our last inspection, by selecting the 'all reports' link for Burgess Park on our website at www.cqc.org.uk.

This comprehensive inspection was carried out on 23 and 31 January 2017 to check that the registered provider had followed their plan and to check that they now met the regulations inspected. During this inspection, we found evidence that the provider had made some improvements. We found that the breach in relation to staffing was now met. We found a continued breach of good governance. We also found new breaches of safe care and treatment and need for consent. We found that further action is required to meet all the regulations we inspected.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider was recruiting for a home manager. There is an interim manager at Burgess Park supporting the service whilst a permanent manager is recruited.

People did not receive safe care and treatment that met their needs because staff had not acted to manage them. People's health conditions were not managed well and they were at risk from deterioration of their health. Staff had not always followed health care professional's advice and recommendations to manage people's health needs effectively.

People did not have their medicines provided to them in a safe way. We found examples where staff did not

administer medicines to people a way that helped maintain their health.

The quality assurance systems in place did not identify the areas of concern we found. The provider's governance systems and audit systems were not always well organised. People did not receive safe quality care because the governance systems did not identify any concerns with the service.
People and their relatives, gave feedback to the provider about the quality of care they received. However, we found that the quality of care experienced did not match our findings at the inspection.

Assessment identified people's care and support needs. These were completed with people and their relative. A plan of care was developed in order to provide guidance for staff to meet those assessed needs. However we found that reassessments of people's needs did not take into consideration new health needs. Risks to people's health and well-being were not always identified and used to plan their care.

Activities for people did not always meet their preferences or hobbies. The activities provided did not meet the needs of people with dementia or people who do not have English as their first language.

Consent to care was not always obtained by staff. Staff did not have an understanding of how to apply the principles of the Mental Capacity Act 2005 (MCA) to support people effectively in a way that was safe. People are not supported to have maximum choice and control of their lives.

People told us that staff showed them compassion and respect when supporting them. People and staff engaged and knew each other well. We found that staff did not always treat people with dignity in the provision of care.

There was sufficient staff to meet people's care and support needs. The manager followed the registered provider's staffing planning tool using the staffing level as recommended.

Training, supervision, and appraisals supported staff in their jobs. Resident experience managers supported staff through identifying their strengths, and to support them with their professional needs.

Food and drink provided met people's needs and preferences. People told us they enjoyed their meals and they were able to choose meals they wanted from the menu provided.

There was a complaint process in place. This enabled people to make a complaint about an aspect of their care and support needs. People were aware of the process to follow if they wanted to raise a complaint. People and relatives we spoke with shared with us varied views of the service and the care they received.

Staff received support from the manager, the regional manager and three of the provider's managers who currently provide leadership and management support at the service. Staff told us that the manager was open and transparent. The manager provided opportunities for staff to speak with them and have their concerns listened.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This is because the service is Inadequate in two key questions.

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 be 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.

This service has now remained in Special Measures for over 12 months. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. CQC is considering the appropriate regulatory response to resolve the problems. We will report on action we have taken in respect of this when it is complete. If the service has demonstrated improvements when we inspect it and it is no longer rate as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Risk assessments and management plans were in place for people. However staff had not always followed guidance to manage the recurrence of risks.

People's medicines were not administered to ensure people received them safely.

There were sufficient numbers of staff to provided care and support to people.

Safeguarding processes were in place to protect people from harm and abuse.

Is the service effective?

Requires Improvement

People had access to health care services when required. However staff did not always follow professional recommendations and guidance.

People were not always supported to consent to care and support. Staff did not always have an awareness of supporting in line with the principles of the Mental Capacity Act 2005 (MCA) to keep them safe.

Meals were provided to meet people's needs and preferences.

Is the service caring?

Requires Improvement

Activities for people did not meet their preferences or needs. Staff knew people well and understood their preferences and wishes. People were not always treated with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not have activities that net their needs and preferences.

The registered manager had a complaint system in place for people to make a complaint about the service.

Is the service well-led?

Inadequate

The service was not well led. The service undertook regular quality audits but these did not identify and act on the concerns we found.

The service was managed by an interim manager with the support of other provider's managers. People were unclear of who was managing the service.

Staff told us that the manager listened to their concerns and acted on them as able.

Burgess Park

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 31 January 2017and was unannounced. We carried out this inspection over two days. On day one, two inspectors, an inspection manager and an Expert by Experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, three inspectors carried out the inspection

Before the inspection, we looked at information we held about the service, including notifications we received. We also reviewed the action plan we received about the service on how they intended to improve the service. During the inspection we spoke with 16 people five relatives, the regional manager, the manager and two resident experience managers who were providing additional management support to the interim manager. We also spoke with two nurses, seven care workers, a visiting health care professional, and the maintenance worker.

We used general observations and the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed people in the communal areas and the general environment of the service.

We reviewed 10 care records, 10 staff records, audits, health and safety records and other records for the management and maintenance of the service.

After the inspection, we contacted five health care professionals, commissioning and safeguarding officers from the local authority.

Inadequate

Is the service safe?

Our findings

At our previous inspection on September 2016, we found that the service was not safe. Staffing levels were not sufficient to meet people's needs safely. The manager of the service did not follow the provider's dependency tool on the day we visited. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, people we spoke with and relatives told us that the service was safe. One person told us "I feel safe here yes, the staff make me feel safe to be honest with you." A second person said, "Oh yes, I do feel safe here, I like it." A third person said, "Yes I do feel safe, I have no problem about feeling safe here." Another relative said, "I would say so yes, my [relative] is very well looked after here" However we found that the service was not safe in all areas.

We found that the registered provider had made some improvements in relation to staffing levels at the service. Records showed and we saw that there were consistent numbers of staff on duty. This followed the registered provider's recommendations from their dependency staff tool. People were cared for by sufficient numbers of staff to meet their needs. The views and experiences of people differed concerning the levels of staff available to support them. A person said, "Well staff do try, but I don't think there is enough staff." Another person said, "Not enough, I am honest." A third person said "At the moment they are a little bit short staff and reason being this morning they took a while to get me up from bed and to wash me." A fourth person said "Thank god I can still go to the toilet by myself. But to have a shower it is difficult because I need it every day but they don't have staff for that." A relative said "I think they are OK with staff."

Staff shared with us their experiences relating to sufficient staff. Staff told us staffing levels had recently improved. This included new recruitment, a more stable team and lower levels of sickness and staff turnover. One member of staff told us it was easier to provide care now there were fewer people living at the service. Staff we spoke with had said that the ratio of staff to people was working well. We found people were cared because there were enough staff on duty to meet their care and support needs.

Risks to people were not identified and managed safely. We found examples were the risks to people were not managed well. People's weights were recorded on a monthly basis. However, for one person we noted the last weight recorded was on October 2016. The person was being nursed on pressure relieving air mattress. The person's weight needed to be recorded each month to ensure the air pressure setting was appropriate for them. The setting on the mattress did not correspond to the person's weight. We spoke with the nurse on duty who confirmed the current setting did not correlate with the readings staff had been recording on the air mattress monitoring sheet. The person was weighed and the air mattress pump was then set to the correct setting. The person's care records stated they were at very high risk of developing pressure ulcers because of their medical condition. They were at risk of developing pressure ulcers because they were on a mattress which was at the wrong setting for their needs and not appropriate. Staff had not acted to protect the person from unsafe care.

Staff had not taken health care professional's advice so people received safe care. A person required

specialist support with their nutritional needs. We discussed these needs with staff who told us they had changed a person's tube feeding plan. Records showed this change happened without consultation with a dietician. The nurse on duty could not explain why staff had replaced the feeding plan without the advice of the dietician. The person was at risk of poor treatment because specialist advise was not sought to reduce risks. This meant that staff had not acted safely to manage and reduce deterioration of people's health condition.

We found people's risk assessments were not always accurate. For example, one person's medication needs care plan stated they had been diagnosed with type one diabetes. However, the assessed needs section of the same care plan stated the person had type two diabetes. The person was at risk from unsafe care because their health condition was not clearly recorded so staff could care for them safely.

We found another example where staff had incorrectly completed a choking risk assessment. Staff had identified the person's choking risk as low when it should have been medium because of their health condition. Although the person had a nutrition care plan, this was based on the incorrect choking risk assessment. The person was at risk of harm because staff following the incorrect guidance increased the risk of choking and deterioration in their health.

People's medicine were not always managed in a safe way. On two occasions we found that a person was given the wrong dose of medicine from the 13 January to 30 January 2017. We also found that on two occasions blood tests were not taken when due. The result from blood test would determine the dose of Warfarin a person should take. Records showed that on one occasion blood tests were taken a day later and on the other occasion staff said that there were due to take a blood test later that day. This was also one day later than required according to the person's care records. There was a risk to the person's health because they did not have their required medicine given to them at the correct dose to maintain their health.

People's medicine care plans were not updated to reflect changes in medicines. The medicine care plans were reviewed on a monthly basis and was used to record people's medicines including any changes. However, we noted a person's care plan had not documented a change in medicine from October 2016. This change was not reflected in the medicines monthly review in November 2016. There was no documentation detailing why this medicine change occurred however the medication administration record (MAR) had been amended according to the GP's wishes and these showed the person had the correct medicine. There was a risk of unsafe management of medicines because the information was not accurate.

People were at risk from medicines that were not stored according to the manufacturer's recommendations. We saw the pharmacy had carried out a medicine audit for January 2017, they commented that there were dates when the fridge temperatures were also not recorded. They made a recommendation for these checks to be carried out each day. Staff had not acted on those recommendations. We noted when fridge temperatures were recorded these were within the recommended temperature range. However, we noted recordings were missed on nine days. The missed dates were between 14 January and 30 January 2017. This meant that there was a risk that staff had on occasion administered medicine that may have been stored in sub-optimal conditions. We noted people's insulin was stored within this clinical refrigerator. Medicines may lose their effectiveness if they become too hot or too cold at any time and storage outside of the recommended temperature range of between 2-8 degrees Celsius may speed up loss of potency.

We noted the home did not have an up to date British National Formulary books (BNF). The BNF is a medicine reference book, which is updated every 6 months to include new information such as side effects and contraindications of medicines. Relying on an out of date BNF is potentially unsafe practice. We were concerned that updated risks associated with medicines were not known by staff because the BNF was out

of date. This increased the risk that side effects of medicines would not be known or managed appropriately.

People lived in an environment that was not always clean. Communal areas of the home were not always well maintained, clean and hygienic. For example, the dining room on the second floor was visibly dirty and in poor condition including damaged blinds and a cracked window. A cabinet used to store condiments used for meal times was dirty and sticky. In addition, we saw cobwebs and dead insects lined the top of the window blinds. Cobwebs were also on the ceiling lights in the ground floor lounge library. This indicated the cleaning schedule was not thorough and did not include high-level surfaces and fixtures. Two toilets on the ground floor offered wheelchair access for people and their visitors. Both toilets were in a state of disrepair with missing panels under the sinks, which meant plumbing was exposed. This area was dusty and in one toilet, a panel with an exposed nail had been left lying adjacent to the toilet. This presented health and safety and infection control risks. We also found the hand gel pump on the second floor not to be working so people and visitors did not have facilities to clean their hands when required. We raised our concerns with the manager who told us the maintenance worker was carrying our repairs in the toilets.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the provider's safeguarding policy to keep people safe from harm and abuse. Staff understood the types of abuse and spoke to their manager about safeguarding allegations. This meant that people could be confident that staff would act to protect people and keep them safe from abuse. The manager understood their responsibility in managing allegations of abuse promptly.

The registered provider had a whistle-blowing policy in place. This gave staff guidance to raise concerns about the quality of care. The guidance allowed staff to report poor care or bullying at the service. One member of staff said, "I don't care if I saw something that wasn't safe I would report it."

Requires Improvement

Is the service effective?

Our findings

People lived in a service that was not effective. We found that staff did not always take advice from health professional's when people's health care needs changed. The service did not always follow recommendations from healthcare professionals. We found that a tissue viability nurse had reviewed a person's wound care and pain management needs. The tissue viability nurse had monitored the person's wound care but noticed that the person was experiencing pain when their dressings were being changed. In August 2016, they suggested to staff to make a referral to the palliative care team to assess the person's pain management. Although the referral was made to the palliative care team, this had not been followed up. In the meantime there was a risk the person remained in pain because there was no pain assessment in place for them to monitor their level of pain. We found that people did not always have their levels of pain assessed and managed well. The nurse told us that the palliative care team would be contacted in order to perform a pain assessment and review pain medication. At the time of writing the report we did not receive an update on whether the palliative care team had reviewed the person's pain management needs.

We found another example were staff had not acted promptly on behalf of people. The tissue viability nurse was asked to assess and advise on dressings in August 2016. Records showed that the wound had deteriorated since this visit and staff had not acted to request a reassessment of the person's wounds. This meant that people were at risk of poor care because their care needs were not reassessed and managed safely.

Staff had not acted promptly to follow up health concerns with healthcare professionals. A person had sustained a fall at the service and was taken to hospital for an x-ray. We found staff had not followed up on the results of that X-Rays to ensure the person received appropriate care and treatment. This meant that the person was at risk of unsafe care because staff had not sought feedback from health care professionals appropriately.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave their consent to receive care and support. Records showed that people gave verbal and written consent, which were decision specific. Consent to care or the use of photographs in care plans was not always documented. For example, in two care plans a photograph of the person had been attached to a consent sheet but this was unsigned and undated. The forms used to record consent to care were also blank. When people were unable to consent to care their relative would complete this on their behalf. People with the support of their relatives made choices on the care and support received.

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 so that they can receive care and treatment when this

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that one person did not have a mental capacity assessment to establish whether they could make a health care decision. They had previous MCA in place that supported the DoLS applications to a 'supervisory body' for authority. Staff had not completed a new MCA to assess the person's ability to make a health care decision. There were no records of a best interest meeting decision because staff had not consulted with the person's relatives involved in their care. This meant that people and their representatives were not provided with appropriate health care information to enable them to make an informed choice of their care and treatment.

These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had access to healthcare support when needed. One person said, "I can see the doctor whenever I want to." Another person said", Oh yes, the manager or the [care worker] would sort everything out." A third person said, "Of course, I can see a doctor when I want to." Another person said, "Well yes, I can just tell my relatives or one of the [care workers] and they would sort it out." A relative told us "Yes, I think dad can see the doctor, maybe I need to speak to the manager, but I am sure it is alright." The GP reviewed people's healthcare needs on a regular basis. Each month a meeting was held with a multidisciplinary team (MDT) that had a social worker, occupational therapists, physiotherapist the nurse in charge and a consultant physician. The aim of the MDT meeting was to review people's care and support and make changes where required. When people needed specialist health care support staff made a referral for advice. We found some examples of effective multidisciplinary working. For example, one person with a trial package of care received coordinated support from a social worker, speech and language therapist, dietician and physiotherapist. Care records showed the multidisciplinary team worked with care staff to establish the needs and goals of the person and to support their achievement. However, we found this approach was not always consistent.

Staff were supported with their training, supervision, and appraisal needs. People and their relatives told us, staff had the skills and experience to do the job. Staff supervision records showed they had regular meeting with their line managers. Staff one-to-one supervision meetings were held with the resident experience manager or their line manager. Staff told us that they were able to explore any concerns they had with their role, care and support and team issues. Actions from previous supervision meetings were followed up for example when staff had requested changes in the staff rota.

The registered provider supported staff through regular training. Staff completed training relevant to their role and it included safeguarding adults from abuse, moving and handling, dementia care and medicine management. Staff undertook training that was E-learning based and face-to-face training. Staff told us that they enjoyed the training, staff showed us the schedule for the next available training that was on person-centred care.

Appraisals took place annually and were completed as required. These identified staff professional development needs. Individual staff goals were set which identified things they wanted to achieve in their role, for example, additional training that was not offered through the mandatory training.
The support provided staff opportunities to increasing their knowledge and be supported by the registered

provider.

People had meals, which met their needs and preferences. People we spoke with told us that they enjoyed the meals provided. One person said, "The food is good to be quite honest with you, I get enough drinks during the day and the carers know exactly what I like or dislike which makes it a lot easier". A second person said, "Food is alright, I like fish and chips on Friday". A third person said "Food is food, but I do like it the Chef is doing a good job". A fourth person said, "Nothing to complaint the food is really good, and of course they know what I like or dislike". However, one person said, "The food doesn't suit me." Another person said, "The food is terrible here, frozen foods mainly." People were able to choose a meal they liked if the one of offer did not suit their needs.

A daily menu was on display in each dining room and people were able to make special requests. We observed a lunch service on the second floor of the home, where most people ate lunch in their bedroom. People had food adapted to their health needs and tastes, including for soft diets and vegetarian diets. Staff spent time with people to encourage them to eat and demonstrated knowledge of each person. A varied and nutritious menu was prepared, and checked for any specific dietary requirements for example soft, purée or solid food, which applied to some people.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind, caring, and respectful. One person told us "Oh yes, staff are caring, I don't have any complaints, they look after me very well." Another person said, "I like them, they are good people". A third person said, "[staff] are very caring, kind and compassionate towards me." A relative said person said, "Really caring, I could not ask for anything else." Another relative said, "Oh yes the staff brilliant, I think they do a good job and mum likes them too."

However, we found staff did not always treat people with dignity. Although we saw that staff and people communicated well and they were able to have conversations and shared laughter. Care and support was carried out in the privacy of people's bedrooms this helped to protect their privacy and dignity. Nevertheless, there were occasions were staff did not treat people with dignity. This included when staff had not supported a person to have a shower when they requested. The person told us "Thank god I can still go to the toilet by myself, but to have a shower it is difficult because I need it every day but they don't have staff for that." Staff told the person that they did not have time to help them with a shower as they requested. There was another occasion where a person's wet continence pad was not changed in a timely way after they had asked staff to support them with this. They told us "My pad was changed at 5am it is now 11.30am, the blue line has gone from the pad [indicating that] it needs changing. I have called the staff and they don't come." We found that people did not have their dignity maintained because staff did not ensure they dignity was always maintained.

Staff worked with people to reduce their anxiety about their care and adapted to changing conditions. For example, one person had moved into the home after experiencing a fall and reduced mobility. Staff documented in their daily notes that this made the person worried about another fall when working with a physiotherapist. Staff worked with relatives to plan the care and rehabilitation of people after they left the home. For example, a physiotherapist and care workers in the home worked closely with the family members of a person who had experienced a sudden decrease in their mobility and who needed help to consider adjustments at home. Staff reminded them about how much they had accomplished in their life and how they could overcome this problem with their mobility. This helped reduce the person's anxiety and motivated them.

People and their relatives were involved in decision about their care. One person told us "I know about my care plan yes, but I have not read it, to be honest my family takes good care of that." Another person said, "I leave that to my family members." A third person said, "My daughter is and I am glad about that to be honest." A relative told us, "Yes, very much so." Another relative said, "I care a lot for my mum and I am the one responsible for everything."

People were encouraged to maintain relationships that mattered to them. Friends and relatives were visited the service to see people when they chose. Relatives said that they were able to come and share a meal if they chose.

People received care and support at the end of their lives. We found people had concise end of life plan.

These records showed that health professionals from the palliative care team was involved in the person's care. The palliative care team ensured the person was comfortable and pain free. Care records including the person's daily food and fluid chart was completed by staff appropriately. The person was being nursed on an air mattress, which was being checked daily and was at the correct setting for her weight. Staff monitored the person's skin and recorded any changes on a daily basis. This was to ensure the person's skin remained intact. This meant that people were cared for in a way that took their needs and wishes into consideration at the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection of September 2016 we found that the provider had breached the regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not have activities that met their preferences or needs. We observed that one person who did not speak English did not have activities tailored to their needs. We also found that people who were unable to leave their bedroom due to frailty did not have individual social activities as identified in their care records. The service did not develop strong links with the local community to reduce the social isolation of people living in the service. We recommended that the service seek advice and guidance from a reputable source, regarding how to provide social activities for all people using the service. We found that the registered provider had not taken action on the recommendation.

At this inspection, we found that people were not encouraged to participate in a wide range of activities of their choices. The views of people varied. One person told us "I like to read and do sing along by myself, I don't think I get bored because I can do things myself." Another person said "Yes, not too much to do, but I think it's enough." A third person said, "I don't think they do much here, I like to watch TV and play on my phone." Another relative said, "I don't think there are enough activities." A third relative said, "People here need extra incentive for activities."

We found people who were scheduled to have individual activities did not always have these activities provided. One person told us "I have not been out of my room since Christmas. I only leave here if I am going to a hospital appointment. I would like to go out but I am not asked." Staff told us that the person often changed their mind and did not want to use their wheelchair. Care records did not show how staff encouraged the person to use their wheelchair or what activities they took part in whilst in their room.

Activities provided at the service did not meet people's preferences. When we visited we saw a care worker in the lounge playing a floor game with people. We noted that some people were not engaging in the activity and others were asleep. This meant that the activities provided did not meet people's interests because some people did not take part in them. There were no structured activities for people who were unable to leave their bedrooms.

We spoke with the manager about our concern of the lack of social activities for a person who did not speak English as their first language. They told us they had contact with a community organisation to make a referral for this person. However this request was not followed up with other local community groups that could support the person. We discussed the availability of activities with the manager at our previous inspections in July 2015, December 2015 and September 2016. We were told that there were two activity co-ordinators, one was recently employed at the service and had not worked at the service yet. The other activity co-ordinators had recently returned to work and had not developed the activity programme for people.

It was not always evident that people were supported to maintain an awareness of their environment. For example, one person had a whiteboard in their room that was used to remind them of the day and weather.

We saw this had not been updated for three days and so had inaccurate information displayed. The person's care records recorded that they had reduced mental cognition. There was a risk of increased disorientation and in their level of confusion.

These issues were in breach of regulation 9 (CQC Registration) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Assessments were completed of people's care needs to ensure the service could meet their needs. Assessments involved people and their relatives to ensure their views and opinions, likes and dislikes were captured in their assessment. Care plans used information from assessments to provide guidance for staff to support people. People's care records included their personal histories and their likes and dislikes. Each month staff reviewed people's care records. This demonstrated that people's care needs were looked at and updated. However we found that not all care records were updated with all relevant information, for example we saw that the person's medicine care plan had not reflected the change in their medicine.

There was a system in place to manage complaints received. One person told us "Oh yes, staff caring, I don't have any complaints, they look after me very well." The manager ensured complaints were managed in accordance to the registered provider's complaint policy. People who raised a complaint had them managed and resolved appropriately. Relatives we spoke with told us that they raised any concerns with staff on duty; these issues were resolved and therefore did not need to make a formal complaint.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on September 2016, the service was not well-led. The quality assurance systems in place were not effective because it did not identify the areas of concern we found. People and staff told us the manager of the service was not open and approachable. They told us when they wanted to speak with her she was not available at the service. People were at risk of receiving inappropriate care because staff did not review and monitor care records for their effectiveness and accuracy. These issues were in breach of regulation 17 (CQC Registration) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found governance systems in place did not identify the concerns we found on the quality of care we found. The governance systems in place did not review and monitor the quality of care records for their effectiveness and accuracy. We found care records were not always accurately updated. For example, we found that staff had not completed the repositioning chart at the required intervals of 4-6 hours for two people. This increased the risk of pressure ulcer development because staff did not record people had been repositioned appropriately.

The provider's medicine audit tool had not identified the concerns we found with the management of people's medicines. We found records to manage people's medicines were not always accurate. We found gaps and medicine administration errors in two of those records. We also found people did not have their medicines at the correct dose. The clinical fridge temperature was not taken and recorded regularly. We also found changes in medicines were not always recorded in the medicine care plan. The registered provider's medicine audit had not identified these issues we found. This increased the risk of poor medicine management for people and their health care needs not being met.

We found care records were not organised well. During the inspection we wanted to look at completed care records for people. This task was time consuming because people's care records were not located in one area of the service. We found that people's care records had information held over a number of care records held within the service. For example, people's weights and wound management records were held in different files. The manager had used agency staff and had newly employed staff who were unfamiliar with the service and people's care records. The disorganised filing system for people's records were concerning because these staff would have difficulty in locating these records. We found that requests from health care professionals were often lost between staff on duty. We found staff had not taken action to support people because staff had not always followed up on requests. This increased the risk of staff not providing appropriate care that met people's needs.

Over the past seven inspections of this service we have found several breaches of the 2010 and 2014 regulations since 2013. We found the same or similar breeches in regulation were the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place. This service had now been in 'special measures' for over 12 months because it has been rated 'inadequate' in at least one key question. CQC is considering the appropriate regulatory response to resolve the breach of regulation we found. We

will report on action we have taken in respect of this breach when it is complete.

These issues were in breach of regulation 17 (CQC Registration) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Staff told us the manager of the service was open and approachable. They told us they made themselves available at the service. Staff told us that they were confident in speaking with the manager because their concerns would be listened to and acted on. One member of staff said, "[manager name] is good, he listens and understands us better." Another member of staff said, "There is also [another manager]. She is good and takes time to listen to us. She also helps us out when we are short [staffed]."

A resident experience manager was based in the home on a temporary basis to provide support and guidance to staff following the departure of the previous manager. Staff spoke positively of this strategy and told us the manager had improved working conditions and morale. One senior care assistant said the support manager had explained the plans for the home in a recent one-to-one meeting and they felt reassured about staffing levels going forward. Staff also spoke positively about the home's interim manager and said he was approachable and supportive of the team. One care worker said they felt the team was more stable and that it was clearer to see how they could get support when they needed it.

Staff attended regular team meetings to discuss any issues related to their caring roles. We saw there were regular 'flash meetings' and 'head of department' meetings. A review of the service took place and any follow up actions staff needed to take to resolve any concerns promptly. For example making a referral to the GP.

People and their relatives met with the manager at the service. People were able to discuss concerns with the service with the manager. People told us that the manager listened to their views. People we spoke with told us that they enjoyed living at the service and said staff were caring,

The manager confirmed that CQC were made aware of any issues or concerns at the service. The provider notified us promptly of any incidents as they are required to do we could take appropriate actions.