Norma Martin Care Homes Limited

Regency 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?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was undertaken on 20, 21 & 26 October 2015 and was unannounced. We brought this inspection forward because we received concerning information about the health and welfare of people at the home. This information suggested that people's health needs were not being managed appropriately.

The Regency is registered to provide accommodation for 15 older people who require personal care. There were 14 people living at the home at the time of the inspection.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers,

Summary of findings

they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We last inspected this service in March 2015 and the service was rated as 'requires improvement'. We found the provider was not meeting one regulation in relation to the safe management of medicines. The need for improvement was identified in relation to meaningful occupation and stimulation, as there were limited opportunities for people to take part in activities. We also found that care records did not always reflect whether care and support had been effective.

CQC received an action plan from the provider on 8 June 2015. This contained information about the action the provider would take to address the issues we raised at the last inspection. During this inspection we found improvements had been made in respect of the safe management of medicines. However little or no improvements had been achieved in relation to activities or care records.

Devon County Council implemented a safeguarding process in August 2015 following concerns raised with them about one person. During their investigations additional concerns about the care and welfare of people at the service were found. Placements to the home were suspended by commissioners on 8 October 2015 as a result of the safeguarding concerns. The provider had agreed to suspend the admission of privately funded people until the conclusion of the safeguarding process.

During the safeguarding process the service is being monitored through a combination of visits by social services staff and the community nursing team, as well as regular multidisciplinary safeguarding strategy meetings.

The Commission had also been made aware of an incident that had occurred at the service which was being investigated by the police. We will continue to liaise with the provider, police and safeguarding strategy meetings on this matter. Part of this inspection considered matters arising from that incident to see if people using the service were receiving safe and effective care.

This inspection found that although people and their relatives told us they were happy with the service, there were significant concerns about how the service was being run and managed. Improvements were needed in several areas where the provider was not meeting the requirements of regulations.

Management and staff in the service had failed to recognise poor practices and had not made referrals to the appropriate agencies, such as the local authority safeguarding teams, when this was needed. This had left people at risk and had not protected them from harm.

Due to staffing levels, practices within the service had become 'institutional' and not person centred or person led. This meant that some people were not always given meaningful choices in relation to their daily routines.

The environment had not been maintained to a high standard. Health and safety risks were not adequately assessed and account had not been fully taken of how the environment should meet the needs of people using the service.

Risks to people using the service were not always identified and some risk assessments were not detailed. They did not contain the information required for care staff to know how best to support the person.

Health professionals were consulted about people's health needs. However records were not always clear about the recommended interventions. This meant there was an increased risk people might not be getting the care and treatment, based on their current needs and professional advice.

Care plans were not always being followed, and were not up to date. Some care plans were not person centred and contained minimal information about the person's support needs, life history and their preferences about care and daily life. This meant care and support might not be provided in line with people's needs and wishes. People did not have access to regular meaningful stimulation or activity.

A lack of effective governance meant the service had failed to independently recognise and remedy problems identified by CQC and the local authority investigations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to

Summary of findings

cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We are considering taking further action in relation to this provider and will report on this when it is completed.

Since the inspection, the provider has submitted an application to cancel their registration of this service and this is being processed by CQC. All of the people living at the service were assisted to find suitable alternative accommodation and care and support, and all were safely moved from The Regency by 20 November 2015.

During our inspection, we found breaches in nine areas of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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.

Incidents of abuse were not always referred to appropriate authorities and acted upon accordingly which meant people were exposed to further risk of harm.

Risk was not always well managed at the service, particularly those relating to weight loss and choking.

There were not enough staff to meet people's needs and preference which put them at risk of not receiving assistance when they needed it.

Not all areas of the service were clean and hygienic and parts of the environment had not been well maintained.

Suitable arrangements were in place for the safe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

Where a person did not have capacity to consent to specific decisions, the service did not act in accordance with the Mental Capacity Act 2005. This meant it was difficult to confirm if decisions made were always in people's best interests.

Health professionals were consulted about people's health needs. However records were not always clear about the recommended interventions.

People's dietary preferences and needs were not always met.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

People were not always treated with dignity and respect. Some people's basic care needs were not being maintained to a high standard. We saw some people looked unkempt in their personal appearance.

Staff were kind and polite, however the delivery of care and support did not focus on or promote individual preferences.

Is the service responsive?

Requires improvement

The service was not responsive.

Although some staff were friendly and supportive towards people, care was

sometimes task based as opposed to meeting the personalised needs of people. This did not support people's choices or dignity.

Summary of findings

Some people's care plans were not comprehensive or person centred to ensure individual care needs could be met.

There was a lack of stimulation and interaction available for people. Some people displayed behaviours which indicated boredom and withdrawal.

Complaints and concerns were not always well managed.

Is the service well-led?

Inadequate

The service was not consistently well led.

The registered manager was not managing the service effectively; as a result we found a number of breaches of regulations.

Monitoring systems were not effective and had not identified shortfalls in the service.

Although people's views had been obtained, action had not been taken as a result of people's feedback to improve the service.

Regency 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, and to provide a rating for the service under the Care Act 2014.

We visited the Regency Residential Care Home on 20, 21 and 26 October 2015. The inspection was unannounced and was carried out by three CQC inspectors.

We reviewed all information about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing the daily life in the home including the care and support being delivered. We spoke with or met all of the people who used the service, one relative and three health care professionals. Following the inspection we spoke with two other health care professionals. We spoke with the registered manager, three permanent members of care staff, one agency staff member and two ancillary staff (the cook and housekeeper.)

We toured the building and looked at all areas, including communal areas and with their permission, some people's rooms. We reviewed a range of records including five people's care records, all medication administration records, the financial transaction records of two people, three staff files and other records relevant to the management of the regulated activity.

Inadequate

Is the service safe?

Our findings

Although people said they felt safe at the service, we found people were not always safe and risks to people's welfare were not always well managed.

Prior to the inspection we had received concerns about staffing levels at the service. The service had experienced significant staffing problems since the last inspection. The registered manager confirmed there had been a 100% turnover of care staff since the last inspection. In addition to this, the service had struggled to recruit new staff, and although regular agency was used, staffing levels had decreased since the last inspection. The registered manager confirmed there had usually been three care staff plus the registered manager on duty from 08.00am until 20.00pm daily. However this had reduced to two care staff plus the registered manager over the past weeks due to staff recruitment difficulties. The duty rota for October 2015 showed there were times when these staffing levels had not been maintained. For example, on 7, 8, 9, 11, 13, October 2015 there had been one member of care staff plus the registered manager on duty to care for and support 14 people.

The registered manager confirmed that four people needed the help of two staff to assist with their safe moving and handling or care needs. They confirmed there was no formal process for assessing people's care needs on an on-going basis and adjusting the staffing levels to ensure care needs were met. The registered manager recognised staffing levels were not always sufficient to meet people's needs, especially at night.

Staff on duty said they felt there were not enough staff to meet people's needs in a timely and safe way. They explained when they assisted a person who used a hoist for safe moving and handling they could be 'off the floor' for some time. On occasion they said people had to wait for attention as a result of staffing levels. Staff said they had no time to spend on social activities with people; one said, "It would be nice to sit and chat sometimes but we just don't have the time. The shifts are busy; there is so much to do." Another member of staff said lunchtime could be difficult to manage. This was because two people required full assistance to eat their meals (in their rooms) and one person was at risk of choking and needed constant supervision when eating. We saw the person at risk of choking was left alone on several occasions with their breakfast and drinks as staff were busy elsewhere attending to people's needs. Staff said they were unable to provide some personal care, for example regular baths; they explained this was partly due to staffing levels and also because bathrooms did not have the necessary adaptations for some people.

During the inspection we found people did wait for support from staff at times. For example on one occasion a person who required two staff to safely assist them move asked to go to their room. They were told politely they would have to wait as the other staff member was busy with a GPs visit. The person waited for nearly 20 minutes before their request was met.

Staff were expected to undertake other duties. For example the cook did not start work until 10.00 am and finished at 13.30 pm. This meant a member of care staff provided people's breakfasts and then had to prepare, serve and clean up after the teatime meal. A cleaner was employed for fifteen hours per week and worked Monday to Friday. At other times care staff were expected to keep the service clean as well as provide support to people. This then reduced the number of staff available 'on the floor' to provide care and support for people.

The deployment of staff at night had placed people's safety and welfare at risk. This was because

one night staff member was unable to deliver the care and support required safely. Historically there had been one staff member on waking night duty plus the registered manager on call. However, people's needs had changed and some required increased support at night. As a result one staff member at night could not safely deliver the care and support people required, for example, where people required changing at night one member of staff was unable to use a hoist alone. Following the inspection the registered manager, who lived on the premises, arranged to be up during the regular two hourly checks with the night staff. Although this was not sustainable in the longer term, it did reduce the risk of people not receiving the care they required at night in the short term. From 25 October 2015 an agency member of staff was booked to ensure a second staff member was on waking night duty.

The local authority was so concerned about staffing levels and the standard of care being delivered they organised

additional staff from an agency to support the service. They also increased monitoring visits from health and social care staff as they were concerned that the needs of people were not being fully met.

There is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to explain the safeguarding adults procedures and the action they would take should they witness abuse or poor practice. However, the registered manager and staff had not recognised two safeguarding issues and had not made referrals to the appropriate agencies. For example contacted the local authority safeguarding teams or notified the Commission, when this was needed.

There had been a number of safeguarding allegations made which were being investigated by the local authority. One incident was being investigated by the police. CQC will continue to liaise with the local authority and police about these matters and monitor the outcome of these investigations.

The registered manager confirmed that the service did not manage people's finances although they did hold small amounts of money for people to use on sundry items, such as chiropody, hairdressing and personal shopping. We looked at how the service handled people's money. Money was kept securely and access was limited to the registered manager, and in the past to a senior member of staff. Financial records were kept for each person, which showed any money paid into or out of their account. The record was signed by two members of staff to verify the accuracy of each transaction or by the person themselves.

The service had a policy to guide staff about how people's money should be managed, however the policy did not state that staff should not have access to people's bank accounts and Personal Identification Number (PIN). This meant people may not be fully protected from the risk of theft or fraudulent practices.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans guiding staff about how to respond to situations that included risks to people were not detailed enough, they were vague and open to misinterpretation. This placed people at risk of receiving inappropriate care from staff who may not know them well, for example a number of agency staff were being used to supplement staffing levels.

One person was a risk of choking; however their current care plan did not provide sufficient information for staff to ensure they remained safe at mealtimes. One member of staff said they had been unaware of the risks to the person during two shifts at the service. We found important information about how to keep the person safe when eating had been removed from their current care file and archived, meaning staff did not have access to the relevant information. This person had been assessed by a speech and language therapist (SALT), who had made recommendations about the food they should eat. However, the person had declined to eat the foods recommended. The care records did not reflect the person's reluctance to adhere to the SALT's recommendations, nor did it provide any additional information about how to support the person while eating 'risky foods'. On one occasion during the inspection this person had difficulties swallowing a cup of tea. They started to cough and used a bin beside them to spit the tea out. There were no staff present at this time to monitor the person and ensure they were safe. This person was also left unsupervised on other occasions whilst eating and drinking, which increased their risk of choking.

One person had experienced at least three falls in October 2015. Falls were reported to the GP. However, care plans and risk assessments had not been reviewed and up-dated following falls to assess if there was any other actions to be taken which could reduce the risk of falls. This meant people may be at risk because the service had not put adequate measures in place to manage this risk. For example the use of assistive technology (pressure mats), which would alert staff to people's movements.

The risk of people developing pressure sores was assessed as part of planning their care. Where risks had been identified we saw that preventative measures such as pressure relieving mattresses or cushions had been put in place. However, care records had not identified the setting for pressure relieving mattresses where in use. One person's mattress was set to support a person who weighed between 120kgs and 150kgs although the registered manager confirmed the person weighed 12.3lbs (77kgs) when weighed on 26 October 2015. This meant the

person was not receiving effective intervention from the use of the mattress and could be at risk of pressure damage. The registered manager confirmed the person's skin was intact at the time of the inspection.

From GP records for another person, we saw their behaviour had in past place them at risk of self-harm. However, there was no risk assessment relating to this behaviour and no information for staff to follow to ensure the person's mental health needs and behaviours were monitored in respect of this. The registered manager said she was unaware of the incident reported to the GP about an event which placed the person at risk.

Another person was at risk of self-neglect and they declined assistance from staff with personal care, which had resulted in them looking unkempt and wearing dirty clothes. There was no 'behavioural plan' in place and no identified trigger factors to guide staff about how best to support the person to maintain their personal care.

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

The planned improvements to the premises had not been completed, which meant the premises had not been maintained in parts to ensured people's safety and wellbeing. We found concerns in relation to the safety, cleanliness and suitability of the environment for people living at the service.

Some people had broken bedroom furniture in their rooms; some rooms were sparse and not homely. One bedroom was in particular need of refurbishment. The room smelt damp and there were damp patches visible high up on wall and ceiling. The walls of the room were stained, particularly where the bed rested lengthways against the wall. There were dark patches where paint was missing. The mattress on the bed in this room was heavily urine stained all over; there were cracks in the vinyl cover and there was a strong smell of urine from the mattress and duvet cover. By the second day of the inspection the registered manager had spoken with the person about their room and they had agreed to move to another bedroom until their room had been decorated. The person told us they were happy with their new room, they added, "much better than my last room…"

In another person's en-suite toilet paint was flaking off the walls and the lino had been removed following a flood. This meant bare floor boards were exposed, which was neither homely nor easy to keep clean.

There was no running hot water in one bedroom or the staff toilet. A plumber was called on the second day of the inspection to address these problems. However on the third day of the inspection we found the hot water was still not available in the staff toilet.

We found two radiator covers had come away from the wall, posing a risk to people from possible burns and other injuries. Risk assessments had been completed for individual bedrooms; these had been reviewed monthly up to September 2015. However the reviews had failed to identify the risk from the broken radiator covers.

The smoking room had been due for refurbishment at the last inspection, but work had not started at the time of this inspection. The floorboards in this room finished approximately 8 inches in front of the patio doors. There was then a concrete lintel. Where the floor boards and lintel met, there was broken concrete visible with a gap of approximately 2 inches before the concrete started. This could pose a trip hazard for people. This room had no floor covering but bare floorboards, making it difficult to keep clean. The room was also used as general storage area; there were two wheelchairs, pressure cushions, and a zimmer frame stored at one end. There was no call bell in the room for people to use should they need staff assistance. The walls were discoloured and the odour from the smoke permeated the room and also at times the nearby dining room/lounge.

The call bell in one person's bedroom was not working, meaning they were unable to summon help when needed. When we met this person they were resting in bed but in need of a drink. They had been unable to call staff, so we found staff and altered them to the person's need. The registered manager said they were unaware that the call bell was not working but would address this immediately.

Some pressure relieving equipment did not look fit for purpose. One pressure cushion in the dining room/lounge was dirty, torn, had cigarette burns in it, smelt strongly of urine and was permanently sunken in the middle, which would impact on the effectiveness of the cushion. Another pressure cushions was dirty, and stained with food and drink debris.

Inadequate

Is the service safe?

Parts of the service were not clean. Four bedrooms had a strong and unpleasant odour of urine. Some surfaces in people's bedrooms were dusty and sticky with food and drink debris. There was food and debris on the floor of two bedrooms; the cleaner had not managed to get to those rooms. We found one person's bed sheet was heavily stained with faeces, as was a hand towel in their en-suite toilet. We brought this to the attention of the registered manager who immediately asked staff to change both the sheet and the towel.

There were bare floor boards in one person's en-suite toilet, the smoking room and staff toilet, which meant the surface could not be cleaned effectively and could pose an infection control risk.

Some equipment, for example, commode inserts and urinals were dirty and stained. The sluice room was cluttered with weighing scales and a Rota-stand (used to aid mobility). This meant it was difficult for staff to get to the commode cleaning equipment. We asked staff how they cleaned commode inserts and urinals. One member of staff said they used the commode cleaning equipment in the sluice. However another member of staff said commodes were cleaned in the sink of people's en-suite toilets. This is not good practice and does not promote good infection control.

A cleaner worked three hours a day, Monday to Friday; they said they cleaned the communal dining room/lounge and bathrooms daily and tried to clean people's bedrooms on alternate days Monday to Friday. However they said it was sometimes a struggle to keep the service clean with limited hours.

There was no colour coded system in place for mops and buckets to help staff identify what area of the home they should be used in, such as the kitchen or toilets. The cleaner explained they had one mop for each floor and that they 'washed the mop' in between each bedroom and en-suite. The infection control policy contained clear instructions for the colour coding for cleaning equipment, however this was not being followed.

The cleaner confirmed they had equipment to help with deep cleaning, such as a carpet shampooer. However they said there was no schedule for deep cleaning and they had little time allocated for such tasks. There was a cleaning schedule in place; however records used to show tasks had been accomplished had not been completed since the end of September 2015. Although the cleaner was an experienced 'house keeper' they had no formal training in infection control.

Parts of the kitchen were not clean. This was the responsibility of the cook and night staff. We found grouting on tiles and seals around window and sink were coming away with dirt/grime on them. Two microwave ovens kitchen were dirty and contained food debris. A cleaning rota was in place for the kitchen but there were several gaps for September and October 2015. The registered manager had identified these issues during a recent kitchen audit. Records showed she had spoken with the cook and was planning to arrange a session with him about the cleaning schedules.

As we were concerned about some aspects of fire safety, especially the fire escape stairs from the first and second floor, we referred our concerns to Devon and Somerset Fire Service, who visited the service following the inspection.

This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded and a GP and a member of the rehabilitation team confirmed falls had been reported to them. The rehabilitation team had visited to assess and support some people with their mobility. A member of team said they had no concerns about the care and support during their visits.

At our last inspection in March 2015 we found a breach of regulation with regards to the management of people's medicines. At this inspection we found improvements had been made and medicines were managed safely.

The registered manager was the only member of staff who had responsibility to order, give, record and dispose of people's medicines; with the exception of applying prescribed skin creams. This was because several members of care staff had recently left the service. There were no other care staff available who had been appropriately trained and assessed as competent to manage people's medicines. Therefore the registered manager gave people their medicines each time they were due. Following the inspection the registered manager confirmed that a regular agency member of staff, who had been trained in the safe management of medicines, had been booked to mitigate any risk associated with just one member of staff being able to handle medicines.

Inadequate

Is the service safe?

The service did not have a current up to date medicine policy and procedure in place. The registered manager said they would ensure there was one available before any other care staff gave out medicines to people.

There were appropriate arrangements in place for the ordering, receipt and disposal of medicines. Medicine stock levels were maintained only at the required amount necessary for each month. All medicines were stored safely and securely, at a temperature recommended by the manufacturer. Medicines were given out safely and people were assisted to take their medicines in a calm and unhurried way.

Appropriate arrangements were in place in relation to the recording of medicines given out. However, some medicines did not have a specific time at which to give them out. For example, one medicine was to be given between "20.00 – 22.00." This was discussed with the registered manager. They said they would contact the local pharmacy and ask them to print the actual specified time for each medicine to be given as prescribed by the GP.

Where people were prescribed medicines "as required" (PRN) the MAR chart showed people had been offered PRN medicines and, where they had declined, this had been recorded. For prescribed medicines, such as eye or nasal drops, an opening date had been written on them; this meant care staff could easily identify when they has reached their expiry date and needed disposing of. The MAR charts recorded which types of topical skin creams each person had been prescribed. When people had their cream applied, this was not recorded on the MAR chart but on a separate recording chart which was held in people's bedrooms. Records confirmed they had been given regularly and as prescribed.

The recruitment and selection process ensured checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. The registered manager had checked the recruitment records recently and found that one person's file had documents missing. Replacement documents were being organised. Where staff had criminal convictions risk assessments had been undertaken to assess if they were suitable to work at the home.

Inadequate

Is the service effective?

Our findings

We were concerned to find that five people had lost a considerable amount of weight since the last inspection. From the records and speaking with the GP weight loss had been reported and advice sought about two people's weight loss. However records were unclear about the action taken regarding the other three people. The registered manager was unaware of the weight loss of one person. Nutritional risk assessments had not been updated where weight loss was evident for three people and there was no action plan in place to investigate the concerns relating to people's weight, or clear instructions for staff on how to manage. This meant potential risks to people's health and well-being were not being managed.

One person had been prescribed nutritional supplements to their normal diet. The medicine administration record stated six per day had been prescribed, but this had been changed to four recently without any reason recorded. Care staff said they gave the person four or six supplements per day. They also said the person was unable to eat their food at mealtimes as they were not hungry. Different records from health care professionals showed regular reviews of this person but some confusion as to how many supplements were actually needed. The registered manager said they would contact the GP to clarify the issue without delay.

The registered manager said the menus had been changed by a senior member of staff. However staff had raised concerns about the quality and quantity of the food, so the menus had reverted back to the established weekly cycle recently. The meals that were cooked did not always follow the weekly menu.

People who used the service in the main told us they were satisfied with the quality of the food provided. Comments included, "The food is very good…I can't complain"; "The food alright…always plenty for us to eat…" and "I like the food…" This person wrung their hands together to show appreciation. However, people did not know what the main meal of the day was on any of the days we visited. There were no menus on display and people said staff had not told them what meals were available. They were not aware of any alternatives to the main meal.

We observed breakfast and lunch on the first two days of this inspection and lunch on the third day.

Breakfast was prepared by care staff. Some people chose to have breakfast in their room and others came to the dining room. People were offered tea, toast and cereal. We asked whether people were given the option of a cooked breakfast, staff were unsure but confirmed they had not prepared cooked breakfast for people. The care plan for one person said they had enjoyed a boiled egg every day for breakfast prior to moving to the service. From their records and speaking with staff we saw boiled eggs were not offered but the person was offered porridge or toast. The care records for this person showed their appetite had declined and they often refused meals. However it was unclear whether the person had been offered alternative food at different times to ensure they were receiving sufficient food and drink. Concerns about the person's weight loss had been discussed with the GP and the GP advised the service to monitor and report back to them.

Lunch on the first day was mince, mash potato and mixed vegetables with currant sponge for dessert. The menu for the day displayed in the kitchen stated the pudding was apple crumble and custard. The cook said he had changed this on the day although did not explain why. Eight people had lunch in the dining; other people had meals in their room. As staff had to deliver meals over the four floors and assist two people with meals in their bedrooms, there was little staff presence in the dining room during lunchtime. People said they had enjoyed the food and meals in the dining room were mostly finished by people. One person requested a drink on several occasions; they said, "I want a drink", and "I still haven't got a drink". They then asked the table next to them, "Have you got any water in your jug?" However the jugs on the tables were empty, meaning people were not offered a drink with their meal. People had to wait until after lunch when tea was offered. On the second day of the inspection a roast beef lunch was prepared. People using the service and staff said the meat was 'tough'. Some people said they were unable to eat it.

We looked at the teatime menu. Tea was served between 4.30 and 5pm. On the first day of the inspection the tea time menu included fish cakes, baked beans and cheesy pasta. However when we asked the chef what he was preparing for tea he showed us packet vegetable soup and sandwiches. We asked about the fish cakes and cheesy pasta and he said, "we don't have that…" On the second

day of the inspection the menu stated tea was a choice of soup, quiche and salad and assorted sandwiches. However people were only offered soup (no choice of flavour) and sandwiches.

On the third day of the inspection we found that nothing had been prepared for tea. The staff and the registered manager were not aware that the cook had not prepared supper. The menu stated soup and cauliflower cheese with bacon should have been prepared. The registered manager arranged for someone to shop and for staff to prepare tea that evening.

People using the service and staff confirmed the choice at teatime was soup and sandwiches and cake. People said they were not offered the other teatime items on the menu. People told us they were not offered anything else to eat or drink after teatime, which was served by 5pm. This presented a risk to people's health and meant some people may not eat for up to 15 hours. The registered manager and staff said people could ask for drinks and snacks if they wanted them but people were not aware they could do this. One person said, "I never thought about asking."

There was no fresh fruit available during this inspection; people said they had not been offered fresh fruit. The menu did not provide fruit based dishes on a regular basis. Staff confirmed fruit was not often available but recently when a staff member had brought strawberries in for people to share, which they had greatly enjoyed.

Where people had been identified as being at risk of dehydration, fluids charts were in place to monitor their intake. Fluid charts showed that some people a risk of dehydration were receiving up to 2 litres of fluid a day. However these charts were completed in a uniformed way by one member of staff and not the member of staff who gave the fluids. For example fluids given by night staff early in the morning were recorded by the day staff later in the day. There was a risk that fluid records were not accurate as they had not been completed at the time drinks were given. We also found gaps on these records which could mean people had not received drinks. For example, two people's records showed they had nothing to drink from 11am until 8pm. The records showed the last drink people received was at 8pm and the next drink recorded was 7am. This meant people were potentially without fluids for up to 11 hours.

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

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions were made in people's best interests.

Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

People confirmed staff sought their consent when delivering care and support. We observed staff discussing people's care needs with them and asking them about the care and support they required. The registered manager and staff said people using the service were able to make decisions about their care and routines.

One person's care records included some information about their capacity and identified what help would be needed with day to day decisions. However, there was no evidence of any 'best interest decisions' being made. For example where bed rails were in use. A best interest decision is a decision made on behalf of a person who is unable to make their own decision and should involve the person's family or friends and other health and social care professionals. This meant that staff were not always following the principles of the Mental Capacity Act 2005 when planning care.

The local authority was re-assessing people's needs at the time of the inspection. Where people had been assessed as lacking capacity to make specific decisions, for example about where they lived, mental capacity assessments were being completed and best interest decision meetings were being arranged.

At the time of the inspection no-one was subject to a Deprivation of Liberty Safeguards application. However we identified one person who may require a Deprivation of Liberty Safeguards application as they were subject to continuous supervision and control and were not free to leave the premises. We discussed this with the registered manager who assured us they would act on this.

Due to the major changes to staff personnel not all new staff had received training to help them understand the principles of the MCA and how this related to their role.

Inadequate

Is the service effective?

This is a breach of Regulation 11 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had a refurbishment and redecoration programme in place for 2015 at the last inspection, which included new shelving and curtains or blinds in people's bedroom by May 2015. The smoking room was to be refurbished and redecorated, plans to improve access to the garden were to be completed by July 2015, and a number of bedrooms were to be refurbished between March and October 2015. New blinds were in place in several of the bedrooms. The registered manager explained due to problems with recruiting a maintenance person and external builders the refurbishment programme had not been completed as planned. Some work had been quoted for but the builder had not returned calls so the work could not be started. The provider had started to ask for new quotes. The provider had reviewed their refurbishment plan and recorded what work had been completed and what was outstanding.

There was limited communal space, which meant the only quiet areas for people were their own bedrooms. The sitting room/lounge area had been combined with the dining room at the last inspection. At this inspection, an additional small sitting room, which previously provided additional communal space for people to use, was storing three large freezers and one comfortable chair. This room was not homely or suitable to be used as communal space. This meant the lounge/dining room was cramped, especially when staff needed to use equipment, such as a hoist.

Bathrooms and toilet areas were not warm or homely places. Staff explained the lower floor bathroom did not allow them to have easy or safe access to these facilities when people required assistance with a hoist to access the bath. At the last inspection work had started to fit a wet room on the ground floor; this was to have been completed by April 2015. However, the registered manager explained they had experienced problems with the builder and work had not progressed. This meant some people did not have access to suitable bathing/showering facilities to meet their needs.

Several rooms had carpets that showed signs of wear; they were stained and one looked burnt as if someone had used an iron. In one en-suite the paint was flaking off the walls and lino that had lifted; bare floorboards were exposed which were not homely or easy to clean.

This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014.

People saw relevant healthcare professionals when they needed to, such as their GP, community nurses; speech and language therapist; physiotherapist and occupational therapist. Two GPs said the service was quick to contact them with any concerns about people's health needs and neither had any immediate concerns about people's health needs. However, one GP said it was sometimes very difficult to find staff when they arrived, and they felt there was a lack of communication between staff which meant it was sometimes difficult to obtain the relevant information. However they did say that the registered manager had a good overview of the people's health care needs.

Records relating to people's health were poorly maintained in places, especially relating to people's bowel health. For example, the records of one person showed they had not opened their bowls for nearly four weeks. We saw similar deficits in records for other people, indicating they may not have open their bowels for up to two weeks. We discussed this with the registered manager and staff. They confirmed those people had regular bowel habits but that this had not been recorded. We asked one GP if they had any concerns about people's bowel health and they said they did not. They confirmed they had not attended people who were suffering with chronic constipation.

Staff received training and induction to help them to do their job safely. Staff files contained copies of certificates of qualifications or training attended. Recent training in 2015 included health and safety inductions, diabetes, safeguarding, dementia, communication at the end of life, MCA, bed repositioning, DOLS, principles of diet and nutrition, first aid, moving and handling and fire safety.

The provider had supervision with one staff member, which showed that they had observed their work. They had concerns about some aspects of their work. There was a record of concerns and the actions to help support the staff to improve their performance.

Requires improvement

Is the service caring?

Our findings

People said they felt well cared for and comfortable with the staff. People had generally positive comments to make about staff's approach. Comments included, "The staff are very nice. I feel very well cared for, from the top to the bottom…they are all very good…"; "We get along ok. Some staff are better than others, that's the way of things…" and "I find the staff are nice. They are a help to me…I couldn't manage without them…"

A relative felt that most staff were approachable, friendly and helpful. They said the registered manager was always available to speak with. They added, "My only concern is staff turnover." Other than that, they said staff were respectful and kind. They said, "We are happy with the care…Mum is happy. She would say if not." One member of staff said their philosophy was of dignity and respect, to acknowledge and treat people well.

We saw examples of compassionate care and warm interactions from staff towards people using the service. However, the majority of interactions we observed were 'task orientated', meaning interactions and conversations were based on the delivery of care and support. This was mainly due to staff not having enough time.

Some peoples' personal hygiene was not being maintained to a good standard. We noted that a number of people looked unkempt and dishevelled in terms of their personal appearance. For example, three people had dirt underneath their finger nails, people's hair was not groomed, a female had whiskers on their chin and one man was unshaven and had only one shoe on. We recognised that two people could be reluctant to accept assistance with personal care. However, there was no strategy in place to explore how staff could assist people to maintain their personal hygiene standards. The staff approach seemed to be 'there is nothing we can do'. This could have an impact on people's dignity and wellbeing.

There was evidence that some daily routines were institutional and based on staffing levels. One person said they went to bed between 5-6pm to "Fit in with the staff." They said they would like to go to bed at about 8pm. We asked if they had a choice; they said "Not really". They added they were always in bed by 6pm because "It's when they come and do it". Other people who were more independent and physically able said their daily routine was flexible and they could chose when to get up, when to go to bed and how they spent their day. A care worker said that night staff gave breakfast to those who wanted to get up early in the morning. They added if people wanted to get up later they were able to do so. They said other care homes they had worked in were 'very regimented' but it wasn't like this at the Regency.

There were some set routines for people who used the service. For example people ate the main meal of the day at midday and people were not sure if they could request their main meal in the evening. One person said, "It doesn't really bother me…it's what I am used to…"

A weekly bathing list with people's names and bath days was on display on the lower ground floor near to the communal areas. This did not promote people's privacy or maintain confidentiality

We found some people did not have access to their call bell when in their bedroom as it was out of

reach. One person was cold when we visited them and wanted a jumper but they were unable to call staff as the call bell could not be reached. We used the bell to attract staff's attention and they came fairly quickly and assisted the person. Another person said they would like a cup of tea but they could not reach the bell to call staff.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

People had some involvement in the development of their care plan, however it was not clear that people or their relatives (where appropriate) had been involved in the review of people's care plans.

Requires improvement

Is the service responsive?

Our findings

Prior to people moving to the service pre-admission assessments were carried out by either the registered manager or a senior member of care staff. This was to ensure the service was suitable and able to meet a person's support needs. The assessments completed by the registered manager were detailed and covered the 'Activities of daily living'. Additional information had also been obtained from social and healthcare professionals about people's health and social care needs. Assessment information we viewed for two people showed that people (and their relative where appropriate) had been involved in their assessment.

The assessment information was not always used to inform the care planning process. The quality and information within care plans varied depending on who had developed them. Where the registered manager had developed care plans there was detailed information about the person's care and support needs and preferences. However, where another senior staff member had completed care plans the quality of information was poor and did not provide clear information or guidance about the person's needs or how staff should met them. This meant care was not always assessed, planned or delivered in a person centred way.

Some care plans were difficult to follow, inaccurate and in some there was limited information about people's needs, preferences, and life histories. For example in one person's care file the records said the person had epilepsy, dementia and diabetes, however the registered manager and other records confirmed this was not the case. The registered manager explained that the staff member completing the care plan had 'made a mistake'.

Changes to people's needs were not always identified, for example weight loss or risk of pressure damage, and care plans were not reviewed regularly. The lack of effective care planning records meant that we could not be assured people's care and support needs were always met in a consistent and safe way. Where people had lost weight some care plans had not been reviewed to ensure staff were aware of the action to take to support people to maintain their weight.

Another care plan did not reflect the person's mental health needs or how staff should monitor their mental health or what interventions could be used should the person's deteriorate and pose a risk to their overall health. The daily notes for another person showed their needs and behaviour had changed, however the care plan had not been up-dated although the person had exhibited anxiety; aggression, their appetite had reduced and they had experienced falls. Therefore there was a risk that people might not receive the care and support they needed.

A member of staff who had worked at the service said they were told very little about people's needs and preferences and they did not have the time to read care plans. They were concerned they had not been given information of risks to people, for example choking. The care plan for the person at risk of choking did not contain up to date and relevant information even if staff had the time to read it. The lack of comprehensive guidance and care plans meant people were at risk of not receiving a safe and individualised service.

At the last inspection we identified that opportunities for people to participate in regular and meaningful activities was an area for improvement. At this inspection we found no progress had been made to introduce new and interesting activities based on people's interests and preferences. People who required support when out in the community had not had an opportunity to get out of the home to visit the local town or other places of interest to them. One person said they would enjoy being able to get out to the shops occasionally, they added, "Just to see what is going on out there…" As a result of the lack of interaction and planned activities people were often left to their own devices, some wandering around, while others spent time dozing or staring into space. Most of the staff engagement was task led, assisting people with care and support needs. Staff did not have the time to spend with people one to one or facilitating group activities. The service had external entertainers visiting and massage and pamper sessions were offered by an external professional. Apart from these there were no other planned activities that people using the service or staff were aware of.

Several people spent the vast majority of time in their bedroom. Two people said they saw staff when they came to assist them or deliver meals. People said staff were busy and did not have time to chat and be sociable. We were concerned that these people could be at risk of social

Requires improvement

Is the service responsive?

isolation. In one person's room the radio was on but tuned to a Welsh station. Staff were unsure why this was and there was nothing in the care plan to suggest this person enjoyed or had requested a Welsh speaking radio station.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

Some people were able to go out and access the local community facilities independently as this was encouraged and support by the registered manager. Two people commented on how much they enjoyed their regular visits to the local town and that they had made 'friends' in the local shops and supermarkets.

There was a complaints process in place and people knew who to speak with should they have any concerns or complaints. All said they would speak with the registered manager. People said they had confidence in her and that she would listen and act on their concerns. One person said, "(the registered manager) is always around if I want to speak to her…she is very nice and I trust her…" Another person said, "I would not hesitate to speak with (the registered manager) if I needed to. To date I've had no need though…"

One complaint from a relative had not been dealt with by a senior member of staff in a receptive or sensitive way. From correspondence we saw the complainant had been very unhappy about the way their concerns had been dealt with. The complaint was unresolved at the time of the inspection and the registered manager was in contact with the family to try to resolve the issues.

Inadequate

Is the service well-led?

Our findings

CQC received an action plan from the provider on 8 June 2015 following the last inspection. This contained information about the action the provider would take to address the issues we raised at the last inspection. During this inspection we found improvements had been made in respect of the safe management of medicines. However little or no improvements had been achieved in relation to activities or care records.

Since the last inspection, the registered manager had delegated responsibilities to senior members of the team, for example care planning, dealing with complaints and managing staff. However, they had not monitored the impact of this. Our findings, and the findings of local authority investigations, showed the service had not benefited from good leadership since the last inspection. A lack of effective governance meant the service had failed to independently recognise and remedy problems identified by CQC and the local authority investigations. As a result people's health and care needs were not always met and people were not always protected from harm. For example, people's nutritional needs were not being managed effectively to ensure that people had enough to eat.

Although the registered manager had established quality assurance processes, these had not been effective as the areas of concern identified during the inspection had not been addressed. For example, people were not protected from low staffing levels as the registered manager had not completed a needs analysis or risk assessment as the basis for deciding sufficient staffing levels. Staff did not have the time to engage with people, which resulted in several people being isolated and unstimulated.

We found inconsistencies and gaps in record keeping throughout the inspection. The variability in the quality and consistency of record keeping meant we could not be confident that people were receiving the care and treatment they required. There had been no care plan audit to ensure people's needs had been accurately recorded and that staff had relevant information to deliver people's care safely. These gaps in record keeping meant people were at increased risk of weight loss, falls, and possibly pressure damage.

The registered manager had completed recent audits in medicines, the first aid box, kitchen checks, and infection control checks. They identified that the kitchen was not clean and the registered manager had demonstrated to staff how to carry out a deep clean. However the concerns we found about infection control had not been picked up through the infection audit, which meant no action had been taken to address issues. Environmental audits had not ensured the premises were maintained in good order or that the environment was appropriate to support people safely and ensure their individual needs were met.

The registered manager had sought the views of eleven people who used the service and a questionnaire had been completed in August 2015. The results of this showed three people would like a cooked breakfast, three people did not like the activities, another two were not happy with the laundry. The evidence from this inspection shows that people's feedback was not always acted upon. Cooked breakfasts were not provided and there had been no improvements to activities offered. However, the majority of people were happy with the home. One relative had completed a questionnaire and had rated everything as 'satisfied' or 'very satisfied'.

Accidents such as falls had been recorded. At the previous inspection the registered manager had kept a monthly spreadsheet of all accidents and incidents, which helped to monitor any trends. However during this inspection the registered manager was unable to demonstrate how accidents and incidents were monitored overall. This meant possible trends or triggers had not been identified to minimise further occurrences.

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

The registered manager had not always informed the Commission about notifiable incidents in line with the regulations. For example safeguarding concerns.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 Registration Regulations 2009

The registered manager was open and co-operative during the inspection. They recognised the areas where the service was breaching requirements and accepted this was their responsibility. They said they had 'taken their eye off the ball' and entrusted senior staff without fully monitoring their performance.

Inadequate

Is the service well-led?

Regular staff meetings had been held and the registered manager had delegated the responsibility of organising and facilitating these meeting to senior staff. From the minutes of the meeting we saw the style of delivering message and information to staff was unprofessional at times. Some staff said they had been bullied in the past; that the working atmosphere had been unpleasant and one described senior staff's style as 'dictatorial' and 'unhelpful'. Staff said this behaviour had caused the high level of staff turnover. The registered manager had recognised the impact of this approach and had been dealing with this through the disciplinary process.