Four Seasons (Bamford) Limited

Hornegarth House Care Home

Inspection report

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Tel: 01922701702

Date of inspection visit:
29 March 2017

Date of publication:
28 April 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 29 March 2017. This was an unannounced inspection. Our last inspection took place in February 2016 and we found there were not enough staff to meet people's needs in a timely manner and people had to wait for support. We also found medicines were not always managed in a safe way. At this inspection we found the provider had not made the necessary improvements

The service was registered to provide nursing for up to 37 people. At the time of our inspection 33 people were using the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

The service did not have a registered manager. 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.

There were not enough staff to offer support to people in a timely manner. The lack of staff within the home meant people had to wait for personal care, meals and medicines. As the rota was left uncovered we could not be assured there were the recommended amount of staff available for people. The provider used a dependency tool to work out staffing levels however we could not be assured this was accurate as it did not always reflect people's individual needs.

People did not receive medicines as prescribed because we found medicines from previous days in blister packs. When people were prescribed medicines for agitation we did not see any evidence that people had

been agitated when these medicines had been administered. When people needed pain relief they did not always receive this in a timely manner.

People were at risk as there were not enough staff to keep them safe. Injuries had occurred within the home due to the lack of staff available. Risks to people were not managed in a safe way. We saw no evidence after incidents had occurred that action had been taken to reduce the risk reoccurring. Staff did not demonstrate an understanding of safeguarding and so we could not be sure people were protected from potential abuse. When potential safeguarding incidents had been recorded we did not see these had been reported in line with the provider's procedures.

People did not always receive adequate fluids to remain hydrated. Drinks were often left out of reach for people. When people needed support to eat and drink they had to wait due to the lack of staff within the home. We had to alert staff when people had not been offered anything to eat or drink. People were put at risk as they received foods that were not in line with recommendations made by health professionals.

People were not treated in a dignified way as staff were rushing to complete tasks. People were not offered choices and staff did not have time to encourage them to be independent. Staff felt the induction and training they received was inadequate to equip them with the skills they needed to support people effectively. People did not always receive individualised care or appropriate support when needed. People felt there could be more to do and relatives felt the home lack stimulation for people.

Capacity assessments were not always in place and we could not be assured how decisions had been made. Not all restrictions that had been put on people had been considered. Staff did not demonstrate an understanding of capacity and gaining consent from people.

There was a lack of leadership and we were concerned about the culture within the home. Staff did not feel listed to and when they raised concerns no action was taken. Staff told us they felt bullied and intimidated. Relatives also raised concerns about the lack of leadership and management of the home.

The systems that were in place were not always effective in identifying concerns. When action was needed to reduce risks reoccurring we did not see this had been taken. We could not be assured the provider understood their registration with us and significant events which occurred in the home had not been reported to us.

People and relatives were happy with the staff. And the provider ensured staffs suitability to work within the home. Visitors felt welcomed and were free to visit anytime.

During the inspection we contacted senior managers to raise our concerns. We did not leave the inspection until we were assured measures had been put into place to keep people safe. We asked the provider to produce an urgent action plan within 72 hours of the inspection and we are liaising with them in relation to this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
There were not enough staff available to keep people safe. People had to wait and were not supported in a timely manner. When concerns about inadequate staffing levels had been raised within the home no action had been taken to ensure people were safe. Risks to people were not managed in a safe way. When incidents had occurred we saw no evidence that records had been updated or that action had been taken to reduce the risk reoccurring. Medicines were not always administered as prescribed. When people needed pain relief this was not administered in a timely manner. Staff did not understand when people maybe at harm and we could not be sure people were protected from potential abuse.

Is the service effective?

Inadequate

The service was not effective.
People were not supported to remain hydrated. Food and drinks were often left out of reach for people. When people needed supported to eat and drink they had to wait. When recommendations by health professionals had been made to keep people safe these were not always followed putting people at risk. Capacity assessments had not been completed for all the areas needed. Consent forms were signed by relatives with no evidence how this had been agreed in the person best interests. Not all restrictions that were put upon people had been considered as requiring legal approval. Staff induction and training was not adequate to equip them to meet people's needs.

Is the service caring?

Requires Improvement

The service was not caring.
People were not supported in a dignified way. As staff were rushing they did not have time to spend with people. People and relatives were happy with the staff but as they were rushing people were not supported in a kind and caring way. People were not able to make choices. When people did make the choice this was not considered as staff did not have the time. Relatives and visitors felt welcomed by staff and were able to visit anytime.

Is the service responsive?

Inadequate

The service was not responsive.
People did not receive individualised support when they needed it. Staff did not always understand people's needs as fluids were not appropriately monitored. The home lacked stimulation for people. There were daily arrangements in place to share information however this was not always accurate. Relatives felt complaints would not be actioned.

Is the service well-led?

Inadequate

The service was not well led.
The provider had not made the necessary improvements identified at the last inspection. We raised concerns about the culture of the home and it lacked leadership. Staff did not feel listened to or supported and relatives raised the same concerns. The systems in place were not effective in identifying concerns and information was not used to drive improvements within the home. When action was needed to reduce risks it was not always taken. The provider was displaying the previous rating within the home.

Hornegarth House Care Home

Detailed findings

Background to this inspection

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

This inspection visit took place on the 29 March 2017 and was unannounced. The inspection visit was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information of concern we had received from the public. We used this to formulate our inspection plan.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered this information when we were planning the inspection.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with five people who used the service, nine relatives, eight members of care staff and two registered nurses. We also spoke with the manager and the area manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for 11 people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and the staffing rota.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection on 17 February 2016, we found there were not enough staff to meet people's needs in a timely manner and people had to wait for support. We also found medicines were not always managed in a safe way. These were breaches of Regulation 18 and 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found the provider had not made the necessary improvements needed.

There were not enough staff available to support people safely. People had to wait for long periods of time to be supported to get up, receive their medicines and eat their meals. We observed at 1:30pm on the ground floor four people were still in bed and waiting for support from the staff to get up. These people were unable to tell us about this experience due to their communication needs. We observed the last person was supported to get up at 2:55pm. We saw this person ate their lunch in bed before they were given their morning wash. This meant the person had waited all morning for staff to support them.

People and relatives told us they were concerned about staffing levels. One person said, "They could do with some more in the day". Another person told us, "Nowhere near enough". One relative said, "It's not good at all. There are not enough of them. There have been issues with my relation not being got up until late. I think you'll find a lot of the relatives feel like that. I rang up one day and they were still in bed at 12.40pm. I feel that's because of staffing levels. Since my relation came, the dependency of the other residents has become so high. We've got eyes so we can see what's going on. Look, there's no carer in here. Two carers for 17 residents upstairs it's ridiculous". Another relative told us, "They are exceptionally low on staff it's a real problem".

We saw at midday breakfast was still being served to people. A staff member commented, "This is quite common". At lunchtime we observed people had to wait for support with their meals. People's meals were left on tables in front of them and they had to wait until staff were available to offer assistance. At 3pm, one and half hours after lunch had started three people were still waiting for staff to offer support with their hot puddings that remained on tables next to people. This meant there was a delay in people receiving their meals due to lack of staff within the home.

Before the inspection we had received information of concern about the staffing levels within the home. All the staff we spoke with confirmed these concerns. One staff member said, "It can be worse than this". Another staff member told us, "It takes so long to get everyone up; it's just not fair on the people". They went onto say, "There are 17 people on the first floor, 15 of those need support from two staff. There are two of us to support those people. It's an impossible task". Staff told us that they were allocated to different areas within the home; two staff had been allocated to the first floor where 17 people needed support. Staff and relatives told us they had raised their concerns with the management about inadequate staffing levels and no action had been taken. One relative said, "I have told the manager my concerns I was told there are enough staff". The night before the inspection we were told that there had been a staffing shortfall. One member of staff said, "We are supposed to have three care staff but last night there was only two. It happens all the time. The rota is never covered. The night staff usually support some of the people to get up but

because they were down they couldn't, it then impacts on us this morning". We looked at the rota and saw this night shift had not been covered. We spoke with the manager about this who confirmed no action had been taken to cover it. For the remainder of the week we saw there were two outstanding night shifts that had not been covered. The manager also confirmed no action had been taken to cover these shifts. They said, "I have done nothing, I could call an agency but they won't be able to cover it, they never can". This meant we were not assured that action was taken to ensure the correct amount of staff needed, as identified by the provider, to keep people safe were on each shift.

We observed at midday people were still receiving their morning medicines. The nurse told us, "There are about three people left to have their medicines; I am waiting for them to get up. The position they are in means I can't give them their medicines whilst they are in bed". We observed and staff confirmed there were not enough staff available to support these people to get up. The nurse confirmed that these people received their medicines at 2pm with the next medicines round. They said, "This is what normally happens". This meant the lack of staff within the home impacted on the times people received their prescribed medicines.

We spoke with the area manager and the manager about action they had taken since the last inspection in relation to staffing. They confirmed there had been no increase in the amount of staff on each shift. They told us they had reviewed people's dependency levels and were 'confident' there were enough staff available within the home to offer support to people. We looked at the dependency tool that the provider used. For one person they were identified as a low dependency level for mobility. We saw records that this person had recently fallen. There had been no review since the falls and the dependency tool did not reflect a history of falls. This demonstrated that when people's dependency was assessed it was not always accurate.

We told the provider on the day of inspection they needed to take urgent action to ensure people were safe.

This is a continuing breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

People did not receive their medicines as prescribed. We observed that people's medicines were still in blister packs from previous days. For example, for one person all the medicines prescribed for the previous day were still in the blister pack. We checked the medicines administration record (MAR) for this person with the nurse. This had been signed to say these medicines had been administered. We looked at six people's blister packs and found the same concerns for two other people on different days. We raised our concerns with the manager who told us this had not been identified and no action had been taken. Furthermore we were handed a tablet by a person who used the service, the person had got this tablet from their handbag. As the person could not explain this to us we were unsure when this medicine should have been administered. We handed this tablet to the nurse who told us they would take action and dispose of this safely.

We saw that one person was prescribed as required medicines for agitation. There was guidance in place for staff to follow. This stated that the person should receive this medicine 'for agitation'. We looked at the MAR for this person and saw this had been administered nine times since the 13 March 2017. In the daily notes we reviewed there was no records to confirm this person had been agitated on these occasions. We saw documented comments including 'had a settled day' and 'remained in a settled mood'. This meant we could not be sure that people's behaviour was not controlled by excessive or inappropriate use of medicine.

People did not receive pain relief in a timely manner. For example, we observed a person shouting out and

were displaying symptoms that suggested they were in pain. We observed a staff member whose role was not to deliver care walk past the person and say, "[Person] sounds like they are in a lot of pain". We raised our concerns with the manager. The person was supported to change position however they were not offered any pain relief. We discussed this with both the nurses and they told us they had not been alerted to this. We checked records and saw another person had previously fallen which had resulted in an injury. Following their discharge from hospital four days earlier they had been prescribed pain relief. We saw this had been administered. Staff confirmed that this person was still experiencing pain. We checked records and saw this was documented on several occasions. On one occasion it was documented that the person was 'screaming out in pain'. The GP had not reviewed this person and no request for stronger pain relief had been made since their return from hospital six days earlier. During the inspection the person was reviewed by the GP. This was at 2pm and they were prescribed stronger pain relief. At 7:50pm we had to seek reassurances from the provider as the person had still not received these medicines.

People were at risk as there were not enough staff available to keep people safe. At 11:50 a member of staff identified that a person had not been given breakfast that morning, because other people were being supported. The staff member entered the person's bedroom and found them lying on the floor. The person's head was against the wall. We could not be assured when the person had last been checked. On the request of the inspector who was present at this time, the emergency call bell was activated. After five minutes as no one had responded, the inspector stayed with the person whist the staff member went and got a nurse to assist. The person was visually checked by the nurse. Later in the day we observed that the person appeared sleepy and three staff confirmed that they did seem sleepier than usual. The nurse confirmed that the person had been visually checked however no observation such as the person pulse rate or temperature had been taken. Furthermore, no regular visual observation or checks had been introduced for this person. We had to seek reassurances from the manager that checks would be implemented for this person to ensure they were monitored.

Prior to the inspection we had received information of concern that a person had fallen and we had contacted the home to seek reassurance. We spoke with the manager on the telephone who told us that no incidents had recently occurred. At the inspection we requested to see information in relation to this fall. The manager told us this had been documented and reported to ourselves and safeguarding, however we had not received a notification about this. They told us there was no ongoing internal investigation with regards to this. The manager also told us this person was being supported by one staff at the time of the fall and this was the correct levels of support. However, we looked at records for this person, which stated the person should have been supported by two staff. At the time of the incident the staff member had also left the room and the person was unsupervised. This meant people did not receive the correct levels of support from staff to keep them safe.

Risks to people were not managed in a safe way. For example, one person required the use of a walking aid to mobilise. We observed due to the size and layout of the person's room they could not walk around their bed with their walking aid. They told us, "I use the frame to get around. The room is too small. To get across the bed with the frame I would have to lift it over". This meant the environmental risks for this person had not been considered. We looked at records for this person and saw three incidents had been documented in February 2017 where this person had been 'found on the floor' in and around their bedroom area. The incident forms stated that records had been updated following these incidents. We reviewed the records and saw no evidence that these had been updated or that action had been taken to reduce the risk reoccurring.

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

There were procedures in place to report concerns of potential abuse to the local authority; however these procedures were not always followed. For one person we saw documentation and photographed evidence of significant bruising to a person's foot. The cause of this bruising was unknown. No incident from had been completed for this and no internal investigation had taken place. We also saw documented on two other occasions for this person unknown bruising had occurred. The manager confirmed this had not been reported to the local authority for consideration regarding investigation. We saw records for two other people where unexplained bruising had occurred and these had not been considered as potential safeguarding incidents. Staff we spoke with did not demonstrate an understanding of safeguarding. One staff member said, "You mean hoisting people and moving them safely". Another staff member said, "If I was concerned I would write it down, I wouldn't necessarily report it as I'm not sure action would be taken". They went on to say, "I don't know how I could report it outside the home". This meant we could not be sure people were protected from potential abuse.

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

We spoke with staff about the recruitment process. One member of staff said, "I had all my checks before I could start. I waited for my DBS to come back". The disclosure and barring service (DBS) is a national agency that holds information about criminal convictions. This demonstrated the provider ensured that staff were suitable to work with people who used the service.

Inadequate

Is the service effective?

Our findings

People did not always receive adequate fluids. One person told us, "If you look in my mouth you will see how dry it is". We saw there were two full drinks in this person's room, however the person could not reach these drinks. We alerted staff to this situation at 10am. The staff member said, "Don't give [person] the milkshake it's been there all night, they can have the squash it's fresh". We offered the person the drink and they drank all of this straight away. We checked records for this person. It was documented that they last received a drink at 17:00 the previous day. This meant people were not supported to remain hydrated.

For another person at 1:15pm we had to alert staff as we had observed they had not eaten or drank anything that morning. For a second person we saw that staff went into the person bedroom to offer breakfast but as they were asleep the staff member left. They said, "I have left the breakfast there because they are asleep. I will feed [person] when they go downstairs". The person was not offered breakfast downstairs. At 12pm we saw this person was offered some cakes. The cake was left in front of the person and no assistance from staff was offered. Shortly after this the cakes were removed uneaten. We also observed that they did not eat lunch or receive any support to do so. We raised our concerns with staff, who checked and confirmed the person had not had anything to eat until 18.30.

We observed that food and drinks were often left out of reach of people. For example, we saw at 09:10 one person had a hot drink and toast on a table next to them in bed. The table was out of their reach. We observed a staff member go into the person room at 09:50 and move the table closer to the person. They then started eating the toast that had been there for 40 minutes. When asked the person said, "No dear it's not warm it gone cold". We observed three other people in their rooms that had food or drink that was out of their reach. This meant people were not offered the necessary support to eat and drink enough to maintain good health.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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.

We looked to see if the provider was working within the principles of MCA. We saw when needed that some capacity assessments were not always in place. For example, people may be given their medicine without their knowledge if it is in their best interest and this is called covert medicines. We saw that some people received covert medicines without an assessment for this decision. Furthermore, some areas of the capacity assessments were unclear. In some mental capacity assessments, we did not see how the decision had been made and understanding the person had to make this decision. The provider used a checklist which offered a yes or no response to the questions asked. For some people we saw they had a capacity

assessment in place, however relatives had signed consent forms on their behalf. For example, for flu jabs and lap belts. This was recorded as a best interest decision however there was no evidence how these decisions had been reached. Staff did not understand the importance of gaining consent from people. When people were supported to eat or drink their meals in bed as staff were rushing, the positions of the beds were changed without staff explaining to people what they were doing or gaining consent from them to do this. This meant the principle of MCA was not always followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Not all restrictions put upon people had been fully considered. For example, we saw one person wearing a helmet. Some staff told us this was due to the risk of falling. Records and the manager confirmed that the person wore this to prevent them from pulling their hair. This had not been considered as a restriction and no application had been considered. Staff did not have an understanding of MCA or DoLS. One staff member said, "Absolutely no idea, is it about safeguarding people?" Another person said, "I'm not sure if I had training, I don't know what this is". All the staff we spoke with including the manager were unable to tell us who had a DoLS authorisation in place. When applications to the local authority had been made we did not see any evidence that people were being supported in the least restricted way whilst approvals were being considered.

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

Staff received an induction and training, however they told us this was inadequate and did not meet their needs. One member of staff told us, "I came in for induction on my first day; it was a few hours for moving and handling training. I was asked to stay and work a double shift which I did. I was counted in the numbers. I did not shadow anyone I just got on with it; I didn't really know what I was doing". Another staff member explained as part of their moving and handling training they supported a person to get out of bed as the service was short staffed. We observed one person was sliding out of the chair they were seated in. At the time they were sat on a slide sheet. We observed that two staff lifted the person back up the chair by holding them under their arms. This would be considered an unsafe moving and handling practice. This meant we could not be sure staff received the level of training required to support them in their role. Staff received training on the computer and felt this was rushed. One staff member said, "I was supposed to have a few months to do it, however they said I needed to do it in two weeks. I didn't really learn anything as I just had to get it done. No one tested my knowledge or asked what I had learnt. It was a waste of time".

This is a continuing breach of Regulation 18 (2) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

We saw when needed referrals had been made to professionals, however we could not be sure the recommendations were always followed. When people needed specialist diets to reduce the risk of them choking this was not always provided for them. At lunchtime we observed two people eat 'normal diets'. When we checked records for these people we found they were on soft folk mashable diets as recommended by the speech and language therapists (SALT). We alerted our concerns to the manager immediately. After we had raised our concerns, during the evening meal another person was offered a meal that was not consistent with recommendations made by SALT; a staff member intervened to stop this person eating this meal. This meant people were offered and ate food that had not been recommended and put them at risk of choking.

Requires Improvement

Is the service caring?

Our findings

At our comprehensive inspection we found people were not always supported in a dignified way. At this inspection the provider had not made the necessary improvements.

People were not treated in a dignified way and their privacy was not always respected. We saw that people were lying in their beds with their bedroom doors open. People were not always wearing clothing and were not covered by sheets. The environment they were in was often unclean with strong odours. We observed people had protective mats next to them that had spilt drinks on them. One staff member said, "It's not dignified, it's awful. I want to make [person] comfortable and tidy them up. However, if I do that then four other people will have their breakfast late". We observed a person come out of their room and seek support from staff. As there was no staff available at the time we supported the person back to their room until assistance could be found. The person was only wearing the top half of their night clothes.

At 09:10 we observed that there was a lot of food on one person's bedroom floor. The person was in bed sleeping. We spoke with staff who confirmed this person would often throw their food on the floor. They also told us, "It may have been there from the night before". As no action was taken to clean this up and we raised our concerns with the managers at 11:45. We observed at 1:45pm this food was still on the floor and had not been cleaned.

People and relatives were happy with the staff that supported them, however they did not feel they had time to spend with them. One person said, "The girls are good there are just not enough of them". A relative told us, "The girls are lovely but they haven't got ten pairs of hands". They went onto comment, "Good staff are leaving in droves because they get despondent. A lovely one left at the weekend, they feel like they can't do a good job anymore". As staff were rushing they didn't have time to spend with people or explain what they were doing. For example, when people had been supported to eat or drink in bed, the beds were lowered to a flat position straight away without giving people time to digest their food. We saw staff were rushing around and they shared information about people in the communal areas. We also observed in communal areas that staff stood over people to assist them with meals, before quickly moving onto the next person. This meant staff did not have time to treat people in a kind and caring way.

This is a breach of Regulation 10 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Staff told us the night staff should support people with personal care in the morning. They told us seven people would be allocated the night before to get up before 8am. One staff member said, "The nurse allocates who it is, it's not the person's choice". One person said, "I don't blink now after midnight unless they get me up". A relative told us, "They don't have a choice in the matter, my relation gets up and 4am most mornings now if they want to or not". The manager told us it was the choice of the individual if they got up early or not. We did not see any records to confirm who chose to get up supported by the night staff. This meant people were not always offered choice.

Relatives and visitors we spoke with told us staff were welcoming and they could visit anytime. One visitor said, "They staff say hello when I am here. I can come anytime". Another told us, "We visit every day, we can come anytime". We saw relatives and friends visited throughout the day.

Inadequate

Is the service responsive?

Our findings

People did not have care that was responsive to their needs. We saw that one person had slept in their chair the previous night. The person had several crash mats and cushions around them. We spoke with staff about this. One staff told us, "[Person] had a fall last week. They are crying out in pain when lying flat so the night staff thought it best for them to sleep in the chair". The person had recently been discharged from hospital with an injury and had slept in the chair for the last two nights. It was noted that the person had a mark on their back. The nurse checked this and the GP later confirmed this was positional fluid. We looked at records for this person and we did not see any action had been taken to resolve the issue of how to make the person more comfortable at night. No referrals to a health professional to advise on how this person would best be supported during this time had been made. We spoke with the manager who told us they were unaware that this was how the person had been sleeping. This meant people did not receive adequate support when needed.

We observed that no one living at the home had access to a call alarm in their bedroom. One person said, "I just shout all the time and hope someone hears me". Another person told us, "I wanted to go to the toilet during the night, I shouted for half the night for some help". Both people we spoke with confirmed they would be able to use an alarm if offered. Staff confirmed that this would be helpful to those people When we spoke with the manager they told us it was because there was only one extension lead available in the home. This meant people did not receive care that was individual to them.

Staff did not always understand people's support needs. For example, we looked at records for two people who had a catheter in place. Both people were on a fluid balance chart. There was no documentation identifying how much fluid each person should have daily. The staff we spoke with were also unable to confirm this to us. Furthermore, records showed us when people had not received adequate amounts of fluids no action was taken. For one person we saw recorded that for five consecutive days the person had below 1000mls of fluids recorded. The staff we spoke with confirmed that no action had been taken on this. One of the nurses told us that the person should be receiving more fluids than this.

This is a breach of Regulation 9 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that there was often a task focussed approach to supporting people within the home. Staff told us they were encouraged to complete tasks quickly and had little time to spend with people. For example one staff member told us that a member of the management team had told them to, "Give people a cat lick for a wash", as a way of saving time. We saw that this impacted on people's dignity because they were sometimes not fully supported when staff were rushing.

Staff had lack of understating about people's diversity and human rights and confirmed they had not received training in this area. For example people religious beliefs were not always considered. A relative told us, "They are catholic, they might enjoy a catholic service but this isn't available".

People's records were not always monitored and reviewed to ensure that they were receiving the care and support required. When people needed changes of position to prevent them from getting sore skin we could not be assured this had been completed. For example, for one person they were identified as needing two hourly changes of the position. Records showed that the previous night the person had been turned at 21:30, 01:30 and 07:01. One member of staff told us, "When we are short it impacts we have to prioritise. So that is more than likely accurate and the person wouldn't be able to be turned. I will check them as they might be sore now".

People were not encouraged or supported to access their interests. One person said, "There is nothing to do." Another person told us, "I stay in my room there is nothing going on in the communal rooms most days at least I can hear myself think in here". We observed when people were in their rooms there was nothing to stimulate them, people did not have televisions on or radios and the doors were often closed. Staff only went into people's rooms to complete a task. For example, to support with personal care or with a meal. A relative said, "It goes back to the lack of carers, there's not enough time for them to do activities. Another relative commented, "They don't get enough stimulation, there aren't enough staff here to do that for them, it's very frustrating". We saw there was an activity coordinator in post; some people were offered the choice to have their hair washed.

Staff told us there were daily arrangements in place to keep staff informed about people's needs. A staff member told us that, "It's not fit for purpose. Like this morning the night staff never told us they hadn't supported people to get up, so when we went upstairs we couldn't believe it". Another staff member commented, "Surely the point of handover is to know what's going on". This demonstrated that information that was handed over was not always accurate.

Relatives told us if they had any concerns or complaints they were not assured they would be actioned. One relative said, "I have told every manager that there are not enough staff". Another relative told us, "We complain all the time but you don't ever hear the outcome". The provider had a policy in place however we did not see any evidence that any complaints had been made. This meant we could not be assured complaints were responded to in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection in February 2016 we found there was a breach of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At that time we found there were not enough staff to meet people's needs in a timely manner and people had to wait for support. We also found medicines were not always managed in a safe way. At this inspection we found the provider had not made the necessary improvements to comply with this breach of regulations. The PIR had not identified any actions that had been taken in relation to these breaches.

We could not be assured that the provider understood the responsibilities of their registration with us. At the inspection we found there were safeguarding concerns that had not been identified by the provider. These concerns were around the alleged abuse of people who used the service. The management systems that were in place did not identify these as concerns and the provider had failed to notify us of these events.

We saw from records that incidents and accidents were reported. When incidents had occurred we did not see action was taken to mitigate further risks. For example, we saw three incident and accident forms had been completed in February 2017 where the same person had fallen in the same area. On the incident and accident forms it had been documented that following each incident this person's care had been reviewed. There was no evidence of this is the risk assessment. The person was identified as low risk. We spoke with the manager who confirmed they had not checked this action to see if it had been completed. This demonstrated that when action was needed to reduce future risks this was not taken.

We identified that medicines had not been administered and were still in the blister pack. We were told by the manager a recent medicines audit had been completed and no concerns had been identified. We showed the manager our concerns with the medicines. They told us that, "They would have just counted medicines and cleaned out the cupboard then". They were unable to provide us with a copy of the audit. This meant we could not be assured the systems in place were effective in identifying concerns.

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

There was not a registered manager in post. A manager had been working in the service for a few months and told us they were in the process of registering with us.

Throughout the inspection we raised concerns with the manger about our findings. On occasion the manager left the office to look into our concerns. However, they returned to the office before ensuring action had been completed. For example, at 1:30pm we observed people were still in bed and had not received personal care that morning. We brought this to the attention of the manager. The manager asked the nurse to 'get the people up'. The nurse explained there were other people on the first floor that still needed support, so was unable to do this. The manager then returned to the office, without taking further action. We also observed that one person was having a shave in the communal area, there were other people and relatives present during this time. This meant the person was supported in a dignified way. The manager

walked past without acknowledging this. Relatives also raised concerns with us. One relative said, "I wanted to talk to the manager the other day. The staff said she had gone off site again, she doesn't ever tell anyone she is going". Another relative told us, "The manager comes most days but she doesn't stop very long, no one ever knows who is in charge that is half of this homes problem". When we arrived at the inspection we were told the manager was not present and staff were unable to tell us when they would be expected. As there were two bank nurses on shift no one knew who was in charge. The demonstrated the home lacked leadership.

We raised concerns about the culture of the home. Staff told us they felt unsupported and bullied. One staff member said, "It's really bad, you get a hand put up to your face if you make a challenge". Another staff said, "I feel bullied and intimidated". During the inspection we raised our concerns with the area manager and the manager. All the staff, despite our concerns about people's safety, were taken off the floor for a meeting. After the meeting one member of staff told us, "We have been told to pull our finger out". Another staff member said, "It's all our fault again if we don't book our ideas up we are all getting reported to social services and the home will be closed". We were told by the management team that staff were jeopardising the inspection. They requested names of staff so they could take action when incidents had occurred, due to our concerns we did not provide this on the day of inspection.

Staff we spoke with did not feel listened to. They told us they had raised their concerns about staffing levels and no action had been taken. One staff member said, "There was a meeting and we tried to raise our concerns". Another staff member told us, "We have meeting but we are not allowed to talk. We raise concerns about staffing and the manger says she can get 15 people up in an hour". They went on to say, "You get told If you can't hack this job then you can leave".

We saw the provider was displaying their rating within the home. This was in line with our procedures.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have care that was responsive to their needs. Staff did not always understand people's support needs. People did not receive care that was individual to them

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated in a dignified way and their privacy was not always respected. Staff did not have time to spend with people to treat them in a kind and caring way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not always followed. restrictions placed upon people had not always been fully considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were procedures in place to report concerns of potential abuse to the local authority; however these procedures were not always followed and we could not be assured people were protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People did not receive their medicines as prescribed. We could not be sure that people's behaviour was not controlled by excessive or inappropriate use of medicine. People did not receive pain relief in a timely manner. Risks to people were not always managed in a safe way. People were at risk as there were not enough staff available to keep people safe. People did not receive the correct levels of support from staff to keep them safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive adequate fluids. And people were not offered the necessary support to eat and drink enough to maintain good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance When action was needed to reduce future risks this was not taken. We could not be assured the systems in place were effective in identifying concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to offer support to people and keep them safe. Staff received an induction and training, however they told us this was inadequate and did not meet their needs.