Mr & Mrs S Arithoppah

Sheldon Lodge

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection was unannounced and carried out on 31 January and completed on the 1 February 2017. Sheldon Lodge provided accommodation with personal care for up to a maximum of ten people.

There was a registered manager in place who was also one of two providers whose legal entity was a partnership. 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.

Prior to this inspection concerns were raised to us about people's safety. We found the provider had not responding appropriate to an allegation of abuse. People were not protected from the risk of harm due to the lack of timely medical intervention and people were placed at risk due to unsafe moving and handling practices by staff.

People received their medicines on time and medicines were stored safely. However, the provider did not follow the least restrictive action when administering medicines.

There was a lack of activities and meaningful occupation and there was no documentary evidence that the activities which did take place were planned and evaluated for their effectiveness.

We saw some positive interactions between staff and people however there were some staff practices which demonstrated a lack of empathy.

People had a care plan in place however we found they were not involved in the review of their care plan. Care plans and other documents were not being updated in order to ensure current information was accessible, particularly when providing guidance to staff.

The provider had failed to notify the Commission when required to do so, in relation to a change in their legal entity and notifications in regarding incidents.

Staff training had fallen behind as had staff supervision. Staff had received an annual appraisal.

The provider was not adhering to the principals of the Mental Capacity Act 2005 and we found that people were not involved in the decision making process.

The provider had a system in place for auditing the quality and standard of the service they provided, however these had not been completed to highlight potential shortfalls in the delivery of the service. People and families were not involved in how the service was run and were not asked for their opinion about this.

Staff reported they felt well supported by the provider and were able to approach them if they had any concerns.

Following the inspection, the provider notified us they were closing the service and submitted the relevant notifications to the commission as required.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

The provider did not act immediately and appropriately when informed of an allegation of abuse.

People were placed at risk of not receiving appropriate and timely medical intervention when required.

Staff were not adequately trained in order to be able to offer safe care and treatment.

Is the service effective?

Inadequate

The service was not effective.

People were not involved in decision making and the provider had failed to adhere to the principles of the Mental Capacity Act 2005.

People were not involved in selecting the food menu's and did not have a choice over the main meal.

Staff did not receive supervision and training was not kept up to date.

Is the service caring?

Inadequate

The service was not always caring.

People were not routinely treated with dignity and respect.

Some staff showed a lack of empathy towards people.

Care records did not always demonstrate a person centred approach and which involved people in making decisions.

Is the service responsive?

Inadequate

The service was not responsive.

People and families were not involved in the planning and in the review of their care.

There were institutionalised approaches with regards to personal care routines.

Care plans, risk assessment and monitoring documents were either not sufficiently detailed, had gaps in the recording of were out of date.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not carried out audits to ensure the service was effective in meeting people's needs.

People, families and professionals were not asked for their views about the standard of the care and support delivered.

The provider had consistently failed to meet requirements of their registration.

Sheldon Lodge

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 checked 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.

Prior to this inspection we received information of concern about the provider not following up an allegation of abuse in an appropriate and timely way. In addition, concerns were raised about staff not following the provider procedures and contacting appropriate medical services in an emergency. Unsafe moving and handling practices by staff and adequate staffing levels on some night shifts.

We carried out an unannounced inspection on the 31 January and completed the inspection on the 1 February 2017. The inspection 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 spoke with seven people and with three visitors about their views on the quality of care and support received. We spoke with both of the providers, one of whom is also the registered manager. In addition, we spoke with three care staff and the cleaner. We looked at seven people's care records, which included people who had previously lived at the home. We also reviewed documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we received information of concern about the provider not following up an allegation of abuse in an appropriate and timely way. In addition, concerns were raised about staff not following the provider procedures and contacting appropriate medical services in an emergency, unsafe moving and handling practices by staff and adequate staffing levels on some night shifts.

People told us they felt safe living at Sheldon Lodge and most families were appreciative of the support their loved one received. However this was not reflected in the way the service was managed in relation to safety and to the systems and processes in place.

People were placed at unnecessary risk of harm because the provider did not take appropriate action to protect them. In December 2016, a person reported to a member of staff an allegation that they had been verbally abused and intimidated by another member of the staff team. The member of staff informed the provider about the allegation of abuse. The provider failed to take appropriate action such as either temporarily removing the alleged perpetrator from their employment or ensuring an action plan was in place to protect the person.

The provider failed to document the incident and to submit a notification to the Commission as required. There was a delay between the provider becoming aware of the allegation and of them reporting the matter to the local Adult Care Safeguarding team. Upon becoming aware of the allegation on the 4 January 2017 the Commission reported the incident to the safeguarding team. Immediately following this, we contacted the provider and informed them a safeguarding referral had been made. The provider subsequently made a safeguarding alert on 4 January 2017. A delay in reporting was not in line with the providers own safeguarding policy and procedure and did not protect the individual.

People were placed at risk of neglect and further harm due to a lack of timely medical intervention. In three separate incidents, staff had contacted the provider rather than a GP or the emergency services when medical attention was required. The provider was not a registered health professional and the service is not registered to provide nursing care. Therefore, the provider was not the decision maker as to when medical attention should be sought. During the inspection on 31 January 2017, we raised this practice with the provider who told us 'staff should be telephoning the emergency services'. However no action had been taken by the provider to remedy this practice after the first such incident.

Staff had varying levels of understanding around safeguarding people from abuse and what abuse entailed. One member of staff had not received training in the safeguarding of vulnerable adults and all other care staff had not received refresher training. For staff who administered medicines, they had not updated their training nor had their skills and competence checked to determine they had the skills to continue to administer medicines safely. This meant that the provider could not be assured that staff had the relevant knowledge and skills to keep people safe. The providers safeguarding policy had out of date contact information on and this was the policy which staff used. This meant staff would not have access to accurate information should the need arise to contact the adult care safeguarding team.

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

The provider had not ensured that potential risks to people had been identified and appropriate action taken to minimise these risks. People had not been assessed and appropriate action taken to ensure they remained safe at night time. From Monday to Thursday the providers told us they were the waking night care staff and they also completed part of a day shift. The provider told us they would either be in the care home or in their private accommodation which was joined to the service premises. There was a call bell alarm system linked from the home to the provider's accommodation.

Two people who shared a room on the ground floor were not able to use a call bell and there was no risk assessment or support plan in place relating to how they could alert staff. Another person had their room on the first floor adjacent to the top of the stair way. Consideration had not been given to the risk of this person from falling down the stairs due to their impaired vision.

The provider told us that when they completed a night shift as a carer they went between their personal accommodation and the care home. The provider(s) had not considered the potential risks to people when they as carers were not on the residential premises but undertaking a work shift. There was no documentation which evidenced the provider(s) were available during the times stated and no documentary evidence of support being given or of people being checked during the night-time when the providers undertook a work shift .

The staff and the provider in their role as carer place people at risk because of unsafe moving and handling practices. This has been a concern raised by families and we observed this to be the case during the inspection. On the first day of the inspection we observed on two occasion's staff pulling people up from their seat by the wrists. The family of one person raised concerns with us that staff supported their loved one to get up from their bed by pulling their arms rather than using a slide sheet. This practice could cause injury to people, particularly those who are frail.

On the second day of the inspection the provider with another member of staff held one person under the arms to help them walk to the dining room. The person was frail and could not fully weight bear on their feet and therefore their feet dragged behind them. This resulted in the person being lifted and dragged in order to walk. We also observed people in their wheelchair being supported by staff to move to the dining room, however staff had not checked their feet were placed on the foot plate and one person had their foot trailing to the side of the wheelchair.

There was an increased risk of falls and a failure to identify preventative measures in relation to falls. The provider's falls recording and observation tools were not being used effectively to mitigate the risk of falls. Falls guidance for staff was limited. One person was stated in their care records as being at high risk of falls. They had sustained five falls in one month since they moved into the home. The risk assessment had not been updated to reflect this and any action taken to prevent further occurrence of falls. The provider did not audit the number of falls either individually or collectively in order to inform care planning and practice.

There was a system in place for the ordering, administration and disposal of medicines. However, people were placed at risk of receiving unnecessary medicine and were not involved in the decision making process about taking their medicine. One person was not protected from the misuse of a sedative. The protocol in place stated the person was to be administered the medicine when they became 'agitated'; however the guidance did not give clear instructions and was not cross referenced to a behaviour risk assessment. There was no explanation of how the behaviour was exhibited and therefore staff based their decision to

administer the medicine based upon their own interpretation of what 'agitated' meant. The risk assessment did not mention the use of this medicine.

The provider had failed to consider and use the least restrictive approach without resorting to the use of a sedative and there was no support plan in place to manage this. Care staff administered the sedative without checks if the medicine was required or reference to a senior worker. We observed the person was given half of a tablet of the sedative with the staff member saying 'here we go, we don't want you to get all worked up, do we?' We observed the person was not agitated or distressed in any way. This medicine had been administered for a week prior to the inspection and care records did not evidence a clear rationale for this. At the end of the inspection the provider made the decision to request that the GP change the administration of this medicine from an 'as and when required' to a permanent prescription. The person was not involved in the decision made to change from a PRN to a prescribed medicine and we saw no rationale for changing how the medicine was administered.

There were a lack of protocols in place which gave guidance to staff on when people were to take 'as and when' PRN medicines. The provider stated they checked the balance of stock each morning however there was no documentary evidence of this. The monthly stock audit was a check of the medicines stocks which had been delivered, however there was no other monitoring of refusals and review of medicines partly taken, or errors in recording and expiry dates.

Upon entering the home there was a strong odour. This permeated through the ground floor and some way up to the first floor. This odour did not dissipate throughout the day. The downstairs bathroom toilet had a dirty toilet brush and the bathroom was not clean due to dust and dirt behind the toilet and sink area. The raised toilet seat and frame was stained and not clean. There was no toilet lid in place which increased the infection through micro-organism in the air when the toilet was flushed. There was a residue of lime scale on the shower head which had not been cleaned. The upstairs toilet did not have a wash basin which meant people needed to use the sink in the bathroom, thereby risking cross infection from door handles.

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

Safe recruitment practices were not adhered to by the provider. We reviewed four staff files. For one member of staff their application form did not include details about any previous employment or reasons for gaps in their employment. There was no documentary evidence this was discussed in the interview. There was very little information in the application form about the staff member's skills, attributes and experience and no evidence which stated why the person was suitable for the post or the rationale behind employing them. Another application form for a member of staff did not contain information on the start and leaving dates on their previous employment. There were also gaps in information in the remaining two staff files we looked at. This meant that the provider could not be assured they had a clear understanding of the employee background and that the staff recruited were the most suitable for the position.

There was no record of when the provider(s) worked as carers in the home as they had not been included in a written staff rota. We could therefore not be assured there were sufficient numbers of staff at all times. During Monday to Thursday, the providers (two) worked the night shift from 9pm until morning, however as from mid-night this reduced down to one carer because the other carer was required to come back on shift the next day at noon. As some people in the home required two carers to support them, this would mean waking up the other carer. However, this may impact on their working capability the next day.

On the weekend shifts there were two care staff during the day and night, however no cleaner or cook as

with the week day shifts. Staff told us it was difficult to be able to manage for example, cooking, cleaning and caring for people, particularly those who required two carers for support, who would have to wait until the member of staff was available. There was no dependency assessment tool in place to assess the number of staff required according to people's current and changing care needs.

At the start of the inspection we arranged with the provider for us to speak with staff. The provider told us they would cover the member of staff whilst they were speaking with us to ensure there remained two members of staff on duty. On both days of the inspection, not long into the interviews we were interrupted by the provider stating the staff were required to support and the interviews were terminated. This demonstrated that the level of staffing of two care workers per shift as given by the provider was not adequate.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider was not aware of which families held a legal power of attorney for finances, or health and welfare. This meant that the provider was enabling families to make decisions on behalf of people without knowing if the family or representative had the legal authority to do so.

The provider did not consider the rights of people to be involved in decisions about their care and treatment. When people moved into the home the provider gave the family of the person a 'my life' sheet for them to complete and not the person themselves. This was the case with one person who had recently moved into the home. Staff did not talk with this person to find out about their life and the person was able to talk about this. The paperwork was passed to the family to complete.

The provider failed to undertake mental capacity assessments and record best interest decisions. The provider told us that when new people moved into the home they used a 'listening device' for the first few weeks to ensure people were safe. However, people had not consented to this practice and there was no documentary evidence they had.

For mental capacity assessments which were in place the provider failed to ensure that people were involved in this process. Sections on the MCA forms had not been completed which demonstrated how the provider had sought the view of the person involved.

The provider told us that four people were able to go outside into the community and they would not stop them from leaving the premises. We raised concerns around how they had determined people would be safe, as in the care records for one person it stated they should not go outside unescorted. The provider had not assessed the potential risk of four people leaving the premises and if they required supervision. There was subsequently no risk assessment in place with regards to locking the door, no best interest considerations or any Deprivation of Liberty Safeguards (DoLS) applications with regard to possible restrictions for these people.

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

Staff had not received supervision as required of the provider policy. There was a staff professional development statement regarding two monthly meetings. It stated that two monthly meetings were to be used for measuring performance and monitoring good practice. Performance was to be discussed and it was compulsory for staff to make themselves available. The document was written in 2007 and it referred to the years 2008 to 2009. No updated copy was available.

The provider explained that formal supervisions were supposed to be undertaken every two months but these had not taken place. They stated that as they worked alongside staff daily, then issues were discussed informally and staff confirmed this. There were no formal supervision records or records of any informal discussions in staff files. The provider stated that if staff had not been in for a few days then they would update them on what had been happening. There were no records to confirm this. There were no records of discussions with newer staff during induction that discussed their learning, progress or performance.

For long term staff, appraisals to assess their progress over the year had taken place in 2016 and these were documented.

Staff had not received refresher training and some staff had not undertaken training as required. The cleaner had not undertaken any training, this included safeguarding of vulnerable adults, infection control and in particular to their role, the handling of hazardous substances. The provider did not have an overview of what training staff had completed or which topics required updating. In the staff files we saw certificates which related to training, however most were dated 2015 or before. The provider told us they had fallen behind on training, however they had introduced the care certificate and sourced an external on-line resource for training.

The provider(s) also worked as carers in the home, however they had failed to keep their skills up to date and there were no records in place to demonstrate training or continued professional development.

The provider informed us they completed training with staff and assessed their competence. However they did not hold a qualification to either train staff or assess their competence. One topic was manual handling training which the provider delivered to staff. However, they had not undertaken any recent refresher training in this subject. We observed the provider carrying out unsafe manual handling practices and they did not challenge when staff did likewise. This meant the provider was training staff without having the necessary skills and competence themselves and this placed people at risk of inappropriate and unsafe care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The dining room provided seating on three tables. There were plastic table cloths on the tables, cutlery, tablemats and condiments. People were served a drink of squash, although a choice of drink was not given. The main meal of the day was decided by the provider. The provider told us they knew what people liked but if people did not like the meal on offer they would offer an alternative. There were no written or pictorial menus for people to select from and people were not consulted about the menus.

Once people were seated the meal was served promptly, however one person had their lunch in the lounge because a wheelchair was not available to take them to the dining room. When serving people, the food was pre-plated and staff told people what the meal was. However, they did not ask people if they wanted that type or quantity of meal.

For the evening meal, it was an open menu, with people being asked what they wanted. The provider told us "eggs are very popular, but also beans, ham, snacky things". At tea-time, people chose from a range of food according to their preferences. There was a bowl of fresh fruit but this was in the kitchen and people did not have access to the kitchen. Likewise, people were not able to make a hot drink without staff being available either to make it for them or to allow people access to the kitchen.

We observed that when staff gave people food or drink they did not explain what it was before placing it down in front of the person, this was during the day and during meal times. When people were offered a drink they were not given a choice of drink. We observed the provider approached one person who was eating a breakfast of porridge. Without asking the person, they put jam into the breakfast bowl and then wiped the person's mouth, again without saying what they were doing or asking the person if they wanted them to do this.

People did not have drinks to hand and for people in their room, their drinks were not within reach. If people were not able to reach a drink they may not have a sufficient amount of fluid to keep them hydrated, in addition their fluid intake was not being monitored. This meant that staff may not be aware of potential risks to people's health and welfare.

We asked the provider if we could look at the care records which documented the health care people received. They told us they did not have these as health professionals did not leave any written instructions or document the care given. Within the care plans we saw some evidence of medical intervention and support, however this information had not been collated together to enable staff to have an overview of the care people had received and subsequent care required. In addition, there was no system in place to ensure staff carried out support as directed by a health professional or of the provider monitoring the support which had taken place.

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

The home is registered to provide care for up to nine people and at the time of this inspection there were seven people living at the home. There were two toilets available for people and visitors to use. There was a downstairs bathroom and an upstairs shower room, each of which contained a toilet. Next to the upstairs shower room was a separate toilet. This toilet was locked and when we asked staff why, they told us it was for staff only. They gave us a circular disk which opened the toilet and reminded us to make sure it was locked after use. We asked the provider about the availability of this facility and they told us "No, it is not just for staff use". Each member of staff had a circular disk on their key ring to ensure the toilet was locked when not in use by staff. This meant that people's independence in managing their continence care had not been considered.

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

Inadequate

Is the service caring?

Our findings

People told us staff were kind and comments included "they're alright", "always willing to help", "we had a tiff or two in the beginning, its ok now", "they're [the providers] are alright sometimes". Visitors commented "they care for X in the best possible way, she is always dressed and clean" and "they give the impression of caring a bit more than a previous home".

We found there were some positive and kind interactions between staff and people, for example one member of staff was consistent in the way they tried to engage people in conversation, smiling at the person, listening to the person's point of view and giving people the time to respond at their own pace. However, this was not consistent across the two day inspection and between members of staff.

People were not treated in a way which maintained their dignity at all times and which respected their privacy. During the inspection we heard examples of staff not considering the person's privacy and affording them respect whilst in the company of others. This included staff discussing people's personal care in front of others, in particular around the medicines they took and in relation to bowel movements.

One person was supported to go to the first floor via the stair lift, where staff wheeled the person to their room on a commode. This was not a dignified or safe method of transport. Another person kept shouting out "I'm in pain, please god help me, I know I'm old but stop this pain". The person was touching their hip and side to indicate where the pain was. Staff did not acknowledge what the person was saying and when we told a member of staff this person was saying they were in pain, the staff member responded "no, she's not, she's lost family and friends and that's why she's upset". This demonstrated a lack of empathy by the member of staff. Later this person was given pain relief medicine.

During the inspection there was a mixed response from staff regarding communication. Some staff responded to what people were saying, others did not. We observed one person who asked staff which way it was to the toilet. The member of staff did not respond and when we asked why this was, told us "they use the toilet a lot and always has to ask where it is every time". This demonstrated a lack of understanding around supporting people with dementia.

Within people's care records there was information about people's likes and dislikes and important relationship in their life and we found staff did know people's preferences. However the level of involvement of people, information and detail in the records was inconsistent. Some records did not contain sufficient information in order to determine that people had been involved in the process or for staff to gain an overview of the person and their preferences. This included end of life care and support plans which did not demonstrate that people had been involved and which did not reflect a person centred approach to end of life care.

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

Inadequate

Is the service responsive?

Our findings

We asked a member of staff if there was any one person who had overall responsibility for organising activities within the home. We were told that as it was such a small service, that all staff were responsible for thinking of things to do.

We found that people were not involved in deciding what activities took place, activities were not planned or reviewed and this meant the provider could not be assured that appropriate and meaningful activities were taking place in line with people's needs. We heard one person repeatedly shouting "I'm bored, I'm bored". One person told us "I go out on my own a lot" and other comments included "there's nobody to talk to here" and "I prefer to stay in my room. I used to enjoy a lot of hobbies but can't do that anymore because of my illness. I stay on my own, I have the radio".

A member of staff told us activities took place at around 2pm to 2.30pm each day. In the afternoon there were puzzles out for people to use, however people were not actively participating as many were asleep. Later we saw a member of staff looking at photographs and the person was actively involved. We saw no other activities or social interaction during the two day inspection. We were not able to find any information regarding activities or records to show how effective interactions were for the individual. A member of staff told us they had 'Movie nights' where they had popcorn and watched a film, however, again there were no records which showed how many people had taken part and if they had enjoyed this activity.

We received a mixed response from people and relatives when we asked about the process for making a complaint or raising a concern. One visitor told us they would speak with the staff and another visitor told us a family member had raised the issue of a commode being full. We found people were reluctant to talk about raising concerns. One person showed us the chair in their room where the springs were coming through the seat pad. When we asked if they had told the provider about this, they told us "No, I don't want to make a fuss and don't want to say anything" and "I would rather not say anything". One family told us they had consistently raised concerns with the provider during the course of their loved ones time at Sheldon Lodge. There was no documentary evidence of the individual concerns raised by this family. The family later put in a written complaint which the provider acknowledged to us.

People were not involved in the planning or reviewing their care and care records were not person centred. Out of seven care records, only two had been signed by the person themselves to indicate they were happy with the care and support required or had been involved in contributing towards this process. People and families were not involved in reviewing their support plans.

The provider was updating particular parts of the care records however a complete review of people's care had not routinely been carried out. We saw support plans, monitoring plans and risk assessments had not been updated, some since 2012 and which were still being used by staff as their guidance on how to deliver safe and effective care. This included, risk assessments for the use of a hoist, a bath hoist, nutrition and fluid, behavioural support, weight monitoring and continence care. Likewise, the monitoring of people's care and support was not being completed as given in their care plan.

Risk assessments were kept towards the back of the person's care records but were not cross-referenced to direct staff to look at them. This meant staff may miss important information relating to the risks associated with people's care and support.

The care records were not person centred as they lacked sufficient information about people's preferences, for example in the way people preferred their personal care to be delivered and which clearly demonstrated what the person did and did not like. Information was not routinely available as to how staff should support people to maintain their independence with life skills and which included what tasks people were able to do for themselves and how staff should support this.

Some aspects of the care and support people received was institutionalised. A member of staff told us "we bathe people according to the list. We check who hasn't recently had a bath and then we offer them one." There was a tick list sheet of care and support people had received each day. The list indicated when people had or hadn't received care, however was not descriptive and therefore was not a useful tool in identifying if people had received appropriate care which met their needs. For example, staff indicated that people had received support with their continence needs, but not what care was delivered, how often and if any further intervention or support was required.

Likewise, there were gaps in the recording of people's daily care. For example, in one person's care plan it stated they should receive regular nail care. The frequency of when nail care was required was not given and we found a lack of information about timing of intervention was a common theme throughout all of the care plans. The daily care list demonstrated this person had not received timely nail care as with other people who had not received nail care for the month of January 2017.

There were gaps in the recording of checks made by staff during the night shift. Staff kept a record of their checks in a notebook. This gave a time the check was carried out and that 'all residents' had been checked. This was not accurate as there were insufficient staff to check the number of people who lived in the home at the same time. The records did not also indicate what staff were checking for or the care completed for example, assistance to use the toilet or to have a drink.

In one of the documents staff referred to for guidance, it stated that 'at least three people should be up and dressed by 7.45 am'. The provider told us this was an old document and should not have been in the file. We asked staff how people decided when they wanted to go to bed. A member of staff told us "once breaks are finished then care work begins, one carer will do a bath according to the list while the other carer gets people ready for bed. By 8.15 pm everyone that requires assistance should be ready for bed and watching television or in bed". This did not demonstrate a person centred approach to care and which showed that people were making their own decisions about their daily routines.

There was a lack of detail in the recording of how people had spent their day, in particular around their emotional well-being. Care records and risk assessments around behaviour which may challenge, lacked sufficient information on how staff were to support and manage the behaviour. During our conversation with the provider we found there was a lack of understanding around behaviour which may challenge and which may be indicative of a condition such as dementia. This was borne out in the language which the provider used such as people being nasty or demanding. This meant that when incidents occurred they were not being investigated to determine the reasons behind the behaviour.

Staff completed a handover between shifts and this was recorded in a diary. However, there was little information in this document and staff told us they were not allowed to record personal information. Staff later confirmed they mainly exchanged information verbally between handovers. This meant there was no

record of what information staff were sharing in order to keep people safe and to evidence that timely and appropriate care and support was given.

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

Inadequate

Is the service well-led?

Our findings

Staff told us they felt well supported by the provider and told us they could approach them if they had any concerns. The quality and safety monitoring systems in place were not effective in identifying risks to people to enable timely intervention and actions to reduce the risks. This was because the provider had failed to carry out regular monitoring and auditing since 2015. This meant people's welfare, health and safety was put at risk as the service was not effectively being managed.

The provider did not have an overview of the standard of service they were delivering to people. For example, staff training, practice and skills, if they were meeting the requirements of the Mental Capacity Act, the safe administration of medicines, recruitment practices and monitoring that care and support was meeting people's needs and safe. The provider had not identified the concerns we found during the inspection.

People and their families, outside professionals and agencies were not asked for their views about the quality of the service provided and people were not involved in how the service was run. Meetings involving people and their families did not take place and there was no system in place illicit views through for example, satisfaction surveys. The provider did not seek guidance from other bodies that provide best practice guidance relevant to the service which meant staff did not follow up to date and best practice when delivering care.

When we asked the provider to investigate concerns raised through complaints made to the Commission, we found the provider did not take accountability or responsibility, particularly in line with their responsibility under Duty of Candour.

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

The provider was not meeting the requirements of their registration. This was because they demonstrated through discussion with us and documentary evidence, they did not understand the responsibility placed upon them by their registration. During the inspection, we asked the provider if they had a copy of the provider handbook 'Guidance for providers on meeting the regulations' and were told "Yes, but we haven't read it". We asked how they ensured they were working to the required standards of the Health and Social Care Act 2008, to which the provider responded "we are a small home, I have been doing this for 25 years and I know what I am doing".

During the inspection the provider demonstrated they were not familiar with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider questioned the inspectors as to why for example, consent was required before a person moved into the home, the need for people's preferences to be part of the care plan and staffing levels should be based upon people needs. During the inspection we were required to refer the provider to the relevant regulations in order to validate the reason for compliance with the regulations.

The providers failed to inform the Commission when a change in the provider legal entity from a partnership to a limited company occurred in 2014. The provider told they had "forgotten to do this". They therefore remain registered as a partnership with the Commission which is not their current legal status.

Prior to the inspection we had concerns raised with us about the provider not working collaboratively with other stakeholders. When we asked the provider about this they denied this was the case. During 2016 and early 2017 we received complaints and information of concern around the attitude and the professionalism of the providers. This included health and social care professionals, a whistle-blower, visiting professionals and families and people.

This was a breach of Regulation 4 of the Care Quality Commission (Registration) Regulations 2009.

The provider failed to notify the Commission of a range of incidents as required by their registration. This included the unexplained death of a person, when three people were hospitalised due to a serious injury and when two people made allegations of abuse against the provider(s).

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.