# Pendlebury Care Homes Limited

# Regency Hall

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We inspected the service on 10 & 24 January 2018. The inspection was unannounced on both days.

Regency Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Regency accommodates up to 68 people in one building. On the day first day of our inspection there were 19 people and 16 on the second day living in the service, with one person was in hospital.

Regency Hall has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

This was the first inspection of the service since they registered with the Commission in October 2016.

The service is required to have a registered manager. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service did not have a registered manager. The provider did not ensure the service was managed effectively and in the best interests of people.

The provider did not have systems in place to manage the service and to ensure people's safety. There were no systems in place to establish the number of staff or how they were deployed to keep people safe and meet their needs.

There was no process in place to ensure the control of infection. The home was visibly dirty in places and there were no process or schedule in place to keep the home clean. Care staff had to perform these duties as well as prepare meals. There was a part time chef which meant staff also had to cook meals for people taking them away from providing the care.

Risk was not effectively assessed or updated to ensure they had a reliable care plan to follow. Some accidents and incidents were recorded, but not reviewed to ensure the cause of accidents was recognised and where appropriate acted on to prevent other accidents happening again. People were left alone during breakfast without means of communication or calling for assistance.

No new staff had been recruited since the service was registered with the Commission. There was no system in place to ensure agency staff were given enough information about people to ensure their safety and welfare.

Medicine was stored and administered as prescribed although medicines due for return were not stored appropriately.

People were not consulted on how they wanted their care delivered. Daily information on people's care was not analysed and if appropriate added to their care plan. There was no assessment process in place to re-admit people who had been in hospital. There were no communication systems in place to ensure all staff were aware of the current needs and welfare of people.

Staff were not supported or supervised appropriately to ensure their developments needs were discussed or met. There were no systems to recognise and put best practice in place. Menus were not planned in advance taking account of people needs wants and wishes.

There were no systems in place to recognise signs that the service may no longer be able to meet people's needs. Staff had concerns about their ability to meet some people's needs. The training provided to staff had been completed when the service was registered in September 2016 and not updated since then.

The MCA act was followed and where appropriate the local authority had been involved in determining people's ability to make decisions about their care. Staff had some knowledge on how to safeguard people.

People's dignity was not always promoted as people were not offered baths or showers as they wanted them. People were not involved in the planning or delivery of their care. Staff were kind in their interactions with people.

Care was not person centred and reviews were not completed in a timely manner. People were not supported to pursue their hobbies and interests. Complaints particularly regarding the cleanliness of Regency Hall and laundry services were not effectively responded to.

The provider did not ensure there was a system in place to inform CQC of incidents. Therefore there were incidents we were not informed about. Record keeping was poor and ineffective. Some records such as rotas were not dated and paperwork was not stored in a manner which offered easy access and they were not stored in a confidential manner.

There was no quality assurance process in place. This meant audits of service provision were not completed, therefore there was no way the provider could show the service was recognising and meeting people's needs and wishes. It also meant there was no process to learn from mistakes to ensure they were not repeated.

Staff were without direction and management and only responded to immediate needs of people.

We identified the provider was in breach of six of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see the action we have taken at the end of this report.

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.

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.

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.

People were not protected from the risk of cross infection as the home was not clean.

There were insufficient staff to meet people's needs and care was not planned or risk assessed appropriately.

Risk assessments were not up to date and reflective of people's risk. Accidents and incidents were not monitored, reviewed or timely action taken to reduce the risk of harm.

Medicines were appropriately managed, administered and stored.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The provider could not be assured staff were trained effectively to ensure people were supported to maintain their health, welfare and personal development.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA) and DoLS.

People's needs and choices were not fully assessed so that the provider could be sure they were delivered in a way that helped to prevent discrimination.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People's dignity and independence was not promoted or respected.

People and relatives were positive about the kind and caring attitudes of the staff team.

People were not given the opportunity to communicate in ways

which suited them.

People were not consistently supported to participate in designing or reviewing their care.

End of life care was not always considered.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

The provider did not ensure there were clear processes in place to ensure concerns or complaints raised by people or relatives were managed consistently.

People did not receive personalised care that was responsive to their needs.

People were not supported to communicate effectively by staff who understood their individual styles and methods.

## Is the service well-led?

**Inadequate**

The service was not well led.

The provider did not ensure there was a registered manager in post to provide management and leadership to the service.

There was no quality assurance system in place to aid improvement of the service or support staff.

There were no systems in place to inform CQC appropriately of incidents or events that affected the running of the service.

# Regency Hall

**Detailed findings**

## Background to this inspection

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

We inspected the service on 10 and 24 January 2018. The inspection was unannounced on both days. On the first day the inspection team consisted of one inspector and one specialist advisor with expertise in the care of older people and an expert by experience. On the second day there was one inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, these include allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views.

The provider did not send us a Provider Information Return (PIR). The PIR gives us information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit we spoke with four people who lived at the service, four relatives, three members of care staff, a senior carer who had responsibility for managing the service and the provider.

To help us assess how people's care needs were being met we reviewed all or part of three people's care records including their risk assessments. We also looked the medicines records of two people, three staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out observations of care and support and looked at the interactions between staff and people who used the service.

Inadequate

# Is the service safe?

## Our findings

People's relative's told us, "I think it's a lovely place but there are not enough staff. The people here need a lot of help and it takes two staff to use the hoist. When they are hoisting somebody, then very often there is nobody to help the others. There are one or two people here who wander all the time and nobody watches them. We have found one person in our (relative's) room more than once and sometimes that person has pulled all the drawers open." A second family said, "They are definitely short staffed. They have too much to do which means things get left."

The provider did not ensure there was enough staff on duty to keep people safe. We saw people were left unattended and without means to calling for assistance for up to 12 minutes at a time. One person kept sliding to the front of the chair and was at risk of falling out. People were also left unattended at breakfast time trying to feed themselves when they clearly needed assistance. Two people regularly spilled all their cereal whilst eating. People were exposed to the risk of injury and being unable to feed themselves due to the lack of staff. Staff told us they were too stretched. One staff member told us they often had to stop administering medicines to complete another task. For example they said a few days ago they had to stop administering medicines to iron a shirt for a person who needed to get dressed.

The service had two shifts needing a senior carer to lead the shift and during the day with three carer staff. At night a senior was needed with two care staff. That meant that the service needed at least three senior staff, five care staff, one domestic staff and one chef per day. There was three permanent care staff and three permanent senior care staff one of whom was managing the service. There was no domestic staff and the cook worked part time starting after 10.30 each morning. This meant staff had to prepare breakfast for people as well as provide personal care. Subsequently people were left unattended at breakfast when they needed help.

We spoke with the provider who said they would address this issue and provide more staff on shift. On the second day of the inspection the staffing levels had been increased on both the day and night shift by one staff member to ensure that peoples needs were being met.

The provider relied on agency staff to fill staff vacancies as they were not actively recruiting new staff at the time of our inspection. We observed an over reliance on agency staff to fill gaps in the staff rota. One person said "I don't like the agency staff very much. Some of them are alright but we don't know them and they don't know us." There were three permanent care staff and three senior care staff, while the service tried to use the same agency staff for consistency.

On the first day of the inspection visit we saw nine people in the large sitting room with one agency staff member. We saw they made no effort to connect with people and showed no knowledge of people's needs. Most of the people were out of the staff member's line of vision this meant they could not see if someone was distressed or needed support.

The staff rota showed there were only two members of staff on duty during the night. However, some people

required two staff to assist them which left the remaining people at risk of poor care or having to wait for their needs to be met. The staff rotas were not dated appropriately. They had the date but not the month, which made them confusing to read. The records were not kept in accordance with guidelines and could not be used as an accurate account of staffing levels or deployment within the service. The provider had failed to ensure there were sufficient numbers of staff employed to meet the needs of people using the service. This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured the safety of people by providing a clean environment for them to live in. There was no dedicated staff to clean the home. Systems were not in place to prevent the spread of infection. A member of care staff cleaned the home on three days per week for six hours per day. This left four days when the home was not cleaned. We found the place visibly dirty with people's rooms unclean and unhygienic. This included faeces on the floor and stained toilets in four people's rooms. Another room had a very badly stained bed base. Another room had a pool of liquid on the floor under a chair. The stairs to the kitchen and the corridor outside the kitchen were visibly dirty with pools of liquid on the floor. A review of rotas showed a staff member was responsible for the cleaning Regency Hall, however, they had not received any training on how to keep people safe from the risk of cross infection or how to keep the premises clean and odour free. We found odours associated with urine in different parts of the home.

When the part time chef was not available care staff had to prepare meals for people. We saw staff entered the kitchen without protective clothing; this raised the risk of cross contamination. There was no rota for care staff who worked in the kitchen preparing meals so there was no evidence available to show staff had the qualifications to fulfil this role. We noted the last completed food hygiene training by permanent staff was in September 2016.

Some of the toilets did not have soap and paper towels; therefor there was no way for people, staff and visitors to wash their hands. There had been an outbreak of diarrhoea and vomiting (D&V) in November 2017. There were no details available on this including the dates of the outbreak and the control measures that had been put in place to ensure the outbreak was contained. There was no infection control policy available. When we asked for the provider's policy we were given a Department of Health information leaflet on "Flu Resource Pack for care homes." CQC had also not been informed of the outbreak as they are required to by law.
People were not given appropriate opportunities to maintain their own personal hygiene. They were not offered baths or showers on a regular and frequent basis. One person said they had had one bath in three weeks. They went on to say, they would like a daily shower or bath but staff were too busy. Records we looked at supported this.

There were no systems in place to ensure people had access to clean and fresh clothing. We saw some people's clothing was stained and creased. The management of the laundry was also included in the six hours, three days per week cleaning arrangements for Regency Hall. The staff member was responsible for washing people's clothing and bedding.

People's relatives were not happy with the standard of cleanliness and some were washing their relative's clothing including their bedding. A relative said, "'I am seriously thinking of taking (relative) home and trying to manage. They're killing the staff here. We are just taking two steps forwards and four steps back. Every time I visit I clean the toilet in (relative's) room and I've been bringing a mop and bucket in to wash the floor because it just isn't done. They don't have dedicated cleaners and the staff are expected to do it. Laundry is a disgrace. Everything comes back pink. I won't let them wash (relative's) bedding because it was expensive so I take it home and do it myself."

The provider failed to ensure that care and treatment was provided in a safe and effective way that would protect people from the risk of the spread of infections, including those that are health care associated. This is a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not protect people from risk because there was no effective and up to date system in place to recognise and mitigate risk. Incidents were recorded however, they were not reviewed or managed to reduce the risk of the incident happening again. For example, one incident a female staff member was subject to physical and emotional abuse. No actions had been taken to protect staff or to ensure people were not subjected to the same abuse. We were concerned about staff and made recommendation on how to reduce the risk.

There were risk assessments in place; however they were not up to date. For example, a person was admitted to hospital with a serious injury. They were re-admitted to the service without an up to date risk assessment or directions for staff on how to care for them while recovering from their injury. This lack of information on their injury and the lack of direction to staff could put this person at risk of further injury, pain or distress.

Another person had bruising to their cheek and we were told that they had fallen 'a couple of weeks ago'. However, the staff member couldn't tell us anything about it or show us records of how the incident had happened.

One relative told us about a person's unexplained bruising and how the management team were unable to recall how it happened. They felt the staff were too busy to watch over people and there was a lack of management, no leadership and staff being overstretched. Staff we spoke with were aware of safeguarding and whistleblowing procedures. However, no staff had raised with the Commission or the local authority about the conditions we found at our inspection. Staff had not ensured CQC or the local authority were aware of incidents such as unexplained bruising.

The provider failed to have an effective overview of the risks associated with peoples care and treatment to promote their on-going safety. This is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems to ensure record keeping was managed in a manner that promoted people's safety. Daily records were completed; however, they were not stored appropriately. There was no system in place to capture information and use it to update care plans or the risk assessments. This meant staff and agency staff did not have the most up to date information on people and how to keep them safe from harm. The lack of effective record keeping resulted in the provider not being able to provide us with the information we needed.

People had personal emergency evacuation plans (PEEP) in place. They were embedded in care plans making staffs' access to them in an emergency difficult. Most plans had not been reviewed since people had been admitted to the home. We saw some people were admitted in late 2016 and if their needs had changed staff may not have the appropriate information on how to evacuate people safely. For example, one person received a life changing injury resulting in changes to their mobility. The PEEPs did not record the level of assistance they required in an emergency which could result in a delay to them being evacuated from the building.

People's medicines were safely administered. Most of the people we spoke with said they were taking

regular medicines. Few people were able to tell us precisely what medicines they were taking, however people were able to tell us they were offered their medicines that were prescribed as required.

Staff who were responsible for the administration of people's medicines had taken part in appropriate training. We observed a medicines round. Accurate records of this were made in the Medication Administration Records (MAR's). We saw staff administer medicines, they gave people enough time to take their medicines and some people were gently coaxed to take them when appropriate.

Medicines were stored appropriately, however the fridge used was iced up and temperatures were not regularly recorded. The last recorded temperature was 17 December and the last room temperature was 12 December 2017. This could leave the medicines stored in the fridge at risk of deterioration and render them ineffective.

There was no system in place to audit medicines or return unused medicines back to the pharmacy. We found these medicines stored in haphazard manner and there was no record of accurate opened medicines.

We recommend the provider seeks appropriate guidance and support on the safe management of medicines.

Adequate steps had been taken to ensure people were protected from staff that may not be fit and safe to support them, as a safe recruitment process was in place. Each of the three staff files we viewed had the necessary information on the staffs identity, work history and security checks. Despite staff vacancies on all areas of the service, as the staff turnover was very high, including care staff and domestic staff we were told by care staff no new care staff had been appointed since the service was registered with the commission.

Requires Improvement

# Is the service effective?

## Our findings

People did not have their needs assessed in relation to their physical, mental, emotional and spiritual care and wellbeing. Care plans we looked at varied in the content. The provider told us this was because different managers had introduced different formats but had not stayed in post long enough to process them. There were no processes in place to ensure care plans were reviewed on a regular basis. Therefore, none of the care plans showed up to date details that represented the current needs and wishes of people. One care plan we looked at held a collection of papers, including a pre-admission assessment. None of the information had been pulled together to create a care plan to direct staff on how to care for the person.

People's relatives we spoke with said, "The only thing they did was give us a form to fill in when (relative) first came here. I've never seen a proper care plan and there has never been any discussion with us about it.' A second relative said 'Relative has been here a year and I insisted on seeing a care plan. There has not been any review of it though and I keep asking. Most of the people who visit relatives here don't know anything about care plans at all."

Staff we spoke with were unaware of the protected characteristics under the Equality Act and were unable to describe how they incorporated these in their day to day practise. Staff could not ensure their care and support was delivered in line with legislation and nationally recognised evidence based guidance. Steps had not been taken by the provider to ensure people were supported to have their varied and diverse needs identified and met. Without this the provider could not be sure that people did not experience any discrimination.

The provider had failed to ensure that people had a plan of care that was up to date, inclusive and gave staff directions on how best to meet people's needs, wishes and preferences. This is a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure staff were trained to meet people's diverse needs. Some people living at Regency Hall were living with dementia. Staff had not been trained in how to respond to people's behaviours they found difficult to understand and manage. They had no senior staff they could go to for guidance and direction and no registered manager to support them to develop behaviour plans. A relative told us "Staff try their best but I don't think they get the training they need. They have very little awareness of the different ways dementia affects people and how to respond to the individuals. I feel sorry for the staff. There is no leadership or direction for them and they get burnt out very quickly." Staff told us they had become used to not asking for assistance which had resulted in them trying to manage people's care without the knowledge and skills to do so.

The last recorded mandatory training for staff was in November 2016. This included moving and handling and medication. Staff were not up to date on assisting people to move safely. We observed people being assisted to move. We saw this did not put people at risk. However, one person told us the night staff did not like using the hoist, they said, "There is one of the night staff who tries to make me walk and I can't. My family has left notes saying she must use the hoist and the senior carer has told her she must. She does it

now with somebody else but she grumbles about it and calls it 'that thing'."

Staff were not supported and supervised in a manner that ensured they had the opportunity to discuss any problems or issues they may have in the work place. There were no annual appraisals to identify any personal development plans or for staff to receive feedback on their work. Supervision had not been completed at regular intervals to allow staff the time to express their views, to reflect on their practice, their training needs and to discuss their professional development.

The provider failed to ensure that people were looked after by suitably trained, supervised and experienced staff. This is a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's physical health was promoted as GP's and community nurses visited on a regular basis or when called. On the day of our first inspection visit a community nurse visited the home. Relatives confirmed they were happy with the health care provided and that the communication was good and they were usually alerted if their family member was unwell. A relative said, "They are not bad in that respect. They will always get in touch if (relative) isn't well or they are worried at all. They do involve us." However, we found no evidence of involvement of health care professionals such as speech and language therapist – despite some people being on a soft diet and being at risk of choking.

People told us their general health was supported. One person said, "The district nurse comes in to do my insulin and blood sugars". We asked about obvious oedema in the person's ankles and were told, "[Nurse] never looked at my ankles and my feet are painful." A staff member overheard our conversation and came and said they would arrange for the doctor to come and look at the person's ankles. While this response was appropriate, it was reactive to this having been picked up at inspection and not during day to day care provision.

Meals were haphazard as there was no permanent chef and therefore no effective menu planning. We received mixed opinions of the food served. One person told us they got the 'same old thing every day.' Another person said, "I don't like the food. It's always baked beans, every day and I don't like baked beans and I can't eat them" However a relative said, "I think the food here is good and (relative) has put on some weight since (relative) has been here which shows they are eating well." On the second day of our inspection visit we saw people were served an 'all day breakfast' type lunch. We asked four people's opinion and they all said it was good and tasty.

Staff were unable to provide us with an overview of people' nutrition as there were no systems in place to ensure people had enough to eat and drink. Meal times were not always supervised. Our observations showed when people had been left without assistance to eat breakfast; no note was taken of people who had not eaten or those who had spilled their food. Staff did not know how much people had to eat. There was a system in place to weigh people weekly or monthly to ensure their weight loss or gain was monitored. However, this was not up to date, the last records of people's weight was in November 2017. This lack of planning and monitoring could put people at risk of poor nutrition and malnutrition.

People using the service lived in a safe, well maintained environment. Most bedrooms were personalised to reflect their own interests and preferences. This included people's bedrooms with their personal possessions around them. People had access to comfortable communal facilities, comprising of several large lounges and separate dining area. However while the environment was in good repair and condition, most people we spoke with did not like the colour scheme and found it too dark.

Adaptations and equipment were in place in order to meet peoples assessed needs. However signage was not clear. There was no picture signage to guide people, particularly those living with dementia, around the environment. One two occasions, people we came across were looking, without success, for their room. Toilets and bathrooms were not clearly signed.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had a basic knowledge and understanding of MCA and DoLS. Information available showed that each person who used the service had their capacity to make decisions assessed. Where people were deprived of their liberty, appropriate applications had been made to the local authority for DoLS assessments to be considered for approval.

Requires Improvement

# Is the service caring?

## Our findings

The service was not responsive to people's individual needs and wishes. Complaints were not always responded to. One relative said they had made a complaint on missing and damaged property. They also said they were too concerned about raising a complaint because of possible repercussions if they did.

A member of staff said they spent a huge amount of time listening to constant complaints about the laundry. We found no record of these but people and their relatives confirmed they made complaints. For example one relative told us, "I think the environment is lovely. It's like a five star hotel but I do think they are short staffed. There are not enough staff and they have too much to do. The main complaint we have is about the laundry. Clothes are never washed properly and everything gets chucked into the tumble dryer so jumpers and trousers shrink." Another said, "I have spoken to the owner about issues with the laundry and all he says is 'we'll have to get somebody to do the ironing.' It's not really good enough."

There were no systems in place to ensure people received personalises care. Care planning did not include sufficient information on people's individuality such as their likes, dislikes and hobbies. A person told us, "I come in here (the lounge) because it's better than being stuck on my own but there's nothing to do and I am bored."
The provider failed to take account of peoples complaints and act on them appropriately. This is a breach of regulation 16(1) Receiving and acting on complaints.

People were not offered 'useful occupation' or engagement. There were no newspapers or magazines or books available for to people look at. Although there was an activity co-ordinator in post they told us they had no budget to buy items that interested people or for outings outside the service. A relative told us, "Everyone here is just bored. I've asked (named carer) who is supposed to do activities to do things for the men as well but all she ever does is paint nail varnish on a few of the ladies fingernails." We saw there were objects and games around the service, however these were not made available to people. When asked, staff told us they needed to keep the place tidy.

The provider did not have processes in place to ensure people's diversity was recognised and respected. For example people could not tell us whether religious needs were considered or met in any way. We were told there was no one with a diverse cultural or dietary need in Regency Hall yet there was no process in place for staff to establish this. One relative told us, "[Relative] is Roman Catholic and was a regular attender at Church. I understand there are occasional visits by an Anglican Vicar and the Priest has visited a couple of times. I don't know whether staff here are aware of my relative's faith."

Prior to the inspection visits we were contacted by people who had concerns about the service. The concerns included people not having a choice of time they could go to bed or getting up in the morning. We were told the night staff got people up too early. The provider told us this did not happen and that people's choices were respected. There were no records to support this. One person said, (indicating another person across the lounge) "(Named person) doesn't like to go to bed too early but as soon as the night staff come they start getting everybody into bed. (Named person) really kicks off and struggles with them but they still

make (named person) go to bed. It's usually about 8pm and they try to get everybody into bed by 9pm whether they want to go or not."

The permanent staff did seem to know residents well but we saw insufficient meaningful interaction because staff were too busy. Relatives said care was not always person centred, for example one relative told us, "The staff here all call (relative) by their first given name but family have always known (relative) by their middle name. Relative does respond when they use the first name but it's a bit confusing when visitors use the middle name. Nobody has ever asked how (relative) would prefer to be addressed." This meant people were not treated as individuals and received care that was task led. By this we mean staff concentrating on the task they were completing rather than focusing on the person they were caring for. For example people were washed rather than being offered a bath or shower and people were left bored because staff did not know what they like to occupy themselves with.

The provider failed to establish care and treatment that met peoples needs and reflect their preferences. This is a breach of Regulation 9(1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not responsive to people's individual needs and wishes. Complaints were not always responded to. One relative said they had made a complaint on missing and damaged property. They also said they were concerned about a back lash if they made a complaint.

A member of staff said they spend a huge amount of time listening to constant complaints about the laundry. We found no record of these but people and their relatives confirmed they made complaints. For example one relative told us, "I think the environment is lovely. It's like a five star hotel but I do think they are short staffed. There are not enough staff and they have too much to do. The main complaint we have is about the laundry. Clothes are never washed properly and everything gets chucked into the tumble dryer so jumpers and trousers shrink." Another said, "I have spoken to the owner about issues with the laundry and all he says is 'we'll have to get somebody to do the ironing.' It's not really good enough.

There were no systems in place to ensure people received personalises care. Care planning did not include sufficient information on people's individuality such as their likes, dislikes and hobbies. A person told us, "I come in here (the lounge) because it's better than being stuck on my own but there's nothing to do and I am bored."

People were not offered 'useful occupation' or engagement. There were no newspapers or magazines or books available to people look at. Although there was an activity co-ordinator in post they told us they had no budget to buy items that interested people or for outings outside the service. A relative told us, "Everyone here is just bored. I've asked (named carer) who is supposed to do activities to do things for the men as well but all she ever does is paint nail varnish on a few of the ladies fingernails." We saw there were objects and games around the service, however these were not made available to people. When asked, staff told us they needed to keep the place tidy.

The provider did not have processes in place to ensure people's diversity was recognised and respected. For example people could not tell us whether religious needs were considered or met in any way. We were told there was no one with a diverse cultural or dietary need in Regency Hall yet there was no process in place for staff to establish this. One relative told us, "[Relative] is Roman Catholic and was a regular attender at Church. I understand there are occasional visits by an Anglican Vicar and the Priest has visited a couple of times. I don't know whether staff here are aware of my relative's faith."

Prior to the inspection visits we were contacted by people who had concerns about the service. The concerns included people not having a choice of time they could go to bed or getting up in the morning. We were told the night staff got people up too early. The provider told us this did not happen and that people's choices were respected. There were no records to support this. One person said, (indicating another person across the lounge) "(Named person) doesn't like to go to bed too early but as soon as the night staff come they start getting everybody into bed. (Named person) really kicks off and struggles with them but they still make (named person) go to bed. It's usually about 8pm and they try to get everybody into bed by 9pm whether they want to go or not."

We saw that permanent staff did seem to know residents well but we saw insufficient meaningful interaction because staff were too busy. Relatives said care was not always person centred, for example one relative told us, "The staff here all call (relative) by their first given name but family have always known (relative) by their middle name. Relative does respond when they use the first name but it's a bit confusing when visitors use the middle name. Nobody has ever asked how (relative) would prefer to be addressed." This meant people were not treated as individuals and received care that was task led. By this we mean staff concentrating on the task they were completing rather than focusing on the person they were caring for. For example people were washed rather than being offered a bath or shower and people were left bored because staff did not know what they like to occupy themselves with.

This is 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

It is a condition of the provider's registration that they have a registered manager; however, there was no manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider did not ensure the service was managed effectively and in the best interests of people.

Since the service registered with the Commission in October 2016 there had been five managers in post, however, only one had been registered with the Commission. This was a regional manager who was in post when the service was registered. On the first day of our inspection the service was being managed by senior member of care staff who did not have sufficient experience or support to manage. We asked for this to be addressed and on the second inspection visit a consultant manager had been employed. They were on site three days per week and offered telephone support the remainder of the time.

For a variety of reasons the provider had failed to secure a consistent management team within the home. This has affected the overall management and leadership of the service and therefore resulted in the delivery of poor quality care to people.

This ineffective management of the service had resulted in a lack of robust systems and processes to assess monitor and improve the quality and safety of the service provided to people. For example there was no quality assurance system in place to monitor and review people's care plans when their care needs changed. This meant the information available to staff, including agency staff was not up to date and did not provide staff with the information needed to care for people safely and effectively. Risk assessments were not reviewed and updated this left people and staff vulnerable and open to possible risk and harm. Risks were not managed effectively and accidents and incidents were not reviewed or action plans put in place to ensure accidents, where possible, were prevented and reduced.

The provider left people open to the risk of infection and subsequently cross infection due to the lack of systems to keep the service clean. The provider did not ensure people had access to clean fresh clothes and clean fresh bedding to promote their wellbeing and respect their dignity.

There were no systems in place to review staffing levels and no systems in place to recruit new permanent staff, including domestic and catering staff. The service had three permanent carers and three senior carers, therefore there was over reliance on agency staff to care for people. Given this over reliance on agency staff, the provider had not mitigated the risk by ensuring agency staff had appropriate up to date information on people's care needs and wishes.

Staff morale was very low as staff felt unsupported by the provider and the lack of management and leadership of the service. There was no clear direction for staff on how to care for people effectively which had resulted in the small staff team trying their best to provide care, cleaning and cooking for people. There

was a risk the permanent staff team would leave the service.

The provider was unable to tell us their values and a vision for the service. This resulted in staff providing basic task led care. Staff told us felt undervalued and there was no evidence they had regular team meetings so the provider could capture their knowledge, training needs and offer them support.

The provider did not ensure accurate records were securely kept and up to date. There was no system of 'hand over' in place for staff to know of people's changing needs. Many records in care plans were not dated therefore difficult to know if they were accurate. For example staffing rotas were not dated, and there was no information on the dates of the outbreak of diarrhoea and vomiting (D&V). Records were not kept in a manner that promoted people's confidentiality as they were stored in an open office which was not locked when not in use.

The provider did not have systems in place to capture and act on people's wishes and needs in relation to their care. They were not included in care planning so the provider had no way of knowing if the care plans reflected people's wishes and needs.

The provider did not have systems in place to inform CQC of events that impact on the running of the service. This included when the service was without management and an outbreak of D&V.

The provider did not have systems in place to investigate and resolve complaints effectively, these included verbal complaints about laundry and cleanliness of the home. People and their relatives had been given the opportunity to provide feedback about the service on one occasion in October 2017, when the then manager arranged a relative's meeting. We saw the minutes of this meeting where various issues were raised. There was extensive correspondence from one relative who was not able to attend the meeting. There was no evidence their correspondence or the issues raised at the meeting were responded to.

The provider had on registration produced a Statement of Purpose. This is a document that sets out how the service will be run and managed. We found no evidence the provider was offering the care promised in this document.

On the first day of the inspection a senior carer had responsibility for running the service and the welfare of people and staff. We were told a manager at a sister home was available for support by telephone should they need them. However, the staff member was inexperienced in management and was unable to recognise areas of concern that we picked up at inspection. Our concerns were fed back to the provider who took action and appointed a consultant manager three days a week with telephone support for two days.

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

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<br><br>The provider did not ensure people's care was person centred and that staff had the information and direction to achieve this. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider did not ensure people were cared for in a manner that promoted their dignity and independent. The provider did not ensure people's wishes were captured and included in the delivery of care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider failed to take account of peoples complaints and act on them appropriately. This is a breach of regulation 16(1). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not ensure there was sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. There were no systems in place to support staff. |