Holme Bank Residential Home Ltd

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Inspection report

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05 September 2018

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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 site visit took place on 04 and 05 September 2018 and was unannounced. At the last inspection completed 09 November 2016 the provider was meeting all legal requirements and the service was rated as 'good'. At this inspection we found widespread and significant concerns about the care being provided with multiple legal requirements not being met.

Holme Bank is a 'care home'. People in care homes receive accommodation and 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. The care home accommodates up to 20 people in one adapted building. At the time of our inspection there were 15 people living at the service. Most of the people living at the service were older people living with dementia.

The provider had failed to ensure a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager remained registered with CQC although they had left their post in 2017. A new manager had been appointed although had left prior to registering with CQC. An 'acting manager' was in place during the inspection who had recently taken on this role.

There were widespread and significant concerns identified about the management of risk within the service. People were exposed to multiple risks including those connected with choking, challenging behaviour and skin integrity without appropriate mitigation being in place. People were not protected from potential abuse due to safeguarding incidents not being recognised and reported. People were exposed to the risk of harm due to the poor management of medicines within the service.

People were not supported by sufficient numbers of suitably skilled and experienced care staff. There were widespread issues with the lack of training and supervision of care staff.

People's rights were not being upheld as the Mental Capacity Act (MCA) was not being used effectively. Decisions were being made about people's care without the required legal steps being taken under this Act.

People's nutritional needs were not always met. Advice and intervention from healthcare professionals was not always sought in a timely manner which exposed people to the risk of harm.

While people recognised individual staff members as being kind and caring, they did not always feel the support they received was caring. We found the lack of staff numbers, training and supervision resulted in care standards being poor. Support provided was not always caring. People's dignity was not always upheld and their independence was not actively promoted.

People were not always fully involved in the planning of their care. People's needs were not always appropriately assessed and the care and support people received did not always meet their needs. People did not have access to sufficient leisure opportunities.

People's complaints were not always actively sought and listened to. These complaints were not always responded to appropriately and they were not used to drive improvements across the service.

People were being supported by a staff team who were demoralised and under supported. The culture within the service had become closed and care staff had become afraid to speak out about concerns they had.

People were exposed to significant risks due to the inadequate governance and management arrangements in place. We found there were no auditing and quality control systems in place which had resulted in the provider not identifying the significant issues present within the service.

Due to concerns being identified during the inspection about people's immediate safety, we contacted the local safeguarding authority and commissioners to raise concerns. As a result the local authority were present during the final part of our inspection and took immediate action to safeguard people living at the service.

We found the provider was not meeting the regulations around providing person-centred care, obtaining appropriate consent, safeguarding, staffing, safe care and treatment, nutrition, complaints and the overall governance of the service. The provider had also failed to send CQC certain statutory notifications which are required by law. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Following the completion of our inspection, the local authority decided to move all people living at the service to alternative homes due to concerns about the standards of care being provided. The provider had also announced their intention to close the service. At the time of publication of this report nobody was

living at Holme Bank and receiving care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were widespread and significant concerns identified about the management of risk within the service.

People were not protected from potential abuse due to safeguarding incidents not being recognised and reported.

People were exposed to the risk of harm due to the poor management of medicines within the service.

People were not supported by sufficient numbers of suitably skilled and experienced care staff.

Is the service effective?

Inadequate

The service was not effective.

There were widespread issues with the lack of training and supervision of care staff.

People's rights were not being upheld as the Mental Capacity Act (MCA) was not being used effectively.

People's nutritional needs were not being met. Appropriate support from healthcare professionals was not always sought.

Is the service caring?

Inadequate

The service was not caring.

People did not always receive support in a kind and caring way.

People's dignity was not always upheld and their independence was not actively promoted.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always fully involved in the planning of their

care.

People's needs were not always appropriately assessed and the care and support people received did not always meet their needs.

People did not have access to sufficient leisure opportunities.

People's complaints were not always responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

People were being supported by a staff team who were demoralised and under supported.

The culture within the service had become closed and care staff had become afraid to speak out about concerns they had.

People were exposed to significant risks due to the inadequate governance and management arrangements in place.

Holme Bank Residential Home

Detailed findings

Background to this inspection

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

This inspection commenced on 04 September 2018 and was unannounced. We also visited on 05 September 2018 which was announced. The inspection was prompted due to concerns being received from the public and the local authority about the quality of care being provided at this service. The inspection team consisted of two inspectors, a Specialist Advisor 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. The Specialist Advisor was a qualified nurse with experience working with older people and people living with dementia.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. They can advise us of areas of good practice and outline improvements needed within their service. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with eight people who used the service and two relatives. We spoke with the two proprietors of the service, the acting manager, the deputy manager, the cook, the assistant cook and nine care staff. We also spoke with one healthcare professional who had raised concerns about the care provided to one person living at the service. We carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, 12 people's care records and records relating to the management of the service; including recruitment records, complaints

and quality assurance records.

Inadequate

Is the service safe?

Our findings

We identified widespread and significant risk within the service putting people at immediate risk of significant harm. We identified six people that were at risk of choking while eating and drinking. Care plans did not consistently and clearly outline people's needs in this area and we saw care staff providing inappropriate support. Care staff and kitchen staff we spoke with were not always aware of people's needs and we saw some instructions provided by healthcare professionals not being followed. Staff did not understand how to meet people's needs due to a lack of training and leadership.

One person had choked on food twice and concerns had been raised by relatives about the person's ability to swallow safely. The relative requested staff contact a doctor. As a result a referral to speech and language therapists (SaLT) was arranged. SaLT are healthcare professionals that can assess people's ability to swallow and recommend texture modified diets to reduce the risk of choking and harm. The provider had failed to make this referral without prompting and they were not managing the risk to the person while awaiting advice. The person continued to eat a normal diet without supervision. Staff present in the building were not trained in first aid and how to respond in the event a choking incident arose. We found further examples of where people were exposed to harm due to choking risks. Another person was on a texture modified diet although food intake records indicated this diet was not being followed. Daily care records confirmed the person had choked on bread. No action had been taken by the staff or management team to seek advice from healthcare professionals and to manage the risk to this person of choking following this incident. Another person required a texture modified diet in the form of fork mashable and pureed food. Despite us highlighting this person as being at risk of harm to the provider during the inspection, we saw staff continued to provide high risk food such as fish cake, chips and peas in it's standard form. This increased the risk of the person choking on food. We also saw in this person's care plan they could put non food items into their mouth and staff should ensure the person had support at mealtimes and items such as napkins were out of reach. We saw this person eating unsupervised with napkins on the table they were dining at. People were not being supported in a way that protected them from the risk of harm that posed a risk to their health and lives.

We identified over half of the people living at the service had lost weight that required either action to be taken by care staff, further monitoring or intervention by a healthcare professional. Care staff and the kitchen staff were not aware that people had lost weight and what action they should be taking to protect people from the risk of harm. We found a district nurse had intervened regarding one person's weight loss and had requested staff contact the person's doctor. We found some people were not being weighed despite a knowledge of prior significant unresolved weight loss. We also found where people were losing significant amounts of weight no consideration had been made around the risk and requirements to monitor these individuals more closely. Systems were not in place to ensure prescribed supplements were given as instructed and that other healthcare recommendations were followed such as the provision of high calorie snacks and fortified food. This exposed people to the risk of significant harm due to poor risk management by the provider.

We found multiple people had damage to their skin which had arisen in the service due to poor

management of risk around people's skin integrity. One person had a serious pressure ulcer which had been reported by healthcare professionals to the local safeguarding authority. We looked at care records for this person which showed as the pressure ulcer was developing, care staff were not following instructions to manage the risk, such as ensuring the person was repositioned at regular intervals. We found despite concerns being raised about this person's care, staff were continuing to fail to provide safe and appropriate care. For example; care staff were not ensuring the person's nutritional needs were met to aid healing, they were not ensuring adequate hydration and care staff did not understand how to use equipment such as air mattresses safely. A member of staff providing support and the acting manager were not aware of the correct settings this mattress should be at to ensure the person was protected from further damage to their skin. Another person had developed a blister to their heel while living at the service. Their care plan stated their foot should be elevated at all times and the foot should not be in contact with the floor while seated. We saw this person seated both in their bedroom and the lounge with their feet in contact with the floor. Care staff were not ensuring the risks to people's skin integrity were being managed safely in order to prevent harm and to protect them from any further harm.

We found risks relating to people's health conditions were also not being managed effectively. One person required a low salt diet and a restriction on their daily fluid intake to no more than two litres in order to manage their heart condition. We found care staff were not always aware of the dietary requirements and we saw from food records the person's dietary needs were not being met. Care staff were not aware of the restriction on their fluid intake. One staff member told us, "It's more than everyone else because of [their] heart condition. It's quite high, possibly three litres". Another staff member said, "We just prompt [them] to drink as much as possible during the day". Healthcare professionals had also stated this person should be weighed daily and this action had not been completed. We saw other risks including those associated with people's health and medicines were not being managed appropriately. For example; risks had not been appropriately considered and risk assessed around a person drinking alcohol while taking warfarin. Staff did not understand the risks, there was no evidence the person had been appropriately consulted so that they could make an informed choice and records showed staff had provided large drinks including one equivalent to over half the recommended weekly alcohol intake in one evening. Three people were taking a medicine that could cause serious risks to their health and life if administered when their pulse is below a certain level. Care staff administering medicines were not aware of this risk and had not checked their pulse prior to administration.

Medicines overall were not being managed safely across the service although some people were happy with the support they received with medication. One person told us, "My medication is done by the home and it is done properly". Another person said, "I do some medication myself. Sometimes the staff do it for me. I don't know if the staff do my medication properly". A relative raised some concerns about medicines administration, telling us their family member was told to put multiple tablets into their mouth before they were given any water to swallow with. We saw medicines administration rounds were taking an excessive amount of time. The morning medicines round had continued until lunchtime on both days of the inspection. We saw records outlining how much medicine people should have within the service did not always match the stock levels present. We found gaps in medicines administration charts (MARs) and staff members, when asked, were not able to confirm if people's medicines had been given to them as prescribed. We found records relating to people's medicines had not been completed in line with national guidance. For example; where MARs were handwritten they did not always contain required information about the medicine to be given and had not been checked and signed by a second member of staff. This practice reduces the risk of errors arising. Where people had refused medicines the person's capacity had not been considered and steps taken to protect them from harm.

We found behaviours that could be challenging or demonstrated distress were not being managed safely.

Care staff did not always recognise that behaviours could be causing others distress and therefore needed to be managed. We saw several examples during the inspection of people exhibiting behaviours towards other people living in the service that caused them and others distress. We saw some of these people had no information within their care plan to guide staff as to how to support them safely and protect others from harm. We saw where guidance was available to staff in care plans this was not being followed. For example; one person's care plan advised staff to engage with the person talking about their personal history and if required to take them to the quiet lounge and engage them in an activity. We saw care staff didn't follow these guidelines. One staff member said to a person involved, "Pretend you can't see [person]" and, "It doesn't cost anything to be nice" which demonstrated their lack of understanding around how to manage the situation appropriately. The provider had not ensured there were systems in place to consistently and safely identify behaviours that could challenge, assess these behaviours and ensure care practice was in place that managed the risk within the service.

People were not always being supported to move within the service in a way that protected them from the risk of injury. A member of staff told us, "The manual handling equipment isn't used every day". We saw care staff using equipment including hoists and handling belts during the inspection although they did not appear confident in it's use. We saw care staff supporting people in a way that was unsafe, including one member of staff supporting someone to stand while holding them under their arms. This increases the risk of injuries such as bruising, skin tears and even dislocation. Care staff told us and we confirmed from training records, that care staff had not received training in how to support people to move and transfer safely. The provider told us they were arranging training for the week following the inspection. We saw care plans did not always reflect what we saw. For example; one person's care plan stated they could rise from a chair independently although we saw staff struggling to assist them to stand on multiple occasions. While we saw equipment was checked by an external organisation for safety during the inspection, care staff told us when there were faults these were not always reported and repaired. We were told a hoist sometimes seized during operation and, "I was just told to bang it". We were told this wasn't written down or reported as it was common knowledge amongst the staff team. We saw multiple people with metal bed rails in place that had not been risk assessed. Many of these were poorly fitting or had no protective bumpers. The risks to people's safety had not been assessed and therefore steps were not taken to protect them from harm.

We found further concerns with the safety of the building not always being considered or addressed. For example; weekly checks on fire alarms and systems were not always completed. We found the water had not been tested for legionella when it was due in February 2018. The provider advised the testing pack had not arrived and this was never chased and completed. They did arrange for a replacement pack to be sent during the inspection. Staff did not know what to do in the event of a fire. One member of staff working in the kitchen told us, "Never had a fire drill while I've been here". We saw care plans had individual assessments relating to fire evacuation but this had not been considered across the wider service. For example; one person's plan stated they should be assisted to the nearest fire exit with support and that instructions would need to be repeated due to memory loss. The person was rated as low risk despite requiring one to one support and consideration had not been paid as to how multiple people requiring one to one support would be assisted with restricted staffing levels in the event of a fire.

Where incidents or accidents had arisen the provider was not ensuring these events were appropriately reviewed. As a result, risk assessments were not being updated in order to reduce the likelihood of events reoccurring. The provider had not ensured lessons were learned in order to reduce the levels of risk to individual people and across the wider service.

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

People told us they mostly felt safe from abuse while living at the service although this wasn't consistent. One person told us, "The staff make me feel safe. They're good staff". Another person told us, "I'm safe here. I'm looked after properly. I'm treated with respect". A third however said, "I'm prepared to defend myself if necessary. There are people who would like to do me harm. You're not really safe anywhere". We saw this person was involved in an altercation with another person during the inspection. Staff and records confirmed this was not an isolated incident. While care staff could describe signs of potential abuse they, along with management, had failed to identify these altercations as potential abuse, despite threats of violence being used. These incidents had not been reported to the local safeguarding authority, therefore appropriate investigations had not been completed and plans were not put in place to reduce the risk of ongoing harm.

A relative told us about an incident that had arisen when their family member had asked staff to take them to the toilet and they'd failed to do this. They said, "[Person's name] had got faeces everywhere. [They'd] tried to clean [themselves] with tissues and no one had noticed until I pointed it out to them". The manager had acknowledged the person was likely to have been left in this way for some time and offered an apology to the family. However, this incident had also not been reported to the local safeguarding authority. Plans had not been put in place to protect the person from ongoing harm. The person confirmed this was an ongoing problem and told us, "When there's the call of nature, I got to go. I struggle to get someone to take me". They had not been protected from the ongoing risk of neglect.

We also identified incidents involving a person being sexually inappropriate towards staff and another person living at the service. These incidents had also not been reported to the local safeguarding authority, with one recent incident not known to the management team. People and staff had been exposed to the ongoing risk of harm without a plan to minimise risk having been put in place.

The provider had failed to ensure systems were in place to ensure safeguarding concerns were identified, recorded, reported to management and reported to the local safeguarding authority. As a result, they had failed to ensure people were sufficiently protected from the risk of ongoing harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

Some people told us there were enough staff available to support them. One person said, "There are enough staff here". Another person said, "There are enough staff and they treat me well". Other people however told us there were not enough staff. A person said, "When I press the buzzer sometimes they don't come at all". They also said, "You, can't do anything to help me. [The staff] have so much to do; they don't have any time". Another person said, "I say can you please take me to the toilet. Sometimes you wait for hours". Relatives told us they did not think there were sufficient numbers of staff available. One relative told us, "[There's] not enough staff here". They told us when they visited there was sometimes, "No staff to be seen in the dining room". Another relative told us about an incident earlier in the year when there were not enough staff for someone to be present in the lounge. They told us staff had asked a family friend to watch someone displaying challenging behaviour. They also told they felt they couldn't approach staff as they were too busy. Care staff we spoke with all reported concerns with staffing levels due to the high dependency needs of many people living at the service. A staff member said, "There's not enough staff. We're not able to meet people's needs. We struggle". A healthcare professional also said, "Staff seem snowed under and quite flustered, especially the seniors". We saw care staff were consistently busy and lacking in time during the inspection and there was a lack of leadership within the service meaning care staff were not deployed effectively. Care staff told us and we saw from records that a large percentage of care staff were new to the service and staff overall had not been trained. This put additional pressure on care staff who were struggling

to meet people's needs effectively.

We saw dependency assessments were present in each person's care plan although these were not accurate and had not been used to calculate overall staffing levels. The provider and management team were not aware of the need to formally assess the levels of care staff required and therefore this action had not been completed. People were not supported by sufficient numbers of suitably skilled and qualified staff.

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

While people told us they were happy with the cleanliness of the service, some concerns were raised regarding cleanliness within the service. One relative told us they had concerns about hygiene in the kitchen and told us they had found milk that had gone off. During the inspection we found food in the fridge that was out of date and saw staff going into the kitchen without the appropriate personal protective equipment (PPE), such as aprons. We saw various areas of improvements required within the service in relation to infection control. For example; we found a ripped commode, dirty pull cords on lights and used cleaning equipment being left unattended.

We found one person had been diagnosed with ring worm earlier in the year. There was no care plan or risk assessment in place around this and no plan as to how to prevent a potential outbreak within the service. Staff we spoke with were not able to explain how they managed this and they could not locate any records relating to the safe management of this particular condition. People were not always being sufficiently protected from the risk of infection.

We looked at how the provider ensured new care staff were recruited safely. We found basic pre-employment checks had been completed including reference checks and Disclosure and Barring Service (DBS) checks. DBS checks are completed to enable an employer to view someone's potential criminal history in order to determine if they're suitable for employment.

Inadequate

Is the service effective?

Our findings

Some people told us they enjoyed the food they ate. One person said, "The food and drink is good" and told us about the various things they enjoyed eating. Another person said, "The food is very good. I get things that I like. I get a choice". Another person told us it depended on who was in the kitchen as to whether they enjoyed the food. We received whistle-blowing concerns before the inspection stating there were issues with the supply of food. We found during the inspection there was not always sufficient food available to facilitate choices for people. We heard staff say they had run out of certain items which impacted on the menu. The cook told us they regularly did not follow the menu due to the availability of food. We asked care staff what was for tea on the second day of the inspection and they told us, "Whatever is in the pantry". The local authority also shared concerns with us about the availability of food supplies in the days following our inspection.

We found where people had special dietary needs these were not always met. We found some people required a textured modified diet due to swallowing issues. Care staff we spoke with did not always know who required these adapted diets. Care staff were not always clear on who was living with diabetes. We were told by staff they had not received diabetes training for, "Nearly two years". We found care plans did not clearly outline people's needs. Our observations and food charts confirmed people's needs were not always being met. Where people required additional support with their fluid intake this was also not being met. We saw one person who required support to drink had dry lips. We asked care staff if this person required more fluids and they told us not. The person however told us when asked they were still thirsty. We ensured the person received more fluids however this had not been recognised by staff.

We found over half of the people living at the service had lost weight. Some of these people had lost significant amounts that required assessment by a healthcare professional. Care staff and kitchen staff were not aware of who these people were and therefore were not aware who required additional support. We found people's nutritional intake was not being monitored where they were at risk of malnutrition. Where specific instructions had been given by healthcare professionals; for example, around ensuring high calorie snacks were provided, we saw these instructions had not been followed. Due to poor monitoring systems, this issue had not been identified and corrective action had not been taken to protect the risks to these individuals.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the

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

Care staff and management we spoke with did not understand the requirements of the Mental Capacity Act (MCA) and how this should be used to protect the rights of people living at the service. We found generic assessments of people's capacity were in place rather than consideration being made to specific aspects of people's care as required by law. Where best interests decisions had been recorded in people's care plans these were standard pre-typed documents around things such as medication and finances. These decisions were not made considering the specific and unique needs of each individual.

We found decisions were being made on behalf of people who lacked capacity without the required legal processes being followed. For example; two people sharing a bedroom had not been consulted about the decision to share. They had each been moved into the room following decisions made by others without considering the best interests of these people. Their capacity had not been assessed and decisions made in line with the law. One of these people told us, "I share my bedroom and I don't like sharing my bedroom". We asked the provider to explain the reasons for this arrangement and how the decision was made in their best interests but they were unable to do so. We raised concerns about this arrangement and found the following day the acting manager was taking action to move one of the people to another room. We asked if they had spoken with the individuals and had discussed with them where they were moving to and they had not. We asked if they had tested the individual's capacity to understand the decision being considered in line with the law and they had not. The principle's of the law remained unfollowed despite us raising this concern.

We found where decisions were being made that posed a risk to people's life and health the principles of the law were also not being followed. For example; where people were eating food that increased the risk of choking prior to obtaining guidance from a healthcare professional. People had not been consulted, their capacity had not been assessed in relation to this issue and decisions were not being made in their best interests. We found another person had been given pureed food against their wishes. While care staff felt they lacked capacity, their capacity had not been assessed in line with the law. The person's distress resulted in a doctor prescribing a psychiatric medicine to calm them which could be used 'when required'. We found decisions around this person's diet and the medicine had not been made in line with the law. The person was continuing to be given this medicine, without consultation, despite their diet now returning to normal as their risk of choking had reduced.

Care staff told us everybody at the service had some level of confusion and lacked capacity to make some decisions about their care. We saw some people had refused food and medicines who may lack capacity. Their capacity had not been assessed and decisions were not taken in their best interests. Care staff we spoke with did not understand what action they should take when someone refused an aspect of their care that was important to their health. One member of staff said, "I would put a DoLS in place that way we can still give them the meds". Another staff member also said, "We would report to the manager so they could get a DoLS in place then we could give [the person] a wash". This is not the correct legal process and demonstrated a lack of understanding of the actions they needed to take. Staff did not understand how they should make best interest decisions in conjunction with relevant people including relatives and healthcare professionals.

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

Care staff we spoke with did not understand who within the service had a DoLS in place. They named one or

two people who 'may' have a DoLS granted. Care staff did not understand what having a DoLS meant in relation to the restrictions on their liberty while providing care. They told us that everyone in the service was restricted from leaving due to their capacity to remain safe if they went out alone. This had not been identified as a restriction and applications to lawfully deprive these people of their liberty had not been made.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People at the service told us staff were not consistently skilled to support them effectively. One person told us, "Some of the staff are OK and some of them are not so good". Another person told us, "I think that the staff could do with more training". A relative told us there were a lot of new staff. We saw from records given to us by the provider that 21 out of 33 staff had less than 12 months service. Some of these new staff told us their induction had been poor and had not equipped them to do the job. One staff member said, "My induction was a carer going through a piece of paper". Another said, "My induction was on a night shift and it was just talking".

Staff told us they had not received training. One staff member said, "I've had no training whatsoever. I've had to show some of the [care staff how to use] a hoist". Another said, "Staff aren't trained". A third staff member said, "[There is] no training for anything". A fourth said, "[The last manager] said we'd have this training and that training and it never happened". We confirmed with the provider, management team and from records that training had not been kept up to date. Staff also told us that no competency checks had been completed on care practice and one to one meetings had not been completed regularly. One staff member told us, "I've done what I can with no guidance and support". We also confirmed this with the provider, management and from records.

We found there was a widespread issue with the knowledge and competency of the staff team. We found the cook had not received basic food hygiene training and none of the kitchen staff had received training in special diets; including texture modified or diabetes. We found care staff had not received training in moving and handling people, nutrition and dementia awareness which were all areas that we identified significant concerns within. We found no staff had received training in first aid which posed a significant risk to people due to the levels of risk found, in particular around choking. We found less than a third of staff had received safeguarding training and this was an area we found required significant improvement. We also identified that not all staff were actually listed on the staff training records given to us by the provider. Care staff told us this lack of training impacted on the quality of care people received. One member of staff said, "You can't do your practice as others can't". Another said while emotionally upset, "Everyone [staff]'s trying so hard". We saw this in the observations we completed during the inspection which demonstrated poor care practice.

The provider had not ensured the staff and management team were suitably trained and sufficiently supervised. As a result the staff team did not have the skills to support people effectively and people had been exposed to the risk of harm.

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

People told us they were supported to access healthcare professionals around some of their day to day health issues. One person told us, "When I'm ill they look after me. I could see a doctor if I need to but usually they [staff] look after me". Another person told us, "I can see a doctor or a nurse if I need to. I just

need to tell the staff". Relatives told us they found they could gain access to healthcare advice and professionals to support people's health but this required chasing up. One relative said, "[It] feels like I am intruding if I ask for anything". They told us they were not always kept up to date and had to ask for letters to know when appointments would be coming up.

We saw care staff were not always skilled in recognising when people may need medical support. For example; we saw one person struggling to stand during the inspection. Some care staff told us this was due to the person refusing to stand on some days yet another member of staff told us they thought it may be due to their hips hurting. The relatives of this person told us the person required medical support due to their swollen legs and this was not being chased up by the service. We saw the person did have swollen legs during the inspection and found a doctor's appointment had not been chased.

We found the staff were not being led and directed which resulted in them not working together well as a team and sharing information effectively. We saw key information was not always shared in handover meetings. For example; where we saw two people having an altercation we heard the acting manager referring to these people during handover without sharing concerns. They said about one person, "[Person]'s been fine, quite settled" and about the other, "[Person]'s been fine. Bright and chirpy. No problems". This meant the next staff team were not aware to monitor and ensure any ongoing risks were monitored and people's needs were met.

The building was a large adapted residential property which could meet people's basic needs. We found most people at the service were living with dementia. The provider had not ensured the decoration of the building was in line with best practice guidelines around dementia friendly environments. There was outdoor space that could be accessed by people and people had private spaces they could spend time with their visitors if they wished to do so.

Inadequate

Is the service caring?

Our findings

People told us most care staff were kind and caring and were trying their best to support them well. This was not always a consistent view and some people highlighted concerns. Some people felt the support they received was not always delivered in a caring way. One person told us, "The staff do their best". They also told us, "This is my home. Nothing's perfect but it's very good". Another person told us, "Some of the staff are kind and caring. Some of them aren't". They also said, "I don't feel important. I am respected though". A third person told us, "When I ask for help they [staff] don't come and I feel like I'm being a nuisance". A fourth said, "The staff are kind and caring. Occasionally the staff have spoken inappropriately to me". Relatives also gave us mixed views. One relative told us, "The staff are always respectful to [my family member]". Another relative told us that individual care staff were very caring but there were others who were not. They told us the service overall had deteriorated and was not the caring service it once was. They said, "It needs to be the home it was, like a family". Care staff told us they were trying their best to care for people but recognised they were not always achieving this to the standards required. One staff member told us, "There's nobody in this home that doesn't care about the residents". We saw this reflected in the care we observed. We saw individual examples of positive relationships between people and care staff. We saw some interactions were kind and caring although we saw care delivery overall that was uncaring. This was due to poor leadership and management, a lack of care staff and poor staff knowledge and skills.

We found the provider had not ensured there was an effective management structure in place monitoring the care that was provided. As a result they had failed to ensure care staff could recognise when their actions may not be caring. They had also failed to ensure that staff were given the resources and tools they required to provide support in a caring way. For example; issues with staffing levels impacted on how responsive care staff could be to people when they required support.

We found the environment within people's rooms and their personal possessions were not always respected and kept safe which impacted on their emotional wellbeing. One relative told us a photo album used for reminiscing had been taken from a person's bedroom and that their blanket had gone missing. They told us, "There are clothes in the wardrobe that don't belong to [my family member]. "Another relative said, "Even [person's name]'s blanket is on the wrong bed". A third told us an item of jewellery had gone missing. We saw one person who was cared for in bed and had no control over their environment, was being supported in a room that was cluttered with supplies in boxes and was generally very untidy. This person had a blanket over them but no bed sheet in place.

We saw people were not always given choices in a caring way. We saw people were being given choices for lunch verbally from a list. Two people were woken up shortly after 11.30am to ask what they wanted to eat for lunch which startled them. We saw people were not proactively involved in decisions about their environment. We saw care staff making choices about whether music was put on, what type of music and TV channels without consulting people in the room.

One person told us their privacy was respected. They said, "No-one ever comes into my room not ever". However, we saw this was not consistent. We saw where one person was cared for in bed, the maintenance

person knocked their door but then walked straight in and began to complete checks on the taps without consulting the person, asking for their consent or explaining what they were doing.

We found people's dignity was also not always respected and upheld. For example; we saw one person with Parkinson's struggling to eat with a spoon as no adaptive cutlery was made available to them. We saw they resorted to eating with their hands in order to eat their breakfast. We saw another person being supported to walk with staff holding a belt that had been used to help the person stand. This belt lifted their clothes and exposed their skin with their trousers sliding down below their waist. We saw further examples of undignified practice including a member of staff asking someone to open their mouth wide so they could take a look to ensure all their medicines had been swallowed and infrequent baths and showers being completed.

People who were more able told us they tried to be as independent as they could be. One person told us, "I do all of my own personal care and select my clothes and jewellery myself. I keep as independent as I possibly can". We saw examples of where poor care practice did not promote people's independence and where people were not encouraged to be as involved as they could be in day to day decisions.

People were able to see their friends and family without any unnecessary restrictions. One person told us, "They are welcome here anytime". Another person said, "My visitors are made to feel welcome". A relative told us, "I am made to feel very welcome when I visit".

Inadequate

Is the service responsive?

Our findings

People were not encouraged to be as fully involved in their care plan and decisions about their care as it was possible for them to be. One person told us, "I'm not aware that I have a care plan". Another person said, "I don't know about the care plan." They also told us, "I don't make decisions". Relatives gave us mixed views about their involvement in care planning. One relative told us, "[Person's name] does have a care plan and I'm involved in making decisions". Another relative said, "I am involved in [my relative]'s care planning. It was slow though. It took a couple of months. I expected it to be done immediately". Care staff told us care plans were not used as a basis for delivering people's care. One staff member told us, "There's a lot of things I still don't know [about people]". They told us, "I asked for time to read through the care plans but this was a struggle". Another staff member said, "The only time I've seen a care plan is when I had to log my key worker [duties]". They told us, "I had to ask someone to help me when I was looking for something [in the care plans]". While many care plans were not reflective of people's needs, we saw some examples of where care plans did contain relevant information about how to meet people's needs and keep them safe. However, we saw these instructions were not being carried out by care staff. For example; where specific people had dietary needs or exhibited behaviours that could challenge others.

The providers failure to ensure there were sufficient numbers of appropriately skilled care staff in place resulted in staff not recognising when people's needs were not met. This also meant care staff were not responsive to changes in people's needs and they did not always recognise when action should be taken. For example; one person told us, "I have a walker but I don't know where it is. I haven't seen it for a while. I would like it if you could find my walker". Care staff confirmed they were not aware where this walker was. New care staff were not even aware the person had ever had a walking frame. We saw the person's care plan had been updated in June to remove any reference to the walking frame but no action had been taken to locate it or to obtain a replacement. As a result this person had not been able to mobilise independently without support for over two months.

Some people were distressed by the lack of personalised support they received. One person said, "You [CQC], can't do anything to help me. They [staff] have so much to do. They don't have any time". Care staff told us they were not able to provide care in a person-centred way. One staff member told us, "It upsets a lot of [staff] but we can't do it as there's not enough of us". They told us people had not had regular baths and showers as there were not enough staff. We looked at the personal care record for August 2018 which showed a total of only 16 baths or showers had been completed in a one month period. There had been 16 people living at the service during this period of time. The staff member told us, "It's about filling beds and it seems like they're not interested in making sure we can meet people's needs".

We found further examples of where people's individual needs were not considered, fully assessed and therefore not met. We saw a person struggling to stand during the inspection whose care plan did not reflect this issue. Care staff had differing views around whether the person was refusing to stand or whether this was due to pain. We saw the person's legs were swollen and relatives told us the person required a medical appointment which needed to be chased. Care staff and management had not taken sufficient steps to ensure this person's needs were fully understood and that steps were taken to meet these needs. Where

people had a specific physical health or mental health diagnosis their needs were not always assessed. For example, one person's care plan had no reference to their depression and how their needs should be met. Another person's care plan was unclear around whether they had Alzheimer's or mixed type dementia. We saw care plans contained generic consent forms requiring all people to consent to 'terms of endearment' when staff spoke to them. The form stated, 'There are no specific terms of endearment I do not wish to be used when speaking to me'. These had been included as standard in all care plans without considering people's individual preferences about how they wished to be addressed.

Some people said there were sufficient leisure opportunities available to them where others said not. One person said, "I love music. I like to sit here and listen to music. I like to sing too". Another person said, "We play skittles and bingo". A third said, "We don't have anything to do all day". A relative told us, "I don't think [my family member] gets the stimulation she needs. There used to be so much going on". Care staff told us there were insufficient activities available to people. One staff member said, "[People] don't have any activities. We were always told there was no funding for it. [People] are bored. We don't have time to sit with them". Another member of staff said, "Since I've been here I've seen activities about four times. One was an outside company". We saw limited interaction and leisure opportunities for people taking place during our inspection. We saw one person's care plan stated, 'The staff will notify me of what activities are taking place for that day, I will make a decision as to whether I wish to participate at that time'. There was no reference to how the provider and staff team would ensure they were proactively making leisure opportunities available to this person that met their individual preferences.

We saw care plans contained a lack of information around how to meet people's religious and cultural needs. We found one person went to church each week although they told us they had been since they were four so this was something arranged by the church. We did not see any further examples of people's needs being assessed in this area and steps taken to meet their needs.

We found people's needs around their wishes for their care at the end of their life were not fully assessed and considered. We looked at the care plan for one person who had recently passed away and found there was no end of life care plan present. We found this person had been refusing food and supplements. No action had been taken by care staff or management to ensure this refusal was understood, their needs assessed, medical advice sought where appropriate and that their needs were met in the final weeks of their life.

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

Some people and relatives told us they did not feel that their complaints were listened to and appropriate action taken. One person said, "I've made some suggestions and complaints but they don't do them. I feel like I'm a nuisance". A relative said, "[Person's name] has already had one wheelchair broken and I've had to buy this one for him myself. I don't want anyone else to use it for that reason. [Person's name]'s last wheelchair was broken and I asked the home to replace it but they wouldn't". Another relative told us, they had waited to speak with a senior member of care staff for over an hour. They told us they felt they were being avoided and ended up leaving without having spoken to anyone. A third relative told us she had raised complaints that have not been responded to appropriately. They told us, "[The proprietors] have been very rude to me". This relative told us they had raised concerns directly with the local authority as they were not satisfied with the response they received.

We saw complaints records were not held regarding the issues outlined above. The provider was completing an investigation in conjunction with the local authority regarding the care received by one person within the

service although they had not kept a record of this in their complaints file. The provider had no system of ensuring complaints had been captured and were monitored to ensure an appropriate response was sent. The provider also had no system in place to ensure that complaints were reviewed to ensure lessons could be learned and improvements made to the service overall.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Recording and acting on complaints

Inadequate

Is the service well-led?

Our findings

We found widespread, significant failings in the management and governance of the service. At the time of the inspection the most recent manager of the service was no longer in post, and there was an ongoing investigation into their conduct .The registered manager had left during the prior calendar year. There was no permanent manager in the service although a senior member of care staff had stepped up into the role of 'acting manager'. A deputy manager was in post.

The provider had failed to ensure there were sufficient quality assurance and governance arrangements in the service. As a result they had failed to identify the failings we found during our inspection. We found there were no audits or quality checks taking place within the service at the time of the inspection. There were no audits completed on care records which resulted in issues with inaccuracies in care plans not being identified. Incidents recorded by staff in daily records were also not being identified and therefore action was not taken to effectively manage risks to people living in the service. Gaps in the recording of medicines administration had not been identified. Therefore action had not been taken to ensure people had received their medicines as prescribed. The lack of audits had resulted in widespread issues with weight loss and potential choke risks not being identified. People had been exposed to the risk of harm which could have a serious impact on their health and put their lives at risk.

The provider had failed to ensure systems were in place to check that care staff had appropriate skills and training. They had also failed to ensure systems were in place to check that the care people received met their needs. Where advice and intervention by healthcare professionals was required there were no effective systems to ensure that referrals were made promptly without delay. There were also no systems to ensure that any referrals made were chased proactively to ensure people received the support they needed. Handover and communication systems were also ineffective and we found important information was not being effectively shared between staff shifts. These failings had exposed people to the risk of harm and had resulted in poor standards of care being delivered.

We found the policies and processes were not embedded in the service and staff were not certain of the practices they should be following. One staff member told us, "I've seen lots of policies but nobody's said,'these are the policies we have'". We found record keeping was poor and inaccurate with important records such as food intake records not being fully completed. These records were then not reviewed so errors, omissions or concerns about care or people's health were not identified. We found filing systems were unorganised and staff and management were unable to locate certain documents. One staff member told us, "I don't know where anything is filed". A disclosure and barring (DBS) check for one staff member could not be located during our site visit. The provider was required to locate this and to send it to us following the inspection. The provider and management team were unable to locate key information about people's needs and communication with healthcare professionals to evidence that people's needs had been appropriately assessed and met. When we requested records relating to people's medicines following the inspection, the provider was not able to locate people's records for a one month period covering July. The issues with the records meant information regarding people's health and care needs were not readily available. As a result the provider was not able to evidence that people's needs had been met and that risks

had been appropriately managed.

The provider had not developed adequate systems to ensure people's feedback was obtained and they were fully involved in the development of the service. People told us they were not aware of who the manager in the service was. One person said, "I don't know the manager". Another person said, "We have a new manager. I think I know them but I haven't spoken to them". People told us they had not attended residents meetings and they hadn't been asked for feedback via questionnaires. People did not always feel their feedback was heard and acted upon. One person said, "I've asked if we can have serviettes with our meals but we don't get them". One relative told us that relatives and residents meetings had recently been started. They said, "They have only just started to do them. It's the second one tonight". Another relative told us they had not been invited to these meetings and had found out from another relative. People's feedback was not being used in a positive way to drive improvements, reduce risk and ensure improvements were made across the service.

The provider was not aware of their legal responsibilities as owners and operators of an adult social care service. As a result they had not ensured the requirements of the law were being met. They had not ensured there were sufficient systems in place to ensure their management team were effective, were identifying areas of improvement needed within the service and were effectively managing risk to people.

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

A manager remained registered with CQC although they had left their post in 2017. The provider had failed to ensure the commission had been notified of the absence of their registered manager. The manager had been absent for a period of over nine months at the time of our inspection.

This was a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009 Notice of absence

The provider had failed to ensure statutory notifications had been sent to CQC as required by law. Statutory notifications should be sent when serious incidents arise such as allegations of abuse and serious injuries. We identified a serious pressure ulcer that had not been notified in addition to multiple safeguarding concerns.

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

The provider had not ensured they were working effectively with organisations such as the district nursing teams, speech and language therapists (SaLT) and local authority. As the provider had failed to ensure concerns were identified, they were not proactively communicating with the relevant organisations to ensure appropriate support was in place for people living at the service.

The provider had failed to ensure there was sufficient supervision and support in place for the staff team. Staff told us that morale was low and that the most recent manager had created a closed culture where they were afraid to speak out. One staff member said, "[The last manager] was very in your face about not talking to [the proprietors]. It was seen as a risk to your job if you spoke out". Another staff member said, "The last two managers have been horrendous. It's not the proprietors fault. Staff wanted a meeting with [the proprietors]. Basically she was blocking us talking to them". A third said, "It's hard to go up against your manager". Staff expressed concern about the lack of stable management in the service. One staff member

said, "How is there going to be enough improvement unless we've got someone whose got experience".

Relatives also shared concerns about the management arrangements within the service. One relative told us since the changes in management they'd seen the care standards had gone down. They also said during this period they'd seen a lot of care staff leave. They told us, "My concern is a lot of good staff have left. Is management getting rid of people because they are not good or because they are noticing things are wrong?". They did not feel that recent managers had created an open culture where it was safe to question care practice. This was confirmed to us through staff comments and our observations during the inspection.

The provider was receptive to the feedback we provided during our inspection. They recognised the areas of improvement and risk that we identified. Shortly after our inspection the provider stated they did not feel they had the skills and resources to make the required improvements in a timely way. They announced their decision to cease operating as a care provider at a relatives meeting CQC attended on 10 September 2018.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to notify CQC that the registered manager had been absent for more than 28 days.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure the required statutory notifications were sent.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care personalised to their individual needs and preferences.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always being upheld by the effective use of the Mental Capacity Act 2005.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the

provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of harm due to poor risk management. Risks to people's life and health were not always recognised and managed safely.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse as safeguarding incidents were not always recognised and reported. People were being deprived of their liberty without the required legal authorisation having been obtained.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always fully understood and met safely.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were not protected from the risk of abuse as safeguarding incidents were not always recognised and reported. People were being deprived of their liberty without the required legal authorisation having been obtained.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected appropriately due to failings with the governance of the service.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to this service and took action to cancel the provider's registration.