Ingham Healthcare Limited

Ingham Old Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 June 2018 and was unannounced.

Ingham Old Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC (Care Quality Commission) regulates both the premises and the care provided, and both were looked at during this inspection.

The service provides accommodation and care to a maximum of 25 people. At the time of the inspection 22 people were living at the home, some people were living with dementia. One person was staying for temporary respite care.

There was a manager in post, who had applied to CQC to complete the registration process, but was not registered at the time of the 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.

At our last comprehensive inspection on 3 and 4 May 2017 we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for safe care and treatment and good governance. A follow up focussed inspection was completed 25 July 2017 to review medicines management in relation to the breach of regulation for safe care and treatment. The service was found to no longer be in breach of regulation.

During this inspection we identified that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for safe care and treatment including the condition of the care environment and equipment used, protection of people's privacy and dignity, adherence to the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards, management of people's nutritional and hydration needs, good governance and safe staffing.

During this inspection, we identified areas of concern in relation to staff competency in safe management of medicines, cleanliness of the environment and infection prevention control impacting on the care people received.

The service did not have robust governance processes in place for monitoring standards and quality of care provided. Staff did not complete clinical audits in areas such as medicines management and the condition of the environment and this was reflected in our findings during the inspection.

Staff were not up to date with the provider's mandatory training or annual performance appraisals. Staff did not receive regular supervision to review their performance and areas of improvement. The management

team did not have robust oversight of staff performance. We saw examples of where training and good practice was not being implemented in the care and treatment of people living at the service.

People's records demonstrated a lack of adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards. It was unclear if people's movement was lawfully restricted and this was a potential infringement of their human rights.

Low staffing levels impacted on people's access to meaningful activities and maintenance of hobbies and interests. There was not a daily activity timetable, and people told us they often felt "bored".

People were not consistently treated with care and compassion, and their privacy and dignity was not routinely protected. We saw examples of people being hoisted in communal areas, resulting in their underwear and continence products being on show to others.

Due to level of risks identified from this inspection, we wrote to the provider under Section 31 of the Health and Social Care Act 2008, to request for provision of an action plan to address our concerns. An action plan, with clear dates for completion of tasks was received within the stipulated timescales. The action plan indicated completion of all urgent risks and issues would be by the end of July 2018. We will continue to monitor progress made against this action plan and any regulatory action as an outcome of this full inspection report.

Full information about CQC's regulatory response to any breaches of regulation found during inspections is added to reports after any representations and appeals by the provider 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.

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.

Staff did not monitor or follow guidance in relation to infection, prevention control and the care environment was unclean. This increased the risk of spread of infection.

Medicines were not robustly audited with low completion of staff competency checks. Medicinal creams were not stored safely in people's bedrooms.

Significant environmental safety concerns were identified throughout the service, with no environmental risk assessments in place.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff were not up to date with all the necessary training for their roles.

Staff did not receive annual performance based appraisals.

Staff did not assess people's mental capacity or document best interests decisions.

Staff did not know if people had authorised Deprivation of Liberty Safeguards in place to lawfully restrict their movements. This was a potential infringement on people's human rights.

Is the service caring?

Inadequate

The service was not caring

The condition of the care environment was not conducive to provision of high quality care.

We observed people were not consistently treated with kindness, respect, dignity and compassion during the inspection.

Is the service responsive?

Inadequate

The service was not responsive

Care plans did not consistently link to risk assessments, with guidance for staff to follow in relation to the management of risks such as choking and prevention of sore skin.

Staffing levels impacted on people's engagement with meaningful activities onsite and in the community.

Is the service well-led?

Inadequate

The service was not well-led

There was a lack of managerial oversight and quality audits in relation to areas such the condition of the care environment, administration of medicines, consistent completion of people's daily written records.

No staff had up to date performance appraisals.

The management team did not actively encourage feedback from staff, people or relatives to drive improvement within the service.

Ingham Old Hall Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 June 2018 and was unannounced.

The inspection team consisted of one CQC inspector, one CQC medicines inspector and one 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. On the second day, the team consisted of one CQC inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with eight people who lived in the home. Due to the healthcare conditions that people were living with, some people were unable to tell us about their care. We observed care and support being delivered in communal areas and we also spoke with the relatives of two people and ten members of care staff including carers, senior carers, housekeeping and catering staff, the nominated individual, manager, and deputy manager.

We reviewed ten people's care plans in detail as well as seven sets of daily notes, two sets of night time care notes and one set of behaviour recording charts. We looked at a sample of medicine administration records (MAR) and the medicines management procedures in place for the whole service. We looked at three staff recruitment files as well as training, induction, supervision and appraisal records. We attended the afternoon shift handover meeting on the first day of the inspection, and the morning shift handover meeting on the second day of the inspection.

Inadequate

Is the service safe?

Our findings

During our inspection on 3 and 4 May 2017, we found the service was not always safe and was rated 'Requires Improvement' in this key question. This was because risks associated with medicines management had not been fully mitigated. A focussed inspection 25 July 2017 found these concerns to have been addressed and the service was no longer in breach of regulation in relation to medicines management.

During this inspection, on 13 and 14 June 2018, we found concerns in relation to management of infection prevention and control. There was unsafe storage of prescribed skin care creams. Care plans and risk assessments were not up to date or an accurate reflection of people's care and support needs. Therefore, we rated this key question as 'Inadequate'.

The service had poor cleanliness and poor furnishing throughout the home. We found bedrooms, communal bathrooms and toilets that had a strong malodour throughout each day. The housekeeping team kept logs of all cleaning tasks completed, but these did not accurately reflect living conditions found during the inspection.

We found an example of a person living at the service who had a potentially contagious condition, and staff were overheard to inform a visiting community healthcare professional. It is recognised good practice to keep bedroom doors closed to prevent the spread of infection, and implement management plans for staff and visitors to follow. The person's bedroom door was observed to remain open throughout the inspection and they received visitors. Risk management plans for this person were not in place in their care records, and information was not shared during shift handover meetings to ensure staff were aware of processes to follow. The inspection team were not advised of any risks or precautions to follow when visiting this person.

There were bins in communal bathrooms containing used continence products. The lids for the bins were removable and in areas of the home accessed by people living with dementia without staff supervision. The bins smelt unpleasant and not regularly emptied, and there was a risk that people could open the bins and tamper with the content. Lids were found to be inconsistently replaced after use, increasing the risk of the spread of infection.

We identified concerns in relation to the safe storage of creams for management of skin conditions. These were in open plastic baskets, on the tops of people's wardrobes increasing the risk of people ingesting items accidentally. We spoke with the provider about these risks and they agreed to arrange for the installation of lockable cabinets.

Records indicated that the last medicine audit was completed in December 2017, therefore no audits had been completed in the six months leading up to the inspection to check people had received their medicines correctly or that the service managed their medicines safely. Only two staff (out of a possible six) had up to date competencies to ensure they handled people's medicines safely.

Whilst overall records showed people received their oral medicines as prescribed there was a lack of records

for some medicines prescribed for external application such as creams and ointments to confirm they were applied as intended by staff. For people prescribed external medicines, there were no body maps indicating the areas of the body to which they should be applied. Some records for people prescribed medicines on a PRN (as required) basis contained written information for staff to follow but this needed further detail, particularly as not all people living at the service could tell staff when they needed to take these medicines.

Some of the written information listed medicines that were no longer prescribed and so could have led to confusion and error. For people prescribed pain relief medicines but who were unable to tell staff about their pain, there were no pain assessment tools in place.

One person who was staying at the home for respite was recorded as being independent with the management and administration of their medicines. Their medicines were not locked away securely in their bedroom. There was no risk assessment in place for independent medicines management or storage. This placed all people living at the service at potential risk, particularly as bedroom doors were unlocked. We escalated our concerns regarding these risks to the management team on the first day of the inspection. On the second day of our inspection no action had been taken to reduce the risks that we had brought to the providers attention.

People did not have up to date risk assessments in place for issues relating to their dementia care, falls management, pressure care and choking. The risk assessments that were in place were out of date and did not reflect changes in people's abilities and levels of risk. Reviews of care plans were completed monthly, but little or no information was added, other than comments such as, 'no change.' Use of daily contemporaneous notes had only been introduced from 6 June 2018, therefore we were unable to review the care and support offered to people living at the service each day prior to June 2018, and it was unclear what information staff based their monthly review decisions on.

Care plans consisted of a 'pen picture' style document, with sections that contained very brief information. This was the guidance staff were expected to work from and they signed this off as reviewed each month. Some information was conflicting and unclear. For example, one person was listed as having thickened fluids, and all the paperwork from the speech and language therapist was on file with their care plan, yet there was a note on one of the reviews to indicate thickened fluid was no longer needed. This increased the risk of staff following incorrect information.

Staff told us they did not read the care plans as they found them hard to use and lacking in relevant, up to date information. From speaking with care staff and the management team and from reviewing the quality of care plans available, staff did not have clear guidance to follow when working with people living at the service. The lack of up to date care plans and risk assessments, further increased risk to people living at the service, as there were new staff and agency staff on shift unfamiliar with people's care and support needs.

Night staff reported during shift handover that two people had been supported to reposition twice during the previous night. From reviewing the notes written by night staff, these indicated the people had only been repositioned once. When cross referencing this information with the care plans and risk assessments it was unclear how frequently people should be supported to turn during the night to mitigate the risk of developing pressure ulcers. Incomplete records did not enable the management team to accurately monitor people's repositioning overnight.

Each person who needed to use moving and handling equipment such as a hoist, had one sling allocated to them for staff to use. Care plans and risk assessments did not prompt staff to check that the size and fit of the slings remained suitable for each person. There were no spare slings to allow for washing or infection

prevention and control. Maintenance safety checks of the hoists did not include condition checks of all slings in the building. We highlighted this risk to the management team who agreed to arrange with the maintenance company to include regular condition and safety checks of the slings.

Staff completed moving and handling tasks such as hoisting people into seats in the dining room. Due to the position of a fireplace, and furniture, staff stood in the open fireplace, behind people's seats to aid transfers. This resulted in poor standing posture and risk of staff hitting their heads on the roof of the fireplace. Environmental risk assessments did not identify this risk.

Equipment in communal bathrooms was found to be rusty and in need of replacement. Risk assessment had not been completed in relation to the safe use of equipment for people in relation to their weight. This placed people at risk of harm due to the overall condition and suitability of items of equipment in place.

The service did not hold a record of maintenance and safety checks of wheelchairs used with people living at the service. The management team told us they would contact the wheelchair service team for further advice.

Some ensuite toilet floors had damaged or ripped flooring. This increased risk of falls, and where flooring was damaged increased risk of the spread of infection as it impacted on the staff's ability to keep the whole floor clean.

Large items of bedroom furniture such as wardrobes and chests of drawers, along with items in communal areas were not wall or floor fixed. This increased the risk of furniture falling or being pulled on top of people. The furniture was found to move easily when pushed with minimal force. Some people living at the service experienced behaviours which others could find challenging, potentially placing themselves and others at risk. We requested for the service to secure all furniture as a matter of urgency following the inspection visit.

Windows on the ground floor did not have restrictors on to maintain people's safety while having the windows open. For more agile people living with dementia, there was furniture and window sills in positions that would aid a means of exit from the building without being accompanied by staff. Bedroom windows on the first floor did have restrictors in place, although one for a window leading onto a flat roof did not appear robust when pushed on.

Environmental risk audits were not in place. The property was across three floors, with bedrooms on the ground and first floor. There was a lift in situ, but people had full access to a large flight of stairs that was wider than one person's arm span therefore people could not place their hands safely on both hand rails for support. There were not sufficient staff to be able to monitor safe use of the stairs, particularly overnight. We observed people going up and down the stairs without staff supervision during the inspection. One person required hand held support from an inspector due to fatigue and being unsteady once they reached the ground floor.

From speaking with day and night staff, and observing the daytime needs of people living at the service, people required a high level of monitoring. The layout of the home and position of bedrooms at the ends of corridors made it difficult for staff to robustly monitor people across all areas of the home.

There were changes of flooring heights between rooms, with portable and homemade ramps in place. One shower room had a very steep ramp for people to either be pushed or walk up and down. Risk assessments were not in place for staff in relation to pushing people in wheelchairs on gradients. Some bedrooms contained flooring height differences and steps. Most people living at the service used a walking aid or

wheelchair. Staff also had to move equipment such as hoists between levels in the building. We observed staff putting ramps into position and then folding them away repeatedly throughout both days of the inspection. Staff told us they found the ramps heavy and awkward to move. The environment did not reflect the complexity of physical healthcare needs for those people living at the service.

Rooms such as the laundry room were secured by a bolt positioned above head height. This did not stop the risk of people living with dementia unlocking the door and entering the room. The door was found unlocked on our first walk around the home with the manager. The housekeeping trolley was left unattended while the cleaning staff worked in people's rooms leaving people at risk of accidentally ingesting cleaning products.

The management team showed us their programme for ongoing maintenance and refurbishment of the building, but basic furnishings in rooms and communal areas were tired and worn. Some seating was low, we observed people finding it difficult to get in and out of these chairs independently. The condition and size of bathroom and shower room facilities meant that some people using the service could not access them, resulting in them only having access to a strip wash.

The service did not have a legionella water safety certificate. The management team told us that staff completed regular water temperature safety checks and flushing of the water system and descaling of items such as shower heads, but no evidence of this was provided upon request during the inspection. After the inspection visit, we asked the service to arrange for a legionella water safety inspection to be completed and for a copy of the safety certificate to be provided to CQC.

The above information meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team did not use a dependency tool to ensure sufficient staffing levels on each shift to meet people's needs. We examined staff rotas and found that there were only ever two staff on shift during the night, and staffing levels varied during the day. Variation did not link to changes in the needs of the people living at the service. The rotas indicated times where the manager was counted in staffing numbers, and overseeing medicines administration to cover the shortfall in numbers.

On the first day of the inspection, there were four staff on shift, consisting of one senior carer, one agency carer and two care support workers. On the second day of the inspection, there were three staff on shift. One senior carer who started at 8am, one agency carer who started at 8am one care support worker new in post who started at 7am and the manager. Morning shift was due to start at 7am. In the afternoon, there was one senior carer, one agency carer and the manager. The new care support worker was on a split shift and due back at 4pm. The night shift consisted of two staff, usually one senior carer and one care support worker. Staff had a 20-minute break during a seven hour shift. For the level of complexity, oversight and monitoring required for the people living at the service across both floors of the home, there was not sufficient staff on shift.

We observed people living at the service seated in communal areas for long periods of time without staff being present. An example of this was when we entered the dining room on the morning of the second day of the inspection. There were six people sat in the dining room, with no staff present as they were continuing to be with other people living at the service, and making tea in the kitchen. In the event of an emergency such as a fire, of those six people seated in the lounge at least one of those would require full hoist to be transferred into a wheelchair to exit the building, other people would have required pushing in the wheelchairs they were seated in, and staff would also have needed to put the ramps in place to move

people through the building. With two staff on overnight and first thing in the morning, this would not have been sufficient staffing levels to meet these needs.

We observed people living at the service going up and down the large flight of stairs between the first and ground floors of the building, due to low staffing levels during the day and overnight, the staff were unable to monitor use of the stairs during each shift.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated a clear understanding of safeguarding practices and procedures, and recognising types of abuse, however we found a written example of where training was not put into practice, where records indicated that a person had unexplained bruising, but this was not recorded as having been referred to the safeguarding team. This was escalated to the manager during the inspection for further investigation.

Supporting information was available for staff to refer to when handling and giving people their medicines. For people prescribed medication skin patches there were additional charts to record the application and removal of the patches and body maps indicating their application to varying areas of the body to ensure safety. We found that oral medicines were stored securely for the protection of people who used the service and at correct temperatures. Some protocols for medicines taken as required (PRN) needed to be more detailed.

People living at Ingham Old Hall told us they felt safe. One person said, "I have got no problems. I am happy because carers reassure me that everything is all right, and I get my medicines on time." A second person said, "I am comfortable because I know they will look after me. I am safe which is important to me." A third person told us, "I am comfortable and safe, I always have someone when I move around with my frame." One relative told us, "Everything is okay here, I do not have to worry when I leave [relative] because they are in good hands." A second relative said, "I feel that [relative] is safe here."

Each person had a personal emergency evacuation plan (PEEP) in place for use in the event of an incident such as a fire. These were stored in a central place in the building for ease of staff access. The documents were separated into a folder for those people living on the ground floor and one for those on the first floor. Each PEEP was traffic light colour coded to reflect the level of assistance each person required in the event of an emergency such as a fire.

A company visited regularly to complete maintenance checks and repairs of the people carrying lift. The home had contingency arrangements in place in the event that the lift stopped working.

We asked people how long they waited for assistance from staff. One person said, "If I ring the buzzer in the night I do not have to wait long for a staff member to come." A second person said, "They are quick to answer the bell, even during the night."

Two out of the three employment records examined contained references, copies of proof of identity documents and Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) undertaken before new staff started work. This helped to ensure people's safety by employing staff who were suitable to work in the care sector. One of the employment records examined did not contain copies of any character or professional references.

Requires Improvement

Is the service effective?

Our findings

During our inspection on 3 and 4 May 2017, we found the service was effective and this key question was rated 'Good' because people's nutrition and healthcare needs were met in a person-centre way.

During this inspection 13 and 14 June 2018, we found the service was not effective and we rated this key question as 'Requires Improvement'. This was because of a lack of adherence to the principles and recording of mental capacity assessments and a lack of awareness of which people had authorised Deprivation of Liberty Safeguards in place, which could impact on people's human rights.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records and DoLS authorisation paperwork examined demonstrated staff did not work within the principles of the MCA.

Care records did not contain decision specific mental capacity assessments, or examples of best interests decisions involving relevant professionals and family members in relation to aspects of care such as consent to care and support. Staff did not consistently understand the five principles of the MCA, or recognise the importance of least restrictive practice and balancing decision making relating to risk against people's wishes and preferences. For example, plastic covered, foam wedges were being used under people's mattresses in place of bed rails to stop them falling out of bed. The manager told us there were no bed rails in use at the service, with foam wedges used as a preferred alternative. There were no MCA assessments linked to risk assessments in place for their use, or their restrictions on people's movement.

Due to the lack of mental capacity assessments and best interests decisions, the management team were unable to tell us whether anyone living in the home was being deprived of their liberty. They were also unable to confirm whether anyone was subject to a DoLS authorisation. We found one care plan from the ten examined contained a copy of DoLS paperwork, for a seven-day urgent authorisation which expired in October 2017. The management team were aware that people's DoLS authorisation status was unclear, but had not taken steps to address this, such as contacting the local authority to seek further clarification.

We were concerned that the rights of people lacking capacity were not being promoted and protected. We escalated our concerns to the manager and provider and requested for this issue to be addressed immediately. The manager confirmed they would contact the local authority DoLS team to seek further guidance.

The above information meant the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Employment records and feedback from staff identified that staff did not have up to date annual appraisals or provision of regular supervision. From information provided only three members of staff had received supervision up to May 2018, all other records were for supervisions completed in 2017. Supervision offers staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. The manager and deputy manager were working on shifts to make up staffing numbers, impacting on the level of time available to offer regular supervision.

Training figures indicated that staff did not consistently complete the provider's mandatory training including role specific courses. The service accessed training through on line and face to face sessions. Courses with low completion rates (ranging between 8% to 62%) included equality and diversity, principles of dementia care, end of life care, food hygiene, moving and handling, first aid, infection control and fire safety training.

Training figures for the overall completion of the Care Certificate was low (46%). The Care Certificate is a set of induction standards that care workers should be working to.

There was a need for specialist training in stoma care relating to one person living at the service, although the manager was making arrangements for training to be provided. Staff told us they attended training when it was arranged and felt the training available was of a good standard, with night staff attending as needed during the day. From standards of care observed during the inspection, training and competencies was not consistently reflected in staff manor and approach.

The service had a paper sheet that was the record used as a training matrix recording staff completion of courses. This did not contain dates for refresher training and updates. It was therefore not possible for the management team to know when training was overdue. This did not provide assurances that staff had sufficient training to support them to meet the demands of their job role or to provide effective support to people.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were not person-centred to reflect staff knowledge of people's individual care and support needs. People did not have detailed care plans in place to monitor nutrition, changes in swallowing abilities and triggers for when to seek medical assistance or request for the GP to make onward referrals for specialist assessments.

We observed staff supporting people to eat their meals. Not all staff focussed solely on the needs of that person, instead talking to other people and staff members. This resulted in times where the staff member would stop giving the person food or interrupt their meal time which could result in their food becoming cold, and in turn the person not eating enough.

People ate in three seated areas of the home or in their bedrooms. We observed people waiting for their meals up to 35 minutes. One person told us this process could take longer. For people who found meal times stressful or lost interest in eating if the food was not placed quickly in front of them, the time delay affected people's food intake and enjoyment of having a meal. Staff prompted people if they were not eating, but were not observed to attempt this many times before the food was removed. We observed that

people were not offered alternatives if they had changed their mind or did not like the food placed in front of them, however staff told us alternative meals were available.

Due to low staffing levels for the number of areas people were seated at meal times, staff were unable to closely monitor people when eating and drinking to monitor risks associated with eating and drinking such as choking.

There were people living at the service at risk of weight loss linked to poor food intake. Food and fluid monitoring paperwork was held in those people's rooms for staff to complete each day. From a sample reviewed during the inspection, we found gaps in recording. Incomplete records did not enable staff to accurately monitor people's nutritional intake.

The above information meant the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all bedroom doors had room numbers, or names so it was unclear if a room was occupied or not and confusing for those people living with dementia, and was not in line with the provider's dementia management policy. The management team advised that they were awaiting delivery of fire proof paint to stencil signs onto doors, but had not made any temporary changes in the interim to address poor signage throughout the home.

People gave feedback on the quality of food. One person said, "The food is good every day." A second person said, "The food is good and the chef is lovely." A third person said, "I like the food, it is tasty and I always like what is on offer."

Staff understood how to use drink thickener to alter consistency of fluids to prevent risk of choking. Most people living at the service required prompting to ensure they maintained healthy food and fluid levels throughout the day and overnight. Night staff gave updates of drinks provided during the night during the morning shift handover meeting.

The chef held information on each person's dietary requirements, their likes and dislikes. The chef demonstrated a good understanding of food and fluid consistency and techniques used to puree and mash foods.

The GP visited regularly and supported staff with discussions around areas of care such as the decision for a person to have a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. People could also access foot care services.

Staff recorded people's weights monthly, with changes in weight monitored closely and linked to the Malnutrition Universal Screening Tool (MUST), used to identify people, who were at risk of not maintaining a healthy weight. The chef gave examples of meals and supplements added to people's diets to manage people's nutritional needs.

Inadequate

Is the service caring?

Our findings

During our inspection on 3 and 4 May 2017, we rated this key question as 'Good', as people's dignity, privacy and confidentiality was respected and maintained.
During this inspection on 13 and 14 June 2018, we found areas of concern relating to this key question, and rated it as 'Inadequate'. The condition of the care environment was not conducive to high quality care. People were not treated with respect, privacy and dignity.

From observations of staff interaction with people, staff did not consistently treat people with dignity, care and respect and were not familiar with each person's care and support needs and preferences. We observed staff hoisting people in communal areas, resulting in their clothing being raised and exposing their underwear and continence products to people and visitors in the communal area.

Staff did not consistently explain to people what they planned to do before doing it. An example of this was a person seated in a recliner chair. The leg rest was readjusted manually rather than electronically. On more than one occasion, we observed staff to suddenly push the leg rest down with their foot, without warning the person that their seated position was going to change and causing the person in the chair to call out and look shocked. Due to the position of this chair, lowering of the foot plate was observed to happened regularly during the day to enable other people to walk or be wheeled to the adjacent dining room tables.

Fabric armchair cushions were wrapped in clear plastic, with fabric continence sheets placed over the top. This did not offer comfort or dignity to people living at the service and increased the risk of people sliding off the seats.

Care plans were not in place for the management of people's dignity in relation to protected characteristics including disability and sexuality.

There was one shared bedroom for two female people living at the service. This appeared to have been a long-standing arrangement, although care plans did not indicate reasoning for this, or if the people were consulted and wished to share a room. There was no mental capacity assessment or best interests decision relating to these arrangements on their records. The room was open plan, with the beds positioned at opposite sides of the room, so each person would be facing the other when lying in bed. No curtain or screens divided the room to provide privacy and dignity when personal care was being provided. One person had a wardrobe, the other had a hanging rail for their clothes. There was only one overhead light for the whole room. This care environment did not offer privacy or dignity for these two people living at the service.

The main dining room did not contain a television, instead playing music or the radio. On more than one occasion we heard staff ask people if they enjoyed the music that was playing, and were told they did not like it, but staff did not act on this information and change the music. Staff told us they disliked silence, therefore needed to have music or the television on. Consideration was not given to people living at the service preferring quiet times during meals, or the possibility that the noise caused too much sensory

stimulation for some people living at the service.

We overheard one member of staff speaking loudly and in an agitated tone towards a person living with dementia. This did not show care or compassion for that individual. The provider was present when this happened and did not address this matter with the staff member at the time of the incident. This concern was escalated to the manager during the inspection.

Care plans did not demonstrate how people or their relatives were involved to maintain choice, control and involvement in their care. Staff did not record discussions regarding care plans with people and their relatives to ensure inclusion of opinions in the development of their plans; or collect feedback through quality audits. The provider told us that questionnaires were sent to relatives, but this usually coincided with an incident or area of concern and was not completed routinely.

On the second day of the inspection, with agreement from the manager, we arrived at the home early to attend morning shift handover. We found six people were up, dressed and seated in the dining room before 6.55am with support from the night staff. It was unclear how long some people had been up for. One person had their head resting on the dining table trying to sleep. From looking at people's care plans, some indicated a preference to get up around 8am. This did not reflect choice, control or appreciation of personal preferences.

During the shift handover meeting, night staff spoke about people they had woken up during the night to take them to the toilet or offer them use of the commode. This interrupted people's sleep, and was not linked to continence management plans or risk assessments, for example to prevent development of sore skin from remaining in the same position overnight.

People's medication administration charts were in folders with people's photographs and copies of medical information stored in open topped trollies. The trollies were unlocked and in an area accessible to people living at the service and visitors, as the medicines area was in an alcove along one of the bedroom corridors. This did not ensure people's personal information was stored securely to maintain their confidentiality.

The above information meant the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns that we found some people gave us positive feedback on the care they received. One person told us, "The staff are kind and chat to me when they are not busy and I can joke with them. Actually, they will do whatever I ask them to and they never say no. Of course, I might have to wait when they are busy." A second person told us, "They are very kind. I have problems with family relationships and they are very sympathetic and supportive if I am upset." A third person told us, "They are very kind and talk to me and keep me happy."

A relative told us, "My impression is that the staff are caring and friendly." A second relative said, "Everyone is so kind. [Name] is sensitive and if worried, staff will sit with them. Staff are concerned for [relative] and that is impressive because they are busy and pushed."

Inadequate

Is the service responsive?

Our findings

During our inspection on 3 and 4 May 2017, we rated this key question as 'Good', as social and leisure needs were met and people were happy with the level of stimulation they received.

During this inspection on 13 and 14 June 2018, we identified concerns relating to this key question and rated it 'Inadequate'. This was because people did not have access to regular activities and stimulation, and the care and support plans were not holistically written.

Staff did not write care plans collaboratively with people and their relatives. Plans were not person centred or holistic to incorporate areas of personal importance. Care plans were not consistently linked to risk assessments, and did not contain guidance for staff to follow in relation to the management of risks such as falls, choking and pressure care.

Environmental limitations of the bathrooms and shower rooms at the home resulted in some people living at the service being unable to choose whether to have a bath or shower. For some people, due to their level of physical disabilities, the equipment available was not suitable to meet their needs resulting in them only having access to strip washes. Environmental and equipment limitations impacted on the staff's ability to offer personalised care and support.

We found an example of a complaint from a relative, received by the service in 2016 relating to the lack of bathing facilities and that their relative was unable to have a bath but no more recent examples. One female person living at the service gave feedback on receiving personal care from a male member of staff and said, "he was kind and I was not concerned that he was male."

Some care plans and risk assessments contained unclear information for staff to follow. One record indicated that a person living at the service could experience physical side effects linked to constipation. There was no clear guidance for staff to follow in the event this happened, or indicators of things to look out for if staff were unfamiliar with the medical condition named in the plan. This increased the risk of staff not sourcing medical intervention in a timely manner. As records contained out of date documents including risk assessments for choking and falls, assessments indicated that the person was at 'low risk' but records of reviews could indicate that the level of risk had increased, making their actual levels of risk unclear.

The service was planning to review and update the care plans and risk assessments at the time of our inspection, but the old documents were the only ones available for staff to use in the management of risks. This placed staff and people at risk of incorrect procedures being followed or risks being overlooked.

People were not involved with the local community or decisions relating to the running of the home. There was not a daily activity timetable. Some visiting entertainment came but this was on an ad hoc basis, people were not consulted on activities they would like to participate in.

We overheard staff offer to spend time with people doing jigsaw puzzles, but this did not happen during the

inspection. The management team told us that people did not like activities, and that as staff were dementia trained, spending time having therapeutic conversations was sufficient. However, due to staffing levels, staff had very limited time to spend engaging with people.

The home had large grounds around it, which were not regularly used. Staff told us there were plans to make raised beds for people to garden but these were not in place at the time of the inspection. People could not pursue hobbies and interests, and there was minimal information recorded in people's care plans and personal history documents to show what they had previously enjoyed. We observed that most people spent all day sat in the same chairs, either in the television lounge, or in the dining room with nothing to look at and only a radio to listen to. There was a lack of stimulation and meaningful activity. Staff gave an example of having recently taken a small group of people into the garden and for a short walk and acknowledged how much everyone had enjoyed it, this staff member said they recognised the need for people to have more to do and that the manager was open to staff making suggestions.

People gave feedback on activities. One person said, "Nothing going on here. I watch television, read a book or do word searches. I have got to do something. Anything would be good, like bingo. It is such a long time since I have been taken into the garden." A second person said, "I do not think anyone organises activities so there is nothing much going on and as there is not many people to talk to I do get bored." A third person said, "I do wish I had more to do. I sit here a lot and read when in my room. I do get bored and fed up but that is how it is." A fourth person said, "I would like to have the chance to read my poetry to others." A relative told us, "I would love to take [name] out into the garden but I just cannot push the wheelchair over the gravel outside."

The above information meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not received any recent complaints. Information on how to make complaints was displayed in people's rooms and in communal areas of the home for people living at the service and their relatives to follow. As the management team did not encourage feedback on the service, or have relative meetings in place, it was unclear if low complaint levels were due in part to there being no forum to raise concerns and make comments.

People using the service and their relatives did not give examples of any complaints made or an indication that they planned to make a complaint.

We saw examples of care plans in place indicating people's wishes and preferences when needing care at the end of their life, with involvement from the GP. There were no people living at the service receiving end of life care at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 3 and 4 May 2017 we found that the service was not consistently meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for good governance focussing on a lack of effective systems in place to assess, monitor and improve the service and was rated as 'Requires Improvement'.

During this inspection on 13 and 14 June 2018, we found further concerns relating to the well-led domain and we have rated this key question as Inadequate. We found poor governance systems in place, with a lack of oversight of the standards of care provided.

The service did not have systems in place to collect and analyse feedback from staff and people using the service. This feedback would lead to improvements in the service. The lack of team meetings meant staff did not have a forum for discussing concerns.

The service did not complete quality audits in areas such as completion of care plans, infection control, medicines management, accuracy of nutrition and behavioural recording charts. Managers did not complete spot checks during the night to monitor standards of service provision or checks of the care environment. We noted that it took over 15 minutes for night staff to answer the door to us on the second day of the inspection, and the provider was present and did not have a key to access the building.

Staff shared limited risk information during shift handovers. Use of agency and new staff highlighted the importance of sharing detailed information during these meetings as those staff were unfamiliar with the people living at the service and the care environment. From the shift handover meetings observed, this was led by the senior day or night carer rather than the manager. This resulted in no management lead taken with reviewing tasks such as completion and updates of people's care and support plans or reviews of incidents and risks from the last 12 to 24 hours. This would have offered the staff team a good opportunity to discuss outcomes of incidents and investigations, and lessons learnt to be implemented into practice. Due to care plans and risk assessments being out of date and not regularly reviewed following incidents, this increased the risk of key information being overlooked.

Night staff told us they completed checks at 11pm, 1am, 3am and 5am and then responded to any call bells in the interim. All night time records reviewed showed the same times for routine checks to be completed, yet from shift handover information, at least three people had personal care provided at 3am and would have required assistance of two staff. It was therefore unclear from the verbal information provided when reviewed against the written night time records whether the records were inaccurate or if staff were completing personal care tasks alone rather than in pairs as per the guidance in the care records, placing themselves and the person at risk of harm.

Staff completed a 24-hour written log for the whole home, but this did not correlate with information discussed at shift handover. We found examples of incidents such as a person with unexplained bruising that was recorded in the daily notes and 24-hour report that were not recorded in the home's incident book.

The management team did not have oversight of these records or complete spot checks on quality of recording. This concern was brought to the attention of the manager for further checks to be completed. The manager was in the process of arranging staff meetings to ensure information from incidents and investigation findings was shared with the staff team and changes made to practice mitigating risk of reoccurrence. Staff meetings were not in place at the time of the inspection but a date was booked.

There were no checks in place from the management team to monitor the quality of recording of food and fluid charts, or to reflect actions taken for example where a person had not accepted food or fluids for a day or more. This paperwork was not taken to shift handovers to ensure all information was shared between staff including escalation of risks. We escalated our concerns regarding this to the management team during the inspection.

Staff did not complete infection prevention and control audits or quality checks of the cleanliness of the environment.

The service did not actively collaborate with other services or the wider community to keep up to date with current clinical practice and access to resources and advice to assist with development of service policies and procedures.

Staff told us they worked closely as a team to offer consistent standards of care and treatment. Staff morale was observed to be variable and affected by low staffing levels and demands linked to the caring role and environment. Staff gave mixed feedback regarding their relationship with the management team, but acknowledged the manager and deputy had an open-door policy and offered hands on support during each shift. Staff told us they enjoyed their job and that the new manager was very supportive.

People's views in relation to a lack of meaningful activities being provided had not been collected as the home did not have arrangements in place for people living at the service and their relatives to give feedback.

The management team did not use a dependency tool to calculate the number of staff required on each shift, while taking into account the number and complexity of people living at the service, the layout of the care environment or other environmental risks. This resulted in low staffing levels being on shift during the day and overnight. This impacted on safe working arrangements for staff and people living at the service.

With no up to date annual appraisals in place, and a lack of regular supervision we could not confirm that the service robustly identified or managed staff performance issues.

The management team did not have good oversight of people's care plans and risk assessments, or mitigation of risks through review processes and sharing of lessons learnt following incidents.

The home had an improvement plan, to improve the condition of the care environment, however, not all risks and areas of improvement identified during the inspection were included in the plan. Following the inspection, we requested for a more detailed plan with clear timescales for improvement to be provided.

The service had difficulties with staff recruitment and retention. The management team needed to recognise the impact that low staffing had on staff morale and retention. This also linked to management oversight of staff training completion to ensure staff had the skills required to meet the demands of their roles.

The above information meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated awareness of the service's whistleblowing process to enable them to report concerns or areas of unsafe practice. There were no whistleblowing concerns under investigation at the time of the inspection.

Due to level of risks identified from this inspection, we wrote to the provider under Section 31 of the Health and Social Care Act 2008, to request for provision of an action plan to address our concerns. An action plan, with clear dates for completion of tasks was received within the stipulated timescales. The action plan indicated completion of all urgent risks and issues would be by the end of July 2018. We will continue to monitor progress made against this action plan and any regulatory action as an outcome of this full inspection report.

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 10 HSCA RA Regulations 2014 Dignity and respect The care provider was not always protecting people's privacy, dignity and empowering people to make choices or have control over aspects of the daily routine, care and support needs. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not always working within the principles of the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards. Regulation 11 (1) (2) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The care provider was not always effectively monitoring people's food and fluid intake or managing risks associated with areas of care such as weight loss or choking risks. Regulation 14 (1) (2) (a) (I) (ii) (b)

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 9 HSCA RA Regulations 2014 Person-centred care The care provider was not always providing person-centred care in-line with people's wishes and preferences. People did not have access to regular, meaningful activities. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (h) (5)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not always assessing risks to people and the environment, and putting measures in place to mitigate risks and keep people safe from harm. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (h)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider was not completing quality checks and audits of the service. There were not good governance processes in place. People and their relatives were not being encouraged to give feedback on the service to drive improvement. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring there were sufficient staff, with the necessary skills and training to meet people's care and support needs. Regulation 18 (1) (2) (a)

The enforcement action we took:

We issued a notice of decision to impose conditions on the provider's registration at this location.