Care Quality Commission

C & V Residential Limited

C & V Orchard Residential Limited

Inspection report

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21 September 2017

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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

This unannounced inspection took place on 20 and 21 September 2017. At our last inspection in May 2017 we found the provider was not meeting the legal requirements to ensure there were sufficient numbers of staff to meet people's needs. We also found the provider was not meeting the legal requirements because there was no effective quality assurance processes in place to monitor and assess the quality of services people received. We served two warning notices on the provider for a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A Warning Notice is a formal way we have for telling providers they are not meeting people's needs or the requirements of the law, and that improvement is required. At this inspection we checked to see if the provider had made the improvements required.

C & V Orchard Residential Limited provides accommodation and personal care for up to 32 older people, some were living with dementia. The home currently has a registered manager in place. 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.

Staff did not understand how to manage people's individual risks to keep people safe. People were not protected from the risk of harm because staff did not use safe techniques to move people safely. People were not protected from harm because the registered manager had failed to take appropriate action when people sustained injuries. People did not always have their needs met, as there was not enough staff to meet people's needs. People were not protected from the risk of abuse because staff did not always recognise potential abuse; which meant incidents were not investigated and reported to the local authority. Medicines were not always available to people so their well-being was promoted.

People did not receive support from staff that had the knowledge and skills to support people safely. People were not always supported in a way that protected them from unlawful restrictions. Principles of the Mental Capacity Act had not been followed because staff did not have the knowledge or understanding of how to apply the principles in care practice. Staff did not always make sure people had enough to eat and drink. Staff did not always follow the guidance given by health care professionals to maintain people's health needs.

Staff did not always treat people with respect and ensure their dignity. Staff did not have time to spend with people and missed opportunities for interaction. Staff were focused on tasks and people did not receive care that was responsive to their individual needs. People were not involved in making choices about their care and support needs. Staff did not always understand people's needs and preferences. People were not supported to access hobbies and activities and enabled to choose how they spent their time. People knew how to complain and processes were in place to manage concerns and complaints.

The registered manager and provider had failed to monitor the quality and effectiveness of the service

provided to people. Staff did not have effective leadership and support and as a result, people were not protected from risks to their health and wellbeing. The provider had failed to notify us of events as required by law. The culture of the home was not open and transparent.

During this inspection we identified seven breaches of the Health and Social Care Act 2008 and one breach of the Care Quality Commission (Registration) 2009. You can see what action we told the provider to take at the back of the full version of the report.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months. If there is not enough improvement so there is still a rating of inadequate for any key questions 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.

Risks to people have not been adequately assessed and managed to reduce the risk of avoidable harm. There were insufficient numbers of trained staff to keep people safe. People did not always receive the care and support they needed. People were not always protected from the risk of harm or abuse.

Is the service effective?

Inadequate

The service was not effective.

People did not receive support from staff with the knowledge and skills to meet their needs. People did not always have their rights upheld in line with the Mental Capacity Act. Staff did not always follow the guidance provided by healthcare professionals. People did not always have adequate support to ensure they were eating and drinking enough.

Is the service caring?

Inadequate

The service was not caring.

The providers systems and processes did not ensure that people were cared for. People were not always involved in choices and decisions about their care. People did not always have their dignity and privacy respected.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported to take part in activities or hobbies so that they had interesting things to do. People did not have care which was responsive to their individual needs. People and relatives had not been involved in the assessment and planning of their care and support needs. People and their relatives knew how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems were ineffective. Action had not been taken by the registered manager or provider to monitor the quality of care people received, or to make the improvements identified at the last inspection. People were at risk of harm because information about serious incidents had not been analysed by the registered manager and provider so that action could be taken to prevent a reoccurrence.

Care Quality Commission

C & V Orchard Residential Limited

Detailed findings

Background to this inspection

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

The inspection took place on 20 and 21 September 2017 and was unannounced.

On the first day of the inspection the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the team consisted of two inspectors.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We also asked for feedback from the commissioners of people's care to find out their views about the quality of the service. We also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with four people who lived at the home and three family members or visitors. We spoke with the registered manager, deputy manager and provider. We also spoke to three members of staff.

We carried out observations throughout the home to help us better understand the experiences of people living at the home to review the quality of care people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for five people. We also looked at other records relating to the management of the service including four staff files, complaints logs, accident

reports, audit records and four medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2017 we rated the provider as 'requires improvement' under the key question 'Is the service safe?". This was because there were not enough staff to meet people's needs. We issued a warning notice and we carried out an unannounced follow up inspection in September 2017. At this inspection we found the required improvements had not been made to ensure the regulation was met.

At this inspection although additional staff had been recruited, we saw they were not always available to provide people with the support and care they needed. One person told us, "When there is a problem there isn't enough staff to deal with it". A relative told us, "It is very crowded in the lounge there are too many people and not enough staff for them." A member of staff said, "It has improved [since the last inspection] we have more staff." We observed that though one member of staff was present in the communal room for most of the time, this was not enough to respond to people's needs and at times people waited for periods up to twenty minutes for their needs to be met. For example with personal care. We saw an incident where one person had become ill; this had not been noticed by staff. The person tried to attract a member of staff's attention for a period of time. A member of the inspection team intervened and asked a member of staff to respond to the person's needs as they appeared to be distressed. Whilst attending to this person's needs other people in the lounge area were mobilising without walking aids and leaving the room. The member of staff had to leave the person and try and ensure the safety of the other people. We saw other occasions where staff prevented people from moving freely around the home. We heard one member of staff tell a person to 'sit down' when they wanted to leave the lounge. We asked staff about this and why they were restricting their movement and we were told they always ask to leave and there were not enough staff available to respond to this request.

At our previous two inspections in June 2016 and May 2017 we saw people were kept waiting for their meals to be served for periods exceeding 50 minutes. At this inspection people continued to experience delays in receiving their meals. One person told us, "I want my dinner but I have to wait it's always like this." We saw people were sat for periods exceeding 35 minutes before receiving their meals. During this time some of the more independent people had wandered from the dining area. We saw some people did not receive lunch and others did not have sufficient support with their meals. This meant they did not eat much of the food and would have benefitted from encouragement and a degree of assistance. People's needs were not effectively met due to insufficient levels of staff.

At our previous two inspections in June 2016 and May 2017 we were informed by the registered manager and provider that people's dependency levels would be reviewed and a process to determine the number of staff required to meet people's needs implemented. At this inspection we found people's dependency had not been reviewed nor had a system been developed to determine the number of staff required to meet people's needs. The regulation states the provider should ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. At this inspection we found improvements were still required so that people's needs were met and risks managed.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities)

Regulations 2014. Staffing.

We looked at how risks were managed in order to protect people from avoidable harm. We found risks to people were not managed safely. Staff explained to us how some people's risks were managed; however we saw they did not consistently provide care to people in the way they explained to us. We saw times staff moved people in a way that caused distress or increased risk of injury. For example, we saw underarm lifts were used despite lifting belts being available. We also saw staff on occasions using an unsafe technique by supporting people under their arms without the use of lifting belts which caused them distress and caused people to cry out. We looked at one person's care record to see if it contained information how the person should be supported safely. We found it did not contain sufficient guidance for staff to follow when supporting the person to move.

We also found the provider had not ensured staff had the skills or training to move people safely. We saw another person was at high risk of falls. Risks to the person's safety had not been assessed or reviewed following a number of incidents which had occurred. We found no guidance was available to manage the risk of falls or what staff should do to reduce the risk of further re-occurrence. We saw wheelchairs were used repeatedly without the use of the footplate. Staff we spoke with told us people refused to use the footplates. We looked at one person's care record for a person who we were told refused to use footplates when mobilising. We observed their feet were dragged along the floor when mobilising. This meant they were at risk of injury or harm. We found no information about the person not using foot plates when mobilising nor did we find any guidance for staff how to support them safely.

Another person required 15 minute observations throughout the night to keep them safe. Conversations with staff and records we looked at showed the person was checked hourly. This meant the person was not being checked as planned to reduce the risk of harm. The registered manager had failed to ensure there was an effective system in place to ensure risks were monitored and managed in order to protect people from avoidable harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safe care and treatment.

People told us they felt safe. One person said, "[I have] no worries, I like it here." A relative said, "[Person] is safe here." We found people were not always protected from the risk of abuse or harm. Staff could not describe the actions they might take if they had concerns. As a result, we found incidents where staff had not identified potential abuse or harm which had resulted in incidents not being investigated. For example, we saw six people had sustained injuries such as bruising the cause of the bruising was unknown. Although staff had recorded these concerns within the daily records, they had not identified these as potential harm or abuse nor had they reported the concerns to the managers.

We spoke with the registered manager and provider about this and both were unaware of the incidents. This meant they had not identified the cause or taken any action to protect people from further harm. During the inspection we also witnessed a situation which we referred along with the other concerns to the local authority and they are now under investigation. This showed people were not always protected from the risk of harm or abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

We asked people if they got their medicines when they needed them. One person said, "I need my painkillers

sorting out; I haven't had any for four days as they have run out." We looked at the system the provider had in place to ensure people got their medicines as prescribed. Records indicated the person had not received their medicine which included pain relief for a period of four days prior to the inspection.

We spoke to the staff and registered manager about this who explained they were aware medicines were not available for this person. They explained there had been an issue with the ordering of the medicines at the pharmacy and they would chase this as a matter of urgency. On the second day of our inspection the person's medicines had been received.

Staff told us they felt confident in administering people's medicines and said they had received training. However were unclear whether their competency had been checked. We spoke to the management team about this; we were told they would complete competency checks for those staff who administered medicines. We looked at four people's medicine administration records (MAR's) and found these documented what medicine people had received and were completed accurately. Some medicines were prescribed to be given only as and when people needed them. We found guidance was in place for staff to refer to informing them when to give the medicine. This meant people would be given their medicines at the times they needed them. We looked at how the medicines were stored and disposed of and found they were stored securely and unwanted medicines returned to the pharmacy for disposal. Medicines were stored and disposed of safely.

Staff told us pre-employment checks were completed before they started to work at the home. A member of staff commented, "[Registered manager] completed reference checks and Disclosure and Barring Service (DBS) checks." We looked at four staff recruitment records and saw right to work checks, reference and DBS checks had been completed. DBS checks help providers reduce the risk of employing unsuitable staff.

Inadequate

Is the service effective?

Our findings

At our last inspection in May 2017 we rated the provider as 'requires improvement' under the key question 'Is the service effective?". This was because mealtimes were not a positive experience for people. We carried out an unannounced follow up inspection in September 2017. At this inspection we found the issues we identified from our previous inspection had not been addressed.

Although people told us they enjoyed the food offered and commented, "The food is very good and good portions," and "We have four good meals a day with a choice." We found mealtimes were not flexible which meant people continued to experience delays in receiving their meals. Mealtimes were disorganised resulting in some people not having lunch and others not having adequate amounts of food. For example, one person regularly wandered from the dining area; this caused confusion and the staff were unsure whether this person had had anything to eat. When this person asked for a meal staff refused until the cook intervened to say the person had not had their lunch. We saw they left their meal on the table and the other people sitting at the table ate this person's food. Staff did not intervene nor did we see this person being offered any other food following this event. We also found the support people received to meet their nutritional needs were not sufficient. Staff were not available to provide encouragement or support people when needed. We saw people sat for long periods of time with their meals in front of them and ate very little. For those people who required assistance with their food we found they had to wait until staff had finished serving other people's food before they were supported. We saw one person being supported to eat their meal and the member of staff did not take the opportunity to converse with them whilst they were giving this support. Mealtimes were not a positive experience for people.

We looked at the records for one person that required their food and fluid intake to be monitored. This was to ensure they received enough to eat and drink. We saw staff recorded amounts given to the person. However we found information was not recorded consistently and we could not be sure this person received adequate amounts of food and drink to maintain their health. We looked at their care record and found risks in relation to their nutrition and hydration had not been reviewed. Without correct written guidance available people could be at risk of not receiving the right care or support.

People could not share with us in detail if they thought staff had the right skills to meet their needs. One person said, "[Staff] know me well." We found although new staff had been recruited they did not always have the skills or sufficient knowledge to support people effectively. We saw this added increased strain as these members of staff did not know people or their care needs. Some people living at the home had varying levels of dementia and some people displayed behaviours that could be challenging. Staff did not have the knowledge to support these people and this affected the quality of care they received and put people at risk of harm. For example, one person called out frequently asking what they needed to do. Other people tried to reassure the person but staff only spoke with them when asked to do so by other people. A number of different staff tried to reassure the person but did not use a consistent approach when responding to the person's concerns. This resulted in the person becoming more anxious. We looked at the person's care record and saw it did not contain sufficient guidance for staff to follow when supporting with their dementia or behaviours. Staff did not have the knowledge or skills to support people living with dementia effectively.

Staff did not have the skills and knowledge they required to meet people's need. For example we saw numerous occasions when unsafe moving and handling techniques were being used. As a result people were placed at risk of harm. In addition we saw that staff did not ask people for consent when delivering care and were restricting people's movement around the home. This showed that staff did not understand the principles of the Mental Capacity Act which meant it had not been embedded into staff practice. We also found concerns around recognising and reporting safeguarding incidents.

We looked at training records and found that important training had not been completed or updated; for example in areas such as moving and handling and safeguarding which accounted for the practice we observed. We found there were not adequate systems in place to ensure that even where staff had received training the staff competency for their role was not continually assessed to ensure they were equipped with the skills needed and were applying them in their roles. We spoke to the registered manager and provider who confirmed new staff had not received training and they told us they would arrange this straight away along with reviewing what other training was required for more experienced staff. This showed us people were not receiving care and support from staff that had the skills and knowledge to provide safe and effective care.

We saw four staff had been recruited since our last inspection. One of these told us they were shadowing more experienced staff on the day of the inspection. Because existing staff did not always have the skills and knowledge needed to support people the shadowing would not give new staff the knowledge required to support people safely. We also saw throughout the day the new member of staff was left alone to supervise and support people. Without the skills or guidance being available to them people could be at risk of not receiving the right care or support. The provider was not able to demonstrate that staff had their skills and competency assessed in line with the recommended national standards. The care certificate is a set of standards staff should cover as part of their induction. No members of staff had completed this at the time of the inspection.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

People told us staff sought their consent before providing care. One person said, "Staff generally ask me before supporting me and check I am ok." We saw for those people who were able to verbalise staff asked and waited for their agreement before providing care. However for those people who were not able to consent to their care we found staff did not always act in a way that respected their rights. For example, we saw staff moving people without talking or gaining their consent. We saw on several occasions that people were taken by staff to attend to their personal needs without the person's consent being sought.

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's rights were not always upheld and staff were not working in line with the MCA. When staff were asked about people's capacity to understand and make decisions they gave mixed responses. Staff were not able to describe the principles of the act and what this would mean in practice. Some staff felt certain people had capacity to make decisions whereas others did not. We found some decisions were being made on behalf of people who staff or relatives said they did not have capacity. For example, the restriction of movement. We found the provider had not always carried out assessments of people's capacity to make certain decisions and their care records did not reflect how decisions had been reached. This showed the

provider did not ensure staff worked within the principles of the MCA or had made sure staff had sufficient knowledge to make sure people received their care in accordance with the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA and whether there were any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications to the local authority to deprive people of their liberty. Three of these applications had been approved. Not all staff were aware who had an authorised DoLS in place. Staff gave us the names of people who they felt had a DoLS in place; this differed between the members of staff and was not consistent with what we were told by the registered manager. People subject to authorised DoLS were not protected by those conditions in place because staff were not aware of the people whose liberty were being restricted.

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

Most people were not able to share their experiences of staff assisting them with their day to day health needs or helping them access healthcare professionals when required. However, one person told us a chiropodist and optician visited the home. A relative also commented that they were kept informed about their family member's health and well-being by the staff. During the inspection we saw one visiting community nurse reviewing people's skin integrity. They commented staff were quick to make contact with them if they had any concerns. We saw from people's records there was regular contact with healthcare professionals such as the GP and dieticians. However we found advice given by health care professionals was not always followed. For example, completing observations of people following incidents or accidents. This meant we could not be assured people's health needs were met.

Inadequate

Is the service caring?

Our findings

At our last inspection in May 2017 we rated the provider as 'requires improvement' under the key question 'Is the service caring?". This was because staff were busy and focussed on tasks and did not always have the time to spend with people. We carried out an unannounced follow up inspection in September 2017. At this inspection we found the issues we identified from our previous inspection had not been addressed. The provider's systems and processes did not ensure that people were cared for safely.

People had mixed views whether they thought staff were caring. One person said, "Staff are kind." Another person told us, "[Staff] are sometimes strong in their tone to people." A third person said, "Staff are rushed so don't have a lot of time to spend with people." There were occasions we saw positive interactions between staff and people. For example, we saw one member of staff supporting a person to stand talking kindly to them and offering encouragement. However we saw numerous occasions when staff did not listen to people or anticipate their needs. We saw people were ignored when they shouted out. People did not look happy or appeared to be uncomfortable resulting in some people having increased levels of agitation and restlessness which was not addressed by the staff. We saw no attempt to engage with or distract people and staff accepted these behaviours as normal. On one occasion we saw a member of staff take a person's drink from their hand without speaking with them. The person snatched the cup back. We saw staff spoke with people from a standing position and there was limited eye contact and the use of touch. There were missed opportunities for staff to interact with people because they were rushed and did not have the time to spend with people. People were not supported in a caring and relaxed environment. For example, we saw one member of staff hurrying down the corridor pushing a person in a wheelchair. At the same time, another person was attempting to walk in the other direction. As the member of staff hurried past, the person was forced to grab the hand rail and stagger several paces into a doorway. The member of staff did not slow down to accommodate the other person. Care was tasked orientated and this meant there was little time available for one to one interactions with people or respond to their needs in a timely manner. For example, we saw one person calling for staff as they were trying to push themselves up from their chair. Despite staff being in the communal areas no one responded to their request for help until a member of the inspection team drew staff's attention to this person's needs.

At our last inspection we saw on occasions people's dignity was not respected. At this inspection people had mixed views whether they were treated with dignity and respect. One person said, "Everyone respects each other and we all get on famously." Another person said, "I am rushed at times by the staff they are just so busy they don't always have the time." A relative commented, "[Person] used to be very tidy and smart and always had [their] hair tied back neatly. [They are not] any more since they came here." We found people's dignity and privacy was not always maintained. Staff used language that did not promote people's dignity. For example staff talked about people in the third person whilst supporting them with their care needs such as 'she is sitting there now, so he will have to go there.' We saw people were routinely asked about needing to go to the toilet and staff also discussed people's needs in the communal areas of the home. At the last inspection in May 2017 people had to wait for periods of time for their personal care needs to be met. At this inspection we saw people continued to wait for prolonged periods of time for their care needs to be met and toilet doors were left open whilst people were using them. We saw one person had trousers on which were

wet and smelt of urine. Staff did not respond to their needs for a period of five hours. The provider did not ensure people had their dignity maintained.

This was a breach of Regulation 10 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Dignity and respect.

At our last inspection in May 2017, people gave us mixed views about the choices they were able to make about their care. At this inspection we saw staff did not ask people about how they preferred their care to be given or always sought permission before providing support. Staff we spoke with did not have an understanding how conditions such as dementia would impact on a person's ability to make choices. For example, staff had conversations with people around their meal preferences. They had not considered other forms of communication such as pictures when communicating with people who could not verbalise. We saw other instances where staff failed to offer people choices such as how people preferred to spend their time or where they would like to sit. At the last inspection we saw staff were often task led and did not always have the time to respond to people's requests. At this inspection we saw staff did not engage people in decisions about their care and they continued to be focused on tasks and not people. For example, staff gave people a drink without checking first whether they wanted a drink and what drink they would prefer. We also observed staff giving people biscuits without offering them a choice. We saw on two occasions people called staff back to them and asked for a different choice of biscuit. We could not be assured people were involved in their care and everyday decisions.

Inadequate

Is the service responsive?

Our findings

At our last inspection in May 2017 we rated the provider as 'requires improvement' under the key question 'Is the service responsive?". This was because people did not have access to sufficient leisure activities; and people's individual wishes and preferences were not met. We carried out an unannounced follow up inspection in September 2017. At this inspection we found the issues we identified from our previous inspection had not been addressed.

People were not always supported to take part in activities that interested them. One person said, "I get bored. There is no activity here. We don't have days out, we do nothing really. We just walk around and around doing nothing. I like to be active but nobody asks if I want to do anything." Another person said, "They do have some music here but it is the same music over and over again. Its one size fits all with the music." A relative commented, "I have never seen them do any activity here at all. There are no trips they talk about it but it never happens." Throughout the two days of the inspection people were offered very little stimulation and the majority of people spent their time sitting in the communal area without anything to engage with. Some people occupied themselves by reading the newspaper, walking around the home or sitting watching other people.

We saw the television was on with the sound turned down and at one point a person asked for some music. There was no discussion with people as to what they would like to listen to. Most people were reliant on the support of staff to take part in activities that interested them. We saw very few occasions where staff offered people activities to take part in. People were isolated and all were lacking stimulation and the lack of activity appeared to escalate the restlessness and agitation of some of the people living at the home. For example, we saw people pulling at their clothing, calling out or sleeping. Some people were scratching themselves or trying to reach for other people's clothing, cups or walking aids.

At the last inspection the registered manager and provider informed us they were recruiting additional staff and this would mean staff would have more time to support people with their interests. At this inspection although new staff had been recruited people still did not feel there was enough to do. Staff continued to be busy with care tasks and did not have the time to engage with people and undertake meaningful activity. The provider had failed to ensure people had access to activities which would support their wellbeing and meet their individual needs and preferences.

People told us they had not been involved in the development of their care plan. One person said, "I have a care plan in my room but I have never been asked about it." Another person commented," It would be nice to know about my care plan but I have never been asked." A third person said, "They have meetings about us but not with us." One relative told us staff informed them about any changes in their relative's needs but could not recall being involved in the development of a care plan.

At the last inspection in May 2017 we looked at people's care records we found although they contained information about people's care needs they were not personalised. At this inspection, we looked at the care records for five people and found they contained minimal information about people's individual likes,

dislikes and preferences. Care records had not been updated when people's needs had changed. Although people told us they received care that was responsive to their needs, we found staff did not consistently understand people's needs or preferences. As a result this left people at risk of harm.

Staff gave conflicting information about risks for people in relation to falls and those people who were resistant to care. Care records we looked at did not contain information for staff to refer to about how to support, manage and monitor these occurrences. Some people's needs could not be consistently met by the experience and skills of the staff. For example, supporting people that might display behaviours that challenge. The provider did not ensure people's risks were understood which meant there was potential for inappropriate care to be given. At the last inspection, staff told us they shared information at the start of each shift and any changes in people's needs would be picked up by the senior member of staff. This would lead to people's care records being updated.

At this inspection we found information recorded in people's daily notes was not always reflective of the information shared with staff during handover. Information recorded in people's daily notes detailed incidents which had occurred and changes in people's needs. This information was not reviewed nor used to update people's care records so that they were reflective of people's current needs. The provider had failed to ensure people received care which was responsive to their individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Person centred care.

People and their relatives told us they knew how to complain. One person said, "I would speak with staff." A relative told us, "If I needed to complain I suppose I would just tell someone." The provider had a system in place for the management of complaints and we saw a copy of the complaints policy and comments box was available in the entrance of the home. Staff told us they would refer any concerns or complaints they received from people or their relatives to the senior member of staff or registered manager. Since the last inspection we found no complaints had been received.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2017 we rated the provider as 'inadequate' under the key question 'Is the service well-led?". This was because the provider had failed to ensure improvements identified as required at previous inspections were implemented. Quality assurance systems were ineffective and risks to people were not managed. We issued a warning notice and we carried out an unannounced follow up inspection in September 2017. At this inspection we found the required improvements had not been made to ensure the regulation was met and the provider had failed to take action to make the improvements identified at the previous inspection so that safe and effective care was provided

We looked at the systems the provider used to ensure the service was safe and to monitor the quality of care provided to people. We found people's health and well-being was not sufficiently protected as the provider had failed to implement systems and processes to make sure people received the care and support they needed. The regulation states, systems and processes must be operated effectively to assess, monitor and improve the quality and safety of the service provided.

We found that the systems were ineffective. For example, we looked at how the registered manager recorded and monitored information when people had an accident. We found they had not developed sufficient systems and audits to monitor people's needs. As a result incidents had not been acted upon and action had not been taken by the provider to ensure people were protected from harm and the risk of a reoccurrence was reduced.

The communication systems had not been effective and did not ensure information about people's health wellbeing and safety were shared with the managers. We saw incidents such as falls were being documented in daily notes but were not analysed across the service to identify patterns or trends that could reduce potential risk to people or improve the quality of care a person received. We reported our concerns to the local safeguarding authority for further investigation and requested the provider addressed specific concerns immediately.

At our previous two inspections in June 2016 and May 2017 we discussed staffing levels and the deployment of staff. The registered manager told us they would review this along with people's individual dependency levels to ensure an appropriate number of staff were deployed to meet people's needs. At this inspection the registered manager and provider told us they had reviewed staffing levels and were satisfied they were sufficient to meet people's needs. We found although new staff had been employed at the home; people still waited prolonged periods of time for their needs to be met. We found the provider had not reviewed people's individual dependency levels nor given consideration to people's changing needs and behaviours.

At the last inspection in May 2017 we found concerns about the lack of stimulation and activities available to people. The registered manager said as additional staff were being recruited this would provide opportunity for people to partake in activities. At this inspection we saw no evidence the additional staff had resulted in people having access to any meaningful activities. The registered manager and provider had failed to develop a system to assess the numbers of staff required to meet people's needs which meant people were

placed at risk of harm.

We looked at the systems the provider used to ensure staff had sufficient skills and training to meet people's needs. We found audits had not been sufficiently developed to check and identify any areas of improvement. The registered manager had not identified the gaps in the skills, knowledge and training of the staff we found during the inspection. The registered manager had not ensured staff had the skills and training to meet people's needs.

The regulation states the provider should maintain accurate and complete records in respect of each person using the service. We found the care records we sampled were not reflective of people's individual risks and the care they received. Conversations we had with staff about people's individual care needs often conflicted to how we saw staff delivered care and what was recorded in their care record. Checks completed by the registered manager had not identified the gaps we found in people's care and in their individual care records. Systems had not been established to endure risks to people were assessed, managed and reviewed. We found risk assessments were not up to date which meant staff knowledge of people's risks was inconsistent.
The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Good governance.

Prior to the inspection we reviewed the information we held about serious incidents and safeguarding's within the home. We found the provider had failed to complete appropriate notifications about incidents that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law. During the inspection we became aware of incidents and incidents of potential abuse that had not been reported to CQC as required by law.

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

People had mixed views whether they felt the service was well led. One person told us, "It is well run, it can always be better." Another person said, "You never see the people that run it." A third person said, "I don't think it's well managed." People told us they felt happy to approach staff but were unsure who the registered manager was. At the previous inspection people told us their views were sought about the service provided however they could not recall receiving feedback. At this inspection, people and their relatives told us they could not recollect any recent discussions or consultation to gather their views had occurred. One relative commented, "There are no meetings." We looked at the records and found systems had not been effectively developed to ensure people views were sought and information analysed to improve the quality of care people received.

Staff were clear about the management structure and who to go to when there were problems. Most staff told us they felt supported in their roles and received one to one meetings with their manager and had the opportunity to attend team meetings. Staff were aware of the whistleblowing policy and felt they could raise issues with the management team if needed. Whistleblowing means raising a concern about a possible wrong doing within an organisation. However, we found staff were not supported by the management team and the opportunity to guide staff was not available. We observed staff interaction was not cheerful and morale appeared to be low. A relative commented, "The owners never get involved." People and relatives told us the managers were rarely visible or accessible to people or their visitors. We found the leadership staff received was weak with little people engagement from the management team. The culture within the

home was not open or transparent. For example, communication with the staff was mainly conducted via telephone even though the management team were in the building. We found staff did not have sufficient management support and the registered manager and provider had failed to take responsibility for the failings of the service. This had resulted in people being exposed to the risk of harm.

During the inspection we identified a number of areas where improvement was required to the general environment of the home. For example there were areas of the building where there was a strong smell of urine. A number of people living at the home were living with dementia; we saw there was little dementia friendly signage throughout the home and walls, doorframes and rails were painted white. This could mean people would struggle to find their way around the building.

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 18 Registration Regulations 2009 Notifications of other incidents The provider was not ensuring statutory notifications were submitted to CQC as required by the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received care which was responsive to their individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people were treated with dignity and respect.

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 protected through the effective application of the Mental Capacity Act 2005.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's risks assessments relating to the health, safety and welfare of people had been assessed or reviewed.

The enforcement action we took:

Notice of decision to impose conditions in respect of regulated activity.

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 The provider did not ensure allegations of potential harm or abuse were managed safely and people were protected from further harm.

The enforcement action we took:

Notice of decision to impose conditions in respect of regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected as the provider had not ensured quality assurance systems identified the areas of improvement required. The provider had failed to asses, monitor and mitigate risks relating to people's health, safety and well-being using the service.

The enforcement action we took:

Notice of decision to impose conditions in respect of regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there was sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

The enforcement action we took:

Notice of decision to impose conditions in respect of regulated activity.