Anchor Hanover Group

Linwood

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22 November 2018 and was unannounced. Our last inspection was in July 2018 when the service was rated Good. There had been two changes of management since our last inspection and we brought this inspection forward due to concerns raised through safeguarding. This inspection identified five breaches of the legal requirements relating to staffing, risks, dignity, care planning, activities, training, complaints and governance. You can see what action we told the provider to take at the back of this report.

Linwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Linwood accommodates up to 67 people in one purpose built building. The service provides residential care to older people with physical disabilities and long term medical conditions. They also provide support to people living with dementia. At the time of our visit, there were 54 people living at the home.

There was not a registered manager in post. The manager had been recently recruited and was in the process of registering with CQC. 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.

People told us that the staff who supported them were not always kind or caring. We heard examples of staff being rushed, failing to interact with people or not being kind. We observed instances where staff did not consider how best to protect people's dignity and where people had made specific requests, they had not been responded to. There was a lack of interaction and staff did not always respond to changes in people's wellbeing and circumstances.

There was not a positive culture at the service. Staff felt unsupported by management and recent changes had been implemented in a way that had impacted upon people negatively. People, relatives and staff told us that there were insufficient numbers of staff deployed to meet people's needs. Where this had been raised repeatedly, it had not been addressed and people's experience had not changed. The information about people's needs that was used to calculate staffing numbers was not accurate.

People's concerns were not responded to and records of complaints were not accurate. There were a variety of checks and audits taking place, but they did not identify shortfalls in risk management and record keeping that this inspection identified. Staff were not receiving regular one to one support and training to support them in their roles. There was a lack of systems to encourage communication between staff.

Risks to people were not always safely monitored. We identified inconsistencies and shortfalls in charts to

monitor risks and where plans were made to reduce risks, we identified instances where the measures were not being followed. People's care plans sometimes lacked information about how they liked to receive their care, their preferences and needs relating to medical conditions. The records relating to people's healthcare appointments were inconsistent and lacked accuracy.

People told us they sometimes felt bored and whilst there was a programme of activities in place, we identified missed opportunities to involve people. People's wishes and preferences regarding end of life care were not always documented and where people had specific clinical needs, records relating to these were not clear for staff.

Staff understood how to respond to safeguarding concerns and the provider kept a record of any incidents or accidents which they monitored. The home environment was suited to people's mobility needs and there was a plan to improve communal areas for people living with dementia. We saw positive examples of work with the local community which was impacting positively on people at the service.

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.

There were not enough staff deployed to safely meet people's needs and people told us they often waited for long periods for support.

Plans to reduce risk were not always thorough and we found examples where risks were not being managed. We also found some areas of the home which were unsecured and could pose risks to people.

People's medicines were not always being managed and administered safely.

Staff understood their roles in safeguarding people from abuse and the provider monitored incidents at the service.

Checks were carried out on staff to ensure they were suitable for their roles before they came to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Records relating to people's healthcare appointments were inaccurate or incomplete and care was not always planned around people's healthcare needs.

Staff did not always have the right training and support for their roles. One to one supervision as not taking place regularly.

People were happy with the food and we saw instances where nutritional needs were being met.

People's consent had been sought and where they were unable to consent, staff followed current legislation.

People's needs were assessed before moving into the service and the home environment was suited to their needs.

Is the service caring?

Inadequate

The service was not caring.

People told us that staff were sometimes unkind or uncaring.

There was a lack of engagement between people and staff and people were not always supported to be independence.

People's dignity was not always upheld and where people made requests, these were not responded to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a range of activities on offer but people told us they felt bored and we identified instances where opportunities to engage people had been missed.

Care plans did not always contain enough information and people's preferences and routines were not always being taken seriously.

There was a lack of evidence of planning for end of life care.

People's complaints were not always documented and addressed.

Is the service well-led?

Inadequate

The service was not well-led.

There was not a positive staff culture as staff felt unsupported and said their wellbeing was not taken seriously.

People and staff had raised issues with management that had not been addressed by the time of our visit.

The provider's audits and checks had not addressed the multiple concerns identified at our inspection.

We saw examples of positive work with the local community.

There was a vision to improve the service for people with planned updates to training and the home environment.

Linwood

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.

The inspection was prompted in part by safeguarding concerns raised by healthcare professionals. These individual concerns were investigated and responded to by the local safeguarding teams.

However, the information shared with CQC about these issues indicated potential concerns about the management of risk of pressure sores and choking. This inspection examined those risks.

This inspection took place on 22 November 2018 and was unannounced.

The inspection was carried out by three 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority.

As part of the inspection we spoke with 20 people and five relatives. We also spoke with the manager, the district manager, the deputy manager, the activities co-ordinator, two team leaders and six care staff. We looked at care plans for eight people, including risk assessments, medicines records and daily notes. We looked at mental capacity assessments and applications to deprive people of their liberty. We looked at staff files for four staff and saw records of staff training and supervision. We reviewed records of checks and audits and minutes of meetings of staff, people and relatives. After the inspection site visit the provider sent us meeting minutes, records of care and statements from staff. We required them to explain discrepancies we found in the records and they provided an investigation report.

Inadequate

Is the service safe?

Our findings

People and relatives told us there were not enough staff to meet their needs. One person said, "I try not to ring my bell too often as I know staff are very busy. However, there are times when I have rung it and it could take 20 minutes for a member of staff to come." Another person said, "Sometimes you have to wait ages. Sometimes they come quickly, but more often than not you have to wait and you are wet before they come." A relative said, "The carers work very hard but they've not got enough staff."

There were insufficient numbers of staff deployed to safely meet people's needs. Eleven out of 14 people or relatives we asked told us they felt there were not enough staff. Staff told us they had seen reductions in staffing numbers which meant they were not able to meet everyone's needs. On one unit, two people required the support of two staff for personal care due to their mobility. These people also required regular repositioning to reduce the risk of them developing pressure sores. We checked records for one of these people and saw they had not been repositioned for over six hours, despite their care plan stating that staff were to do this every four hours. The person had not had personal care in the morning and staff said they were often unable to support this person promptly, because they did not always have support of another staff member to do so. After the inspection, the provider looked into this and told us the person was repositioned after five hours, not six hours as records showed. This was still an hour later than the person's risk assessment said they should be repositioned.

The calculated numbers of staff required were not based on accurate information. The provider used a dependency tool to calculate the numbers of staff necessary to meet people's needs. The tool graded people's needs as 'low', 'medium' or 'high' and calculated the staffing hours required to meet everyone's needs based on this. One person required two staff to move safely and needed regular checks and repositioning to manage risks. We checked their dependency assessment for October 2018 and it documented they were 'low dependency', despite them having been identified to us by staff as a person who required regular input and two staff to move them safely.

We checked staffing rotas for November 2018 and identified four days when the calculated numbers of staff had not worked. On the day of our visit, the calculated staffing level had not been fulfilled due to staff sickness. We observed that staff were rushed and not able to spend time engaging with people and we received feedback from people and staff that this was their daily experience. A staff member told us, "It's a problem in the morning, we're always rushing. I try to do my best, but some of my colleagues feel like they are drowning."

The registered manager told us recruitment had been a challenge and when a staff member called in sick, they were often reliant upon finding temporary agency staff. There were plans to improve recruitment and attract staff, however we will require further action from the provider to ensure safe staffing levels are achieved and sustained.

The failure to ensure sufficient numbers of staff were deployed was a breach of Regulation 18(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks to people were not always safely mitigated. People told us they felt safe being supported by staff and we saw some examples of risks being responded to, but we identified risks that were not being managed. For example, one person was assessed as being at high risk of falls when alone in their room. Their risk assessment stated that they were to have a 'magic eye' [movement sensor] on in their room, which would alert staff if they attempted to mobilise. We observed this person in their room twice within an hour and noted they had moved without the sensor alerting staff. When we checked, the sensor had been left switched off which meant this person was mobilising without measures in place to keep them safe. Another person's records showed they had had multiple falls since moving into the home in July 2018. In each instance, a post-falls analysis was carried out but there had been no review of the person's risk assessment to consider further measures to reduce risk. The person's risk plan documented they walked with a stick and required 'assistance', but there was no further guidance for staff on the nature of the assistance required to keep them safe.

Risk monitoring was not completed to ensure people's safety. We checked a repositioning chart for one person and a night check chart for another person on the same unit. We were informed that there were two staff on this unit at night, yet the night checks and the repositioning chart documented these tasks were always carried out at exactly the same time, on the hour. The person requiring repositioning needed two staff to do this, which meant it would not be possible for the night check for the other person to be conducted at the same time in every instance. The manager told us that during a recent night check they had found charts completed ahead of time and had taken action against staff. However, we found charts were being completed with similar timings which showed this issue may not have been fully addressed.

We found instances where risks relating to people's behaviour were not appropriately responded to. Records showed one person had been aggressive towards staff. However, the positive behaviour support management plan for this person did not contain any strategies for de-escalation or engaging with them. The manager had written to the person stating they may have to move from the home, but there was no evidence of further work to respond to this risk. For example, there was no recorded attempt to explore what caused the behaviour and what interventions might reduce risk.

People's medicines were not always managed and administered safely. Staff did not always follow best practice when administering medicines to people. In the morning, we found a loose tablet in a bedroom. It had not been taken by the person but all the doses of that medicine had been signed for. The person required staff to support them to take medicines. . The person required support with their medicines, but staff had not waited until the person had taken the medicine before signing the medicine administration record (MAR). Whilst we did find medicines were stored safely, records relating to people's medicines also lacked accuracy.

Medicines care plans did not contain sufficient guidance to ensure staff had clear information about the purpose or potential side effects of people's medicines. The medicines listed in care plans did not always match the medicines listed on the MAR. For example, one person was prescribed pain killing gel and inhalers which were not included in their medicines records. Where another person was prescribed cream to be applied each day, the record of administration showed regular gaps which had not been picked up and addressed through checks and audits. This meant there was not an accurate record to monitor that this person was being administered their cream as prescribed.

Some areas of the home were not kept safe and clean. We observed some areas of the home lacked attention to cleanliness. On the first floor, tables were sticky in the communal dining area and the communal area on that floor did not smell clean. We also found three people's bathrooms were not cleaned properly, despite people using them daily. The provider employed housekeepers but staff told us they were

supporting with some day to day tasks due to staffing levels. We checked the laundry and found a backlog of clothes and soiled linen waiting to be cleaned. Staff told us they were expected to support with this due to laundry staff being on sick leave, despite already being stretched.

We also found areas of the home were not secured. For example, we found a sluice door was unlocked on the first floor and keys were kept in the laundry room doors. This meant there was a risk that people living with dementia may enter these rooms and come into contact with unclean items or dangerous cleaning chemicals. The manager told us they were in the process of changing the lock mechanisms for these doors from keys to keypads as they had recognised there were risks associated with using keys. However, we will require further action from the provider to ensure environmental risks are managed proactively.

The lack of effective risk management, the shortfalls in medicines practice and shortfalls in ensuring the environment was clean and safe were a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff understood their roles in safeguarding people from abuse. Staff had been trained in safeguarding adults procedures and were knowledgeable about the signs of potential abuse and how to respond to them. Staff knew the agencies to escalate their concerns to and were knowledgeable about whistle blowing. We noted during the inspection, staff were open with CQC where they had concerns about staffing levels which showed that they had confidence to raise issues externally when necessary. Records showed that where there had been safeguarding concerns, staff and the provider had worked with the safeguarding team to aid investigations and implement plans to keep people safe.

The provider carried out checks to ensure potential staff were suitable for their roles. Staff files contained evidence of checks such as references, health declarations, proof of right to work in the UK and a check with the Disclosure and Barring Service (DBS). The DBS carries out criminal records checks and holds a database of potential staff who would not be suitable to work in health and social care.

Requires Improvement

Is the service effective?

Our findings

People's healthcare needs were not always met. Care plans contained record of people's medical conditions and how they were treated. However, we identified concerns with people's health that staff had not responded to promptly. For example, one person was showing signs of depression. Records showed they had isolated themselves and told staff they felt life was 'pointless'. The team leader and registered manager told us they had been referred to local mental health services who had visited to complete assessments but these visits and the advice of healthcare professionals were not recorded in the person's file.

Another person told us they had attended an important appointment the day before our visit but their file contained no record of this appointment, its outcome and any changes to the person's needs as a result. This meant people's healthcare appointments were not being adequately tracked in a way that staff could monitor and respond to changes in health needs. Another person's records showed that they were being investigated for a possible urinary tract infection (UTI). Records showed two tests were carried out in May 2018 which were inconclusive. Records then showed a follow up test did not take place for another three weeks, and no outcome was recorded in the person's records.

Where people had specific health related needs, records relating to these were not always accurate. One person had a catheter and their care plan documented that staff were to observe for signs of infection and to check that it was draining properly. However, staff were not recording fluid output when emptying the catheter which meant they would not be able to promptly identify if there had been an issue with the catheter draining. Another person had a long-term condition which affected their skin. There was no guidance about how this might affect their washing and dressing needs other than stating they could not currently have a shower due to dressings. This showed care was not always appropriately planned around people's medical conditions.

Another person lived with diabetes but there was no individual diabetes risk assessment and no guidance for staff about how to identify and respond to high or low blood sugar levels. The shortfalls in information for staff heightened the risk that changes in the person's health would not be identified or responded to. The likelihood of this causing harm to the person was increased due to the high use of temporary agency staff at the service. Where another person had lost weight between April and August 2018, their risk assessment was not reviewed and a referral to healthcare professionals did not take place until September 2018. The outcome of the appointment was for the person to have their fluid intake monitored but records showed this was not taking place.

The lack of monitoring of healthcare appointments and health related needs and the shortfalls in response to changes in nutritional needs were a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Feedback on the competence of staff was mixed. One person said, "The staff are very good." Another person said, "The staff don't know what they're doing." Whilst records showed staff had attended a number of

training courses, staff were not receiving regular one to one supervision with their line managers. Staff did tell us they received an induction and records showed staff had attended training in areas such as fire, health and safety and equality. However, one staff member said they had not received supervision and another told us it was not frequent. This was something the manager had identified and had a plan to address.

We saw supervision was being booked but not every staff member had a one to one meeting booked by the time of our visit. This meant opportunities to identify and respond to training needs for staff were limited. One staff member told us that they lacked confidence supporting people living with dementia and another staff member was not able to describe how the Mental Capacity Act 2005 applied to their work, despite records showing training had been given in these areas. Records of staff training showed 92% compliance across all courses, but there was not a system to track individual staff member's training and courses attended. Despite high completion rates the training was not effective as staff had not always retained the information they needed to perform their roles.

The shortfalls in staff support and training were a breach of Regulation 18(2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's nutritional needs were met. Before the inspection, CQC were made aware of concerns with the way people with swallowing difficulties were supported because staff lacked knowledge of food textures. We saw evidence to show where people required pureed or soft foods to reduce risk of choking, staff were providing foods in line with this guidance. We met kitchen staff and they had undergone training in food textures and further training was booked to provide an update to this where national guidance had changed.

People told us they were satisfied with the food that they were served. One person said, "The food is very tasty." Another person said, "The food is excellent." Another person said, "The chef's very good." Records showed that people were asked about foods at meetings and there was a menu with two choices for each meal. The kitchen were able to prepare an alternative for people who did not want either option and people told us they were able to make requests. Records showed that where one person had said they wanted more traditional sauces with roast dinners, the chef had met with them and this had been addressed.

People's needs had been assessed before they came to live at the service. The provider carried out assessments that explored risks, needs and any preferences. People were given opportunities to express information such as what time they liked to get up and their favourite foods. The examples seen in people's records provided enough detail to create an initial care plan that would inform staff of people's needs and what was important to them. However, we did identify shortfalls in how care was planned and delivered which we have reported on further in the Responsive domain.

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).

We checked whether staff were following the MCA and found that the correct legal process was being

followed. Where one person was assessed as lacking the capacity to make a decision to live at the service and consent to their care, a best interest decision was documented which had input from relatives and a healthcare professional. The best interest decision involved restrictions being placed on the person so an application had been made to the local authority DoLS team. Staff had received training in the MCA and records showed they were following its principals, although our findings above showed staff sometimes lacked understanding.

The home environment was accessible to people. There were lifts installed to enable people to move between floors and we observed them doing so during the inspection. Corridors were wide with hand rails to enable people to move safely around the home with walking aids or wheelchairs when required. There was signage in communal areas, with pictures, to enable people living with dementia to orientate themselves. The communal areas were dated in appearance and there was a plan to improve these to create a lighter and more open environment next year.

Inadequate

Is the service caring?

Our findings

People were not always supported by kind and caring staff. Whilst one person said, "All the staff are friendly" and another person told us the staff were "alright", we received significant negative feedback about the caring nature of staff. One person said, "Sometimes the carers are unkind. If you call them in the night they get very cross." Another person told us, "They [staff] don't come in a nice, friendly way." Another person said, "One or two staff are nice, but they disappear."

People were not always supported by caring staff because there was not a caring culture at the service. Six out of twelve people and relatives that we asked gave negative feedback on the attitude or conduct of staff. We received feedback that staff did not understand people, were reluctant to provide support or that they were unkind. A relative told us they had overheard a member of staff in another room telling a person to 'shut up'. Records showed that people had raised the issue of staff being rude to them at two meetings in September and October 2018, but the feedback we received showed this had not been addressed by the time of our visit.

The manager shared their plans with us to improve the culture at the service and records showed they had met with staff to try to address these issues. However, the feedback we received showed that these improvements had not yet had any positive impact. Staff told us that they were always rushed and this was impacting significantly on their own wellbeing and affected the level of support that they could provide to people. The shortfalls in staffing levels had contributed to a culture in which staff did not feel valued or have time to provide the right care. This had created a staff culture at the service which was impacting negatively upon people. One person said, "They are so short-staffed that no one comes to speak to me."

There was a lack of interaction between people staff. One person said, "I really enjoy talking and some of the care staff don't speak to me, even when they are helping me in my room." Whilst we did observe some elements of good practice and staff who made an effort, we observed that there was a lack of interaction between people and staff. Throughout the day people were sitting in communal areas without any meaningful engagement from staff. Where people were cared for in their rooms, we observed staff carrying out tasks and checks but not spending time engaging with them. People said staff sometimes took no interest in them and rarely spent time to chat or sit with them. We spoke with one person who had recently received bad news and was upset, they told us no member of staff had asked about their wellbeing despite the inspection team observing that this person was crying.

Care was not always provided in a way that was considerate of people's dignity. In the morning, we observed that one person was supported to change their clothing in a communal area. People were moved from the area, but the person could still be viewed from internal windows by people and staff walking past. No additional measures, such as covering the person to protect their dignity, were carried out. After the inspection, the provider submitted evidence to show that this incident occurred because the person was living with dementia and had removed their clothes and become distressed. Whilst this provided some explanation, it showed that there was a lack of supervision for this person as staff were not present and had not been able to intervene to preserve the person's dignity and wellbeing. On another unit, we saw that a

person had a large tea stain on their top in the morning and by the afternoon they had not been supported to change their clothes. We saw people's clothes were high quality and care had been taken to maintain their quality. This was reflected in feedback from a relative about the laundry and clothes becoming damaged or going missing. People had not been supported to wear clothes in a nice way and some people looked unkempt and dishevelled. One person told us they had not been offered to wear underwear even though this was their usual preference

Where people had made specific requests about the gender of care staff, these were not always fulfilled. One person was at the service on respite and had asked to only be supported with personal care by female staff. When we checked their records, we saw that a male staff member had supported the person with personal care a week earlier. This person told us that whenever they made requests, these were not responded to. This showed people's dignity was not at the forefront of practice and there was a lack of involvement of people in their care.

People were not always given the opportunity to maintain skills and independence. Staff were able to describe how they provided personal care in a way that encouraged people to be involved and we saw this was documented in some care plans seen. One person told us that they liked to do their own cleaning in their room and they made their bed each day. However, they said that they would like to do more for themselves, such as going out or preparing drinks and food. Their care plan reflected that they would be able to carry out a number of tasks independently but no work had been done with the person to involve them in these types of activities. Each unit had its own kitchenette that provided a space for people to prepare foods and drinks. However, people, relatives and staff told us these were not being utilised in this way. Another person told us that they had started smoking again due to the frustration of their experiences living at the service. However, they said that they often had to wait to be supported to go outside to smoke due to the lack of staff.

The lack of caring culture, undignified manner of providing care and the lack of effort to encourage people to maintain skills and independence were a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback about the activities on offer. People gave us positive feedback on outings and exercise activities they had taken part in, such as a recent trip to Richmond and some seated exercises. However, these people also said they were often 'bored' during the day. One person said, "There's not a lot I want to take part in." Another person said, "I am absolutely bored."

Activities were not always planned in a way that was responsive to people's preferences and interests. The home employed activities staff and they were on the rota to be at the service all week. There was a timetable of activities taking place at the home that included entertainment, exercise, arts and crafts. People told us that they attended these activities and we received positive feedback on the impact of them. We observed activities taking place on the units during the inspection, including a quiz and a singing exercise. Some people had been supported to visit places where they grew up and visit sites of significance to them. We also heard that people had visits from a local school and went to read to children at a nursery. However, feedback from people was that they often felt bored. Where people were supported in their rooms, records did not always show that one to one activities were taking place for and this matched what people told us.

We identified missed opportunities to support people with activities based upon their interests or previous occupation. One person was an illustrator and told us they would like to draw and print in their room. They had been given a pen and paper by staff but they told us this was not fulfilling. They had requested equipment be set up to allow them to do this activity, but it had not been arranged and the person told us they were bored. Another person told us they wanted to go out more as they found being in a care home difficult. Records showed they had discussed this at a review and a recorded action was that they were to be taken out at least once a month. The person said they had not been taken out for some time and records showed they had not been supported to go out for over a month, despite this being recorded as an action for the person.

People did not always receive personalised care. Care plans documented people's needs and any specific support they required from staff. However, records and staff feedback showed that people's needs were not always met in line with care plans. For example, one person's records showed they could become 'tearful' and required one to one engagement with staff for their mental wellbeing. Staff told us they did not have time to fulfil this and records did not record any recent one to one time spent with the person. Staff also told us that care plans were not always useful to them. One staff member said, "Not everything is in the care plan. We, the carers, know people more than the care plans."

People also told us that staff did not always let them follow their preferred routines. One person said, "They [staff] don't like you going to bed too early for some reason." Another person told us that when they asked for support from two staff to get them up in the morning, they were told that it 'would have to be 5.30 or 6 am'. In meetings in September and October 2018, people had raised that they felt they were being encouraged to go to bed too early. Minutes showed people said that on the ground floor, staff were encouraging them to go to bed at 6:30pm. The manger told us they had worked with the pharmacist to change the dose times for night time medicines, in response to people's wishes to go to bed earlier.

However, where one person's night medicines had been changed there was no record of a discussion with the person to confirm this was their choice. This showed people were not always involved in decisions about their routines.

In some instances, there was a lack of detail for staff about how to meet people's needs. One person required injections to manage pain in their shoulder, but it was not clear how this affected their ability to dress and what kind of support staff should provide. As our findings showed people were often supported by temporary agency staff, the risk of these shortfalls impacting upon people was heightened.

There was not always enough information in people's records regarding end of life care. Care plans did contain a section to document people's advanced wishes, but these did not always contain sufficient detail to ensure dignified and personalised end of life care. We checked the records for a person who had been highlighted to us as receiving end of life care. They had an end of life care document within their file but there was no meaningful person-centred information. Staff had ticked boxes but it did not document the person's wishes with regards to their preferences, spiritual needs or loved ones at the time of their death.

Care plans showed evidence of reviews, however these did not always result in changes to care. We saw there were records of reviews in care files, but these were not always taking place as planned and actions from reviews were not always carried out. For example, where one person's mobility deteriorated and they required two staff to assist with moving and handling, there was no reference to how this would be achieved, including how staff might be deployed to do this.

The shortfalls in activities and lack of information within care plans were a breach of Regulation 9 (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

After the inspection, we received evidence to show that training was booked with the provider's dementia lead in order to provide training for staff on how to provide personalised care to people living with dementia. The provider also informed us there were plans to introduce a programme with staff to encourage more impromptu meaningful activities to carry out with people. We will follow up on the impact of these improvements at the next inspection.

People and relatives didn't always feel confident that their complaints had been addressed. Whilst one person said, "I've never needed to complain." Another person told us, "[Relative] has complained but it hasn't changed." Another person said, "No good complaining, it won't do any good." One relative told us they had raised concerns about issues with the laundry some time ago, but this had not improved. A record was kept of complaints but it did not document some of the complaints people and relatives told us about, such as the laundry issues. People said they had raised issues with lack of activities and lack of staff but these were also not documented. Therefore, there was not a clear system for documenting and analysing complaints to identify and respond to known issues.

The lack of response to complaints was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was not a positive culture at the service. Staff told us that they felt demoralized and did not feel supported by management. Staff said their wellbeing was not taken seriously. Two staff told us that their workload expectations were impacting negatively upon their health. We saw evidence to show a high number of staff were going through disciplinary or had concerns raised about them. Minutes of a recent staff meeting referenced staff 'shouting at each other in the corridors', which staff and relatives confirmed they had observed taking place recently. There had been two changes to manager since our last inspection and the new manager had only been in post for three months. They had identified a number of issues which they were in the process of addressing, however these had not yet led to improvements in people's experiences.

As reported upon in Caring, the impact of this culture was having a significantly detrimental effect upon practice and the care that people received. Recent changes to shifts and break times had been implemented. People, relatives and staff told us this had resulted in staff leaving and changes to break times were impacting on staff wellbeing. This showed that the implementation of these policies had not been carried out in a way that would cause minimum impact on people and staff.

After the inspection, the provider submitted an action plan to CQC stating how they would address our urgent concerns related to staffing levels and shortfalls in practice that had affected people's dignity. The provider identified robust actions but we will require evidence of these being sustained and embedded before applying an improved rating to this domain. Records showed there had been concerns about the conduct of staff which the provider was in the process of resolving. The management changes meant there had been a lack of stability which had impacted upon the culture at the service. Implementing improvements in a way that will ensure they can be embedded and sustained will take time. We will monitor the progress of these improvements and measure their impact at our next inspection.

Staff told us there was a lack of communication at the service. Recent changes to daily handover meetings meant that care staff no longer attended these and information was to be passed on by team leaders when they went onto the units. The manager told us this was to ensure staff were available on the units to meet people's needs at busy times. However, staff told us that information about people's needs was not being effectively handed over to them between shifts. One staff member said, "Now it's just straight to the units when we come in. No handover, no information."

Records were not consistent or up to date. As reported in Safe and Responsive, we found numerous instances where records did not reflect people's needs and did not demonstrate risk assessments and care plans had been followed. We identified one person who's needs had not been met and staff on the unit corroborated that the lack of information in their records reflected care tasks had not been completed. After the inspection, we were sent a daily note which was not consistent with the feedback, documentation and the observations of the team on the day. We used our legal powers to seek an explanation on this which identified shortfalls in recording and communication about how this person's needs had been met.

There were a variety of checks and audits in place, but they had not addressed the concerns raised by our

findings. The management carried out a variety of checks that covered areas such as the environment, cleanliness and medicines. The provider also carried out regular visits that covered all areas of the home and people's care. A recent provider audit had identified gaps in people's records relating to healthcare appointments and risks, which highlighted that these issues were known to the provider but had not been addressed by the time of our visit.

We saw examples of people being involved in the home, but our findings showed more work was required because people felt their views were not responded to. People had raised issues at meetings that had not been addressed and people told us that issues they raised would not be taken seriously. There were examples of positive methods to involve people and relatives, such as a newsletter, social media account and surveys. However, the fundamental issues identified at our inspection meant people did not feel their views were taken seriously.

The multiple shortfalls in the governance of the service were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were benefitting from links with the local community. The activities co-ordinator had engaged with a local nursery and a school, with people having visits from children and people going to a nursery to read. We saw evidence of staff working with the local authority where there had been concerns with a person's care. A visiting healthcare professional told us that they had good communication with the service and staff provided them with detailed information.

There was a vision to improve the service. There was a plan in place to implement improvements to the environment and activities. We saw evidence of workshops and training to implement best practice for people living with dementia. The provider showed us plans to improve communal areas and they had sought best practice around how to ensure the environment would be dementia friendly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always planned in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Plans to manage risk were not always followed and medicines were not always administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always documented and responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of governance at the service and audits had not identified and addressed

the concerns we found at this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to meet people's needs and staff did not always have support in their roles.