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Woolton Manor Care Home

Inspection report

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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

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

The home provides accommodation for people who require nursing or personal care. The home can accommodate up to 66 people. Since our last inspection, the provider took the decision to close the nursing unit in the home. The home at the time of this inspection only provided support to people who required assistance with their personal care. At the time of our inspection, there were 25 people who lived in the home. This inspection took place on the 13 and 15 February 2018 and was unannounced.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this inspection there had been no registered manager in post for a number of years. This was a breach of the provider's conditions of registration with CQC.

At the last inspection in July 2017, there was an acting manager in post who was being supported to manage the home by a consultant. At this inspection, these managerial arrangements had not changed.

At our last inspection, we found breaches of Regulations 9,10,11,12,13,17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this visit we followed up the breaches we identified at our previous visit. We found that the provider had not taken appropriate action to address our concerns and all of the breaches we identified previously remained. This meant people who lived at the home continued to be placed at serious risk. The rating for the service has not changed. The service remains inadequate and in special measures.

At our last inspection people's needs and risks had not been properly assessed and managed. Information in relation to people's care was confusing, contradictory and difficult to follow. At this inspection, we found that no improvements to people's care planning and risk management had been made. People's care plans contained some person centred information but this information was limited. Where people had made their preferences or needs known, support had not always been provided in accordance with them. This placed people at risk of unsafe and inappropriate care.

Concerns were raised at the last inspection with regard to the implementation of the Mental Capacity Act and people's capacity to make specific decisions about their care. At this inspection, people's decision making was still not appropriately supported in accordance with this legislation. This meant that people's

consent was not always lawfully obtained.

People still had no access to social or recreational activities in support of their emotional well-being and we observed that the majority of people sat all day watching the TV. This was the same as at the last inspection, yet despite this, no effort had been made to ensure that people's social and recreational interests were catered for. People told us there was nothing to do at the home and the place was very quiet.

At our last inspection, records showed that people did not receive the support they required with their personal care to preserve their dignity and skin integrity. We found the same at this inspection. Records showed that people went significant periods of time without a bath or shower and for the most part only received 'strip washes' or 'bed baths.

The number of staff on duty was not always sufficient to meet people's needs. We observed that one person waited over 15 minutes to be taken to the toilet. People we spoke with had mixed opinions about whether were enough staff on, some people thought there were enough to assist them but others told us they had to wait for long periods when they rang their call bell.

Staff recruitment was not always robust. Staff records showed that staff had not always received an induction into their job role or sufficient training to provide safe and effective care. Staff had received supervision from their line manager but none of the staff files we looked at showed that staff had an appraisal of staff skills and abilities to assess and monitor their competency.

Care staff had an understanding of safeguarding and the action to take should abuse be suspected but records showed they had not always identified signs of abuse correctly. Some improvements to the way safeguarding incidents were handled had been made but further improvements were required to ensure all incidents were robustly managed. This was because some safeguarding incidents were not identified, investigated or reported appropriately.

Staff were polite and pleasant to people but their support was not always provided in a dignified or respectful way and staff were not always attentive to people's well-being. People told us the staff were kind and caring and people felt well looked after.

The provider's governance arrangements were ineffective. The managerial systems and the provider's oversight of the service failed to identify and address all of the concerns we identified. The provider's lack of action to address these issues both at this inspection and two previous inspections demonstrates they lack the competency and accountability to ensure the service is safe, effective, caring, responsive and well-led. This means people continue to be placed at serious risk.

At the end of our inspection, we discussed the concerns we identified during the inspection with the acting manager. We found they too lacked accountability and the competency to implement changes to the service in order to protect people from avoidable harm.

The overall rating for this provider is 'Inadequate'. It has been inadequate since 2016. This means the service will remain in 'Special measures' by CQC. The purpose of special measures is to:

-□Ensure that providers found to be providing inadequate care significantly improve.
-□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
-□Provide a clear timeframe within which providers must improve the quality of care they provide or we will

seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks were not always assessed or managed adequately.

The systems in place to identify, investigate and report safeguarding incidents were not robust.

Staff recruitment was not always properly verified or considered.

Staffing levels were insufficient to meet people needs at all times.

Medication was not stored safely and the administration of topical medication was ad hoc and inconsistent.

Parts of the premises and its equipment were unsafe and not fit for purpose.

Is the service effective?

Inadequate

The service was not effective.

The provider failed to implement the Mental Capacity Act appropriately when people needed support to make decisions

Staff were not adequately trained and their competency to do their job role had not been assessed.

People told us the food was satisfactory and that they had a choice but people's nutritional information was contradictory. This meant there was a risk they would receive an unsuitable diet.

Is the service caring?

Inadequate

The service was not caring

People failed to receive adequate personal care as access to a bath or shower continued to be extremely limited.

The way in which people were supported was not always

dignified and staff were not always attentive to people's well-being.

People spoke with staff were kind to them.

Is the service responsive?

Inadequate

The service was not always responsive.

People's preferences and wishes in relation to their care were not clearly documented so person centred care could be delivered.

People's needs had not been properly assessed or care planned.

People received support for their medical and physical health needs from a range of health and social care professionals. Records in relation to these visits were difficult to follow.

People still had no access to any social or meaningful activities in support of their emotional well-being. People expressed concerns about this.

People's preferences with regards to how they would like to be cared for at the end of their life were not always documented. Staff training in end of life care had still not been provided.

Is the service well-led?

Inadequate

The service was not well led.

The service has had no registered manager for a number of years.

The service has been rated inadequate at three consecutive inspections.

The governance systems in place were ineffective in identifying and addressing the serious concerns we had about the service.

The provider has consistently failed to take effective action to mitigate the risk of harm and lacks the competence to do so.

Woolton Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 15 February 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an assistant inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with seven people who lived at the home, a relative, the acting manager, the deputy manager, two care staff and the cook.

We examined a range of documentation including the care files belonging to six people who lived at the home, five staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our last visit to the home in July 2017 we identified serious concerns with the safety of the service. These concerns had been raised with the provider in a previous inspection that took place in November and December 2016. At this inspection, we found similar issues again. This was extremely concerning as despite the provider having knowledge of these concerns at two previous inspections they had taken no effective action to address them. At this inspection we identified continued breaches of regulations 12, 13, 18 and 19 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care files belonging to six people who lived at the home. We saw that the assessment and management of people's risks remained poor. For example, one person had a progressive health condition that placed them at risk of seizures. We found that there was no risk assessment or risk management plan in place to advise staff how to support this person with regards to this condition and no risk assessment or risk management plan in place to assess and mitigate the risk of a seizure occurring.

Due to the person's health condition they had difficulty swallowing. A soft diet and thickened fluids was recommended by a speech and language therapist in 2016. Despite this, the person's care plan stated they were to receive a normal diet. The person's care records showed that they had access to drinks in their bedroom which were not thickened appropriately to prevent the person from choking or aspirating on them (aspirating is when food or fluids go down the wrong way into a person lungs). We asked the acting manager about this, they told us this was the person's choice. The risks of this however had not been assessed and there were no risk management strategies put into place should a choking incident occur.

One person was prone to urinary tract infections (UTI) and had a catheter in place. The risk of the person experiencing a UTI or the likelihood of them experiencing complications with their catheter had not been risk assessed. The person's care plan advised staff to monitor and record their fluid intake and output but records in respect of this did not make sense. For instance, no record had been made of when the person's catheter had been emptied or changed and the amount of fluids recorded as being in the person's catheter bag sometimes exceeded the amount of fluid the catheter bag was physically able to hold.

One person was at significant risk of pressure sores developing due to immobility. We saw that the risk of the person developing pressure sores had been assessed but staff had no adequate risk management advice to follow to mitigate these risks. One person's records indicated that they had a tendency to pull their wardrobe over. We checked the person's room. We found the wardrobe doors had been removed but the wardrobe itself had not been secured to the wall to prevent it from falling over. This placed the person at risk of avoidable injury.

The risk assessment in use for bed rails was still inadequate. The same risk assessment that the provider had been advised was insufficient at the last inspection was still in use.

We looked at the way medicines were managed and found that no significant improvements had been made since the last inspection. This meant the provider continued to be in breach of Regulation 12 with regards to the safe medication management.

Some people who lived at the home required the application and use of prescribed creams, ointments and other external preparations. We found that staff had little or no information on how and when to apply these creams. In some instances the creams listed in the person's care plan did not match the creams listed on the person's medication chart. This meant it was difficult to know what creams were in use. When we checked people's records we saw that the application of these creams was often inconsistent . This was similar to what we found at our last inspection. It was clear no effective action had been taken to ensure people's creams and other topical applications were administered properly.

A number of people who lived at the home required a prescribed thickening agent to be added to their drinks to help prevent them from choking or aspirating. We found that no records were kept of when a thickening agent was administered, how it had been administered or by whom. This meant there was no system in place to ensure that people received the thickening agent they needed at all times. There were also no checks in place to ensure that people's drinks were thickened correctly and in safe way.

The home's gas and electrical installation had been inspected and certified as safe. Regular tests of the fire alarm and nurse call bell system were undertaken. Other aspects of the premises and its management were not properly managed.

There was no clear evidence that the home's moving and handling equipment had been certified as safe and suitable to use in accordance with The Lifting Operations Lifting Equipment Regulations 1998 (LOLER). LOLER applies to all lifting equipment used for work purposes. Under LOLER, all lifting equipment such as hoists should be inspected every six months to ensure it is safe to use. This meant that there was a risk that the moving and handling equipment used by staff in support of people's moving and handling needs was not safe or suitable for purpose.

A letter from Merseyside Fire and Rescue Authority was received by the provider in January 2018. The letter drew attention to the fact that some of the fire safety deficiencies identified at a previous fire safety visit in October 2017 had not been acted upon. This meant the home still had improvements to make to ensure its fire safety provision was sufficient. We looked at the provider's fire risk assessment. It had not been reviewed since 2010. We saw that Merseyside Fire Authority had informed the provider in writing of their legal duty to review and update their fire risk assessment regularly and at least once a year in January 2016.

We looked at how the provider monitored the risk of Legionella in the home's water system. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed.

We saw that the risk of Legionella had been assessed in 2015 and a series of risk management actions were identified to monitor and mitigate any potential risks. There was no evidence that these actions had been undertaken or that the risk of Legionella had been reviewed. This meant that the systems in place to monitor and mitigate the risks of Legionella infection were not robust.

At our last visit we identified concerns with the premises and the equipment in use. At this inspection, we found little improvements had been made. For example, in six people's bedrooms, the windows remained sealed shut with paint and were unable to be opened. Two people's bedrooms smelt strongly of urine. One

person's toilet seat was chipped which made cleaning difficult for infection control purposes. One person's bedroom's had an electrical wall socket that was cracked down the middle which made it unsafe to use. Some of the window restrictors in place were still substandard. The floor in one person's en-suite bathroom was only half tiled. The person told us this was due to the tiles cracking under the weight of their mobility equipment but no alternative and appropriate flooring had been sourced by the provider. The tiles in another person's bathroom were also cracked. The brakes on one of the shower chairs in use did not work, which meant that the chair still moved when the brakes were applied. This placed people at risk of avoidable harm during the receipt of personal care.

This evidence indicates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as parts of the premises and its equipment were unsafe.

At this inspection, we saw that some improvements to the way safeguarding incidents were documented and reported to the local authority safeguarding team had been made. Some incidents however had not been reported to CQC in accordance with the provider's legal responsibilities.

Other documentation in people's care records showed that incidents of safeguarding nature had occurred but had not been identified, recorded or reported appropriately as a safeguarding concern. For example one safeguarding incident had been recorded on an accident form and another safeguarding incident was documented in the person's care file. There was no safeguarding documentation to show it had been properly managed and reported. There were also body maps in people's care files that identified people had sustained minor injuries with no known cause. There was no evidence that the cause of these injuries had been investigated or reported to the local safeguarding team in accordance with safeguarding procedures.

Care staff spoken with demonstrated that they knew what action to taken to protect people from the risk of abuse but records showed that they had not always recognised that unexplained bruising or injury could potentially indicate abuse. Consequently they and the manager had not always followed safeguarding procedures.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding people from the risk of abuse.

At our last visit, we found that the number of staff on duty was insufficient. At this inspection no changes had been made. During our visit, we saw that there were limited opportunities for staff to interact with people in any meaningful way and most of the interactions were task related. We did not hear may people's call bells ringing for long periods of time to indicate people's needs were not being met but a significant number of people who lived at the home sat in the lounge for most of the day with limited access to a call bell.

During the afternoon of our visit we observed that one person requested to go the toilet. This person required two staff to assist them. We observed that the person waited over 15 minutes to be taken to the toilet as only one member of staff was available to help.

People's opinions on the number of staff on duty were mixed. Some people told us staff came quickly, others told us that they sometimes had to wait. For example, one person said "It's really tight with four carers" and another said "Staff come, they might be busy with others" when asked if staff came quickly when they rang their call bell. One person who was sat in the lounge said "I don't see call bells in here, if someone was to take ill, upstairs we have an alarm, down here I have to wait, don't trouble them".

We asked the acting manager to provide evidence of how they had used information about people's needs to plan safe staffing levels. They were unable to provide any evidence or explain how they determined the number of staff on duty was sufficient. This meant there were no adequate systems in place to ensure that the staffing levels were safe. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at five staff files and saw that staff recruitment was not always robust. This was because the provider had not verified some of the previous employer references provided in support of a staff application forms. This meant there was no evidence that the references provided were from an appropriate and reliable source. One staff member also did not have a reference on file from their last employer. There was no explanation for this.

We saw that a criminal conviction check was undertaken on staff members prior to employment. We found that where a staff member's criminal conviction check had identified previous criminal convictions, the risks associated with this had not been adequately assessed or considered prior to employment.

These examples demonstrate a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 with regards to staff recruitment.

Inadequate

Is the service effective?

Our findings

At our last inspection in July 2017 we found that the provider had failed to ensure people's legal right to consent was obtained in accordance with the Mental Capacity Act 2005 (MCA). This meant they had breached Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we looked at this again and found insufficient improvements had been made to ensure people's consent was lawfully obtained.

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. We found this legislation was not properly followed.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found this legislation was not properly followed.

One person's care file indicated that they lived with significant cognitive impairment. Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. This meant they required a mental capacity assessment to be undertaken where their capacity to make specific decision about their care was in question. We saw that this person required a thickening agent to be added to their drinks and bed rails on their bed to keep them safe. We found that this person had access to un-thickened drinks and had no bed rails on their bed. We found this concerning and we asked the acting manager about this. They told us it was the person's choice. We asked the acting manager if the person's capacity to make an informed decision with regard to these choices had been assessed in accordance with the MCA. They told us no assessment had been undertaken. This meant there was no evidence that the person had the ability to understand and weigh up the risks associated with these choices in order to make an informed decision. There was also no evidence in the person's care file that advice from other health and social care professional involved in the person's care had been sought to ensure these decisions were in the person's best interests.

We saw that one person with mental health needs had bed rails in place to prevent them from falling out of bed. Bed rails require formal consent for use, as they are considered a form or restraint. There was no evidence that the person's consent had been sought and no evidence that a mental capacity and best interest process had been followed to ensure that the bed rails installed were in the person's best interests.

One person's who lived with mental health needs had a deprivation of liberty safeguard in place that

prevented them from living the home unsupervised by staff. We found no evidence that the MCA had been followed when the application to deprive the person of their liberty was applied for. This meant there was a risk that the deprivation was unlawful.

We spoke with the acting manager about the MCA. They had limited knowledge of what this legislation was and when it needed to be applied in respect of people's decisions about their care.

The examples demonstrate a continued breach of Regulation 11 of the Health and Social Care Act as people's consent had not always been obtained in accordance with the MCA.

People we spoke with told us that the staff were nice and looked after them. People's comments included "They're all good, had not trouble"; "Staff are okay, look after me well"; "The carers look after you well" and "There are some good ones (staff), they try the best they can".

During our visit, we observed the serving of lunch and saw that most people ate their meals in the communal dining room. The dining room was bland in décor and 'school canteen' like. The dining room tables were sparsely set with cups and cutlery but there were no table cloths, napkins or centrepieces in place on any of the tables to make the environment a pleasant one to eat in. The atmosphere in the dining room was muted and there was limited social interaction between people who lived at the home and staff.

The lunch provided was either corned beef hash with beans or sandwiches and soup. The meals were of ample portion size. We saw that one person wanted poached eggs on toast and this was provided. People told us the food was satisfactory. One person said "Food is okay, we get a choice". A second person said "Two good chefs, good food" and another person told us "The food is very good. There is a menu and I get a choice".

We saw that people's nutritional needs were assessed and people had a dietary notification sheet in place to advise staff of the person's dietary requirements. We found that this information did not always correspond with the information on the kitchen noticeboard which catering staff referred to when preparing people's meals. This placed people at risk of receiving a diet that was not suitable for them.

For example, one person was identified on their dietary notification sheet as requiring a diabetic controlled diet. The kitchen noticeboard stated that this diet was tablet controlled. One person was identified as requiring a soft diet, but information on the kitchen's noticeboard made no reference to this. This lack of accurate information placed people at risk of receiving a unsuitable diet.

We looked at how staff were supported in their job role and found the arrangements in place to be inconsistent. We looked at three staff files belonging to staff who had worked for the provider for over 12 months. All of the files we looked at contained evidence that staff members had received supervision (support) from their line manager but there was no evidence that staff members had received an appraisal of their skills and abilities to ensure they performed their job role to an acceptable standard.

We looked at the staff files of two newly employed staff. There was no evidence that either of the two staff members had received an induction into their job role when they started to work at the home. There was also no evidence that the two new staff members had been enrolled onto the Care Certificate. The Care Certificate is a key component of a staff member's induction which an employer must provide legally and in order to meet the fundamental standards set out by the Care Quality Commission.

We were provided with a copy of the provider's training schedule which was designed to list all of the

training undertaken by staff and the date it was completed. The provider offered training in a variety of health and social care topics such as safeguarding, moving and handling, dementia, infection control, fire, food hygiene, diabetes, mental capacity act and first aid but there were significant gaps in all of the training provided. We asked the acting manager about this. They told us that the training matrix was not up to date. This meant it did not provide an accurate picture of what training had been undertaken and when. It was impossible to tell therefore whether staff were sufficiently trained to do their jobs.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to staff training and support.

People's care files identified people's health conditions and any allergies they had that posed a risk to their well-being. People's health conditions and the support they required to keep them well were poorly described. It was unclear what support they were receiving from staff or other health and social care professionals in respect of these needs, as people's care plans had not always been properly updated. This meant it was difficult to tell if people were in receipt of the support they needed to maintain their health.

Most people had an 'emergency transfer' sheet in their care file designed to be used to provide emergency service personnel and hospital staff with the most important information in respect of the person's needs and care in the event of an emergency admission. Most people's emergency transfer sheets were only half completed. This meant that should a person be admitted to hospital unexpectedly this information would not be up to date and critical information would be missing. This placed the person at risk of inappropriate care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because relevant information in respect of people's care would not be available to other health and social care professional when it was most needed.

Inadequate

Is the service caring?

Our findings

At our last visit in July 2017 we identified concerns with the way some people's care was provided as it did not always support their right to dignity and respect. At this inspection, these concerns remained.

At the last inspection, people's personal care charts indicated that people did not receive regular baths or shows and showed that they often went for significant periods of time without having either. This did not demonstrate that people were receiving the care they needed to maintain their dignity or preserve their skin integrity. At this inspection, records showed that no improvements had been made and people continued to go for significant periods of time without having a bath or shower.

For example, two people's personal care charts showed that they had not a bath or shower for seven weeks. Another person's charts showed they had not had a bath or shower for six weeks and two other people's charts showed five weeks. One person told us they got a bath or shower once a week. Another person told us "I went two months without a shower, but had one last week". They went onto say "After the shower, they only dried me with a towel, did not use talcum powder or E45. I could have told them (the staff member) but they should not have to be told". This did not demonstrate that people's personal hygiene was being cared for appropriately or in accordance with people's needs or wishes.

At our last inspection, we observed that people were taken down to have their hair done by the hairdresser and lined up in a row to wait. We also saw that when people's hair was finished, people were left in communal corridors in their wheelchairs for staff to collect. This practice was not very dignified. At this inspection, we saw that the amount of people queuing to have their hair done was reduced so that only one or two people were waiting at any one time. This was an improvement. We observed that when the hairdresser had finished, instead of leaving people in the corridor they now returned them to a communal area where staff were present. This again was an improvement but the way in which people were returned remained undignified.

For example, in the afternoon of second day our visit, the hairdresser brought a person back from having their hair done and left them into the doorway of the dining room. They shouted across the room to a member of staff "Here you go (name of staff member). They did not speak to the person or offer any goodbyes to them before they left them in the doorway. This was not very respectful.

At our last inspection two people's en-suite bathrooms did not have any blinds or window coverings in place to protect their dignity when they used the bathroom. At this inspection, we checked people's en-suite bathrooms again and people now had blinds or window covering in place.

We saw that people's care files were no longer stored in an unlocked cupboard in communal areas which were accessible to unauthorised persons. This meant that action had been taken following our last inspection to ensure people's confidential information was kept securely.

On viewing one person's care file we found that an inappropriate photograph had been taken of the person with no evidence of their consent. This photograph was of a sensitive private nature. Despite this, it had been stored in the person's care file which all staff had access to. This was not appropriate. We asked the acting manager about this, they told us that they had taken the photograph on the request of the district nurse team. They were unable to provide evidence of this request or remember the district nurse who had asked for this photograph. The acting manager acknowledged that the photograph should not have been stored in the person's care file. This meant the person's right to privacy and dignity was compromised. We asked the acting manager to remove the photograph from the care file. They did this immediately.

During our visit, we observed that staff had little time to talk to people in any meaningful way as they were too busy supporting people with their personal care needs. At times, staff did not recognise when people were tired or unable to mobilise without the aid of a wheelchair. For example, we observed two instances where two staff members supported people to walk to the dining room by holding their arms or hands as opposed to using the person's mobility aid or wheelchair to support their mobility. We observed that a chair had to be obtained for one person who needed to sit down on their way to the dining room as they were too tired to go any further. This did not demonstrate that staff were attentive to people's well-being.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to dignity and respect.

At our last visit to the home in July 2017, people we spoke with told us the staff team were kind and caring. At this inspection most people's feedback was the same. Comments included "Staff are very kind"; "Staff look after me well, have a good banter" and "Nurses (care staff) are okay, nothing to complain about".

Staff we spoke with were able to tell us about people's needs and the support they required. People we spoke with felt they were well looked after.

Inadequate

Is the service responsive?

Our findings

At our last visit in July 2017, people's care was not always centred on their individual needs and wishes. At this inspection, we found the same. This meant there was a continued breach of Regulation 9 of the Health and Social Care Act as the provider had failed to take appropriate action to address this.

We viewed the care files of six people. We saw that some people had person centred profiles in their care file. These person centred profiles provided staff with information on the person's background, their family members, interests and hobbies and the things that were important to them in their day to day life. This type of information helped staff to understand and build relationships with the people they cared for.

We saw that there was some person centred information in people's care plans about their needs and care but this information was limited. Where people's individual needs, preferences or interests had been stated, we found the design and delivery of care had not always reflected or achieved them. For example, one person's care file indicated they liked to have a bath or shower two to three times a week. When we looked at their person care charts however we saw that for a six week period between December 2017 and February 2018, no baths or showers had been given. The person had only received a 'strip wash'. Another person's activity care plan stated they liked sing-a-longs, films and quizzes. Yet no activities of this nature were available at the home for the person to participate in.

Some aspects of care planning was satisfactory for example, one person's night time routine was clearly set out and included the person's night time preferences but other care plans lacked sufficient or accurate detail about what people's needs were and they care they required. This meant staff lacked adequate information on how to provide care that was person centred.

For example, one person had an allergy to a specific medication but there was no information on what type of allergic reaction they may have or the action to taken. When we checked the person's district nurse file, we saw that the person had a severe, life threatening reaction to this medication. Despite this, the level of risk had not been documented and staff had no guidance on what to do in the event this medication was inadvertently given.

One person's visit records relating to other health and social care professionals indicated that they had wounds that required dressing by the district nurse team. There was no mention of this in the person's care file. Staff had no information on the cause of these wounds. There was no description of the wounds, no body maps in place to identify their location and staff had no guidance on whether they needed to provide any support to the person with regards to these wounds in between district nurse visits.

One person's care file contained confusing information about the person's eye care. Visit records relating to other health and social care professionals indicated that two sets of eye drops were in use by the person. The person's medication administration charts indicated that three sets of eye drops were in use. When we

checked the person's care file, there was no mention of any eye drops being in use and why they were needed. We asked two staff members and the acting manager about the person's eye drops, none of whom were able to explain which eye drops were in use or why.

People's end of life care plans required improvement. Some people's end of life care plans were generic and did not document people's wishes or preferences with regard to how they would like to be cared for. This meant that people could not be assured they would receive end of life care in line with their wishes. This was noted at our last inspection. At the last inspection, we found that staff had not received training on how to support people who were at the end of their life. At this inspection, records showed that staff had still not received training in end of life care. This meant there was a risk that staff may not know how to support people appropriately at this time.

We saw that people's needs were reviewed regularly but information about the person's progress remained limited. It was difficult therefore if any changes in the person's needs and care had occurred since the last review that staff needed to be aware of.

At our last inspection in July 2017, the activities co-ordinator had left the employment of the provider and no activities were being provided. People expressed concerns about this. At this visit, there was still no activities co-ordinator in post and people had no access to any activities or social interests other than watching TV. People we spoke with raised concerns about this. Their comments included "It's always quiet. No activities that what they don't do"; We need entertainment. Management are looking into it"; "No activities, the person who did activities left" and "The place is very quiet".

We asked the acting manager about why no activities were provided to occupy and interest people. They told us they had difficulty recruiting to the activities co-ordinator post.

These incidences were a continued breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the planning, design and delivery of people's care was not person centred.

On reviewing people's care records we saw that people had access to routine healthcare. For example GP's, dentist, opticians and chiropody. Where people needed specialist support we saw that this had been organised for example district nurses, tissue viability services, speech and language therapy, dieticians and special mental health teams. Information in respect of these visits or appointments was difficult to understand and often had not been considered in the monthly review of the person's care or included in their care plan.

The provider had a complaints policy in place. We saw that where people or relatives had raised a complaint, these had been responded to adequately.

Inadequate

Is the service well-led?

Our findings

At our last visit in July 2017, there was no registered manager in post. There was still no registered manager in post at this inspection. This meant there had been no registered manager for a number of years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider's failure to ensure a registered manager was in post meant that the provider's conditions of registration with CQC were breached.

The acting manager in post at our last inspection was still in post at this inspection. The acting manager was supported by a consultant contracted by the provider to help improve the service. Despite this we found that no sufficient improvements had been made.

During our inspection of the service in November and December 2016, July 2017 and this inspection, we identified the service did not have effective governance arrangements in place to ensure the service was well-led. This was a continued and persistent breach of Regulation 17 of the Health and Social Care Act.

At this inspection concerns were identified again with the accuracy and completeness of people's care records. This was because some of the information about people's needs and risks was confusing and difficult to follow. People's care plans did not cover all of their needs and risks and staff lacked adequate guidance on how to care for people safely or in the way they preferred. The provider's care plan audits had not addressed this. This meant there was a risk that people would not receive the care and support they needed.

There were still no adequate systems in place to identify and respond to incidents of a safeguarding nature. Records showed that the governance arrangements in place failed to be effective in ensuring safeguarding incidents were properly managed to mitigate the risk of abuse. This meant the way in which the provider protected people from potential harm continued to be ineffective and poorly led.

The governance system in place to ensure medication was administered as prescribed required improvement. We saw that there were medication audits in place for tablet or liquid based medication. These were effective but we found this audit did not include a check of the administration of topical ointments, creams and gels or the administration of thickening agents. This meant that the checks in place had not picked up that staff lacked sufficient guidance on when and how to administer this medication or that people's medication records showed that these prescribed creams continued to be applied inconsistently. It has also not identified that there were no record keeping systems in place for the administration of thickening agents.

The governance arrangements in place to ensure the premises and its equipment were safe and suitable

remained ineffective. This was because areas of the home remained in need of repair. The fire safety provision home required improvement. There were no monitoring systems in place to mitigate the risk of Legionella infection and there was no evidence that the home's moving and handling equipment had been inspected and certified as safe. Risk assessments in respect of fire safety and Legionella management had also not been reviewed appropriately. The provider's health and safety checks had not identified or addressed this.

There were no effective checks to ensure the recruitment and ongoing employment of staff was robust. There was also no management system in place to monitor the supervision and appraisal of staff. For example, there was no system in place to record which staff members had received supervision and appraisal at any given time. This meant it was impossible for the acting manager or provider to know which staff members had received adequate support in their job role. The provider's training schedule was also out of date.

We spoke with the acting manager at the end of our inspection. We explained that we still had serious and significant concerns about the service and people's care. During these discussions, it became evident that the acting manager had limited knowledge of the way people's care was delivered and the gravity of the concerns we had about people's health and well-being. When we asked the acting manager to tell us of any improvements they felt they had made to the home since our last inspection they responded with "I will not dignify that with an answer".

These examples clearly demonstrate that the service was not well led. The provider had not done all that was reasonably practicable to improve the service so that risks to people's health, safety and welfare were minimised.