Long Meadow (Ripon) Limited

Long Meadow 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

This inspection took place on 25 July and 7 and 20 August 2018 and was unannounced. At the last inspection in October 2017 we rated the service as requires improvement with breaches of regulations 12, 17 and 18 in relation to safe care and treatment, good governance and staffing.

At this inspection we found the three breaches of regulation were still not being complied with and a further six breaches of regulations were identified. These were Regulations 9, 10, 11, 13, 15 and 19 in relation to person-centred care, privacy and dignity, consent to care and treatment, safeguarding, environment and fit and proper persons employed.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led? to at least good. During this inspection we found the provider had made some improvements to the environment such as the purchase of new carpets and chairs, but there had been insufficient progress to improve the quality of care and risk management within the service. This left people at risk of harm.

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

The service accommodates up to 35 people over the age of 18, including people living with dementia, in one adapted building. On the first day of inspection we were informed that 33 people used the service. People live in single rooms on two floors. The service is provided in an old building which has been adapted over the years to provide a care provision. There is a small new build wing on the right of the building.

The provider is required to have a registered manager at the service, but at the time of our inspection the position had been vacant since August 2017. 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. There was an acting manager in place who assisted us during our inspection. We have referred to the acting manager as 'the manager' throughout this report.

The environment of the service was not clean and did not maintain standards of hygiene appropriate for the purpose for which they were being used. People were living in bedrooms that had unpleasant odours and dirty equipment such as overlay mattresses and commodes. People were not being supported to wash or bathe on a regular basis which meant their skin integrity was put at risk and they appeared unkempt.

Insufficient numbers of staff had impacted on all aspects of the service. The system used to determine the

number of staff needed to meet people's needs and deploy staff around the service was not effective. People were left isolated in their bedrooms and their calls for assistance went unanswered or there were delays in them receiving the support they needed.

The recording, administration and return of medicines was not managed appropriately in the service. People did not always receive their medicines as prescribed by their GP.

People were living in an environment that did not promote their wellbeing. There were some areas of the service that had unpleasant odours and the temperatures of bedrooms were extremely hot and people were visibly affected by this. There was no monitoring of the temperatures at the start of the inspection, but action was taken by the provider to put fans into bedrooms to reduce the heat.

The manager failed to notify CQC about safeguarding incidents and falls that resulted in people receiving injuries. Further action on this will be taken outside of this report.

We found that the recruitment process for staff was not consistently carried out in line with the provider's policy and procedure. Documentation of employment checks and references was not carried out to a high standard so we could not be assured that people were protected from the risk of harm/unsuitable workers.

The induction, supervision and training programme for staff was not robust and did not adequately enable them to carry out the duties they were employed to perform. The provider and manager did not monitor this which meant people were at risk of being cared for by staff who lacked the knowledge, competency and skills to meet their needs.

People's weight and nutritional needs were not being monitored by staff. Records of food and fluids were not consistently documented and people were not being weighed in accordance with their care plans. This put people at risk of weight loss and malnutrition.

The manager was unable to demonstrate they had a good understanding of the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The legal requirements of the Mental Capacity Act (2005) had not been followed.

Care files were not completed in a consistent manner. Care plans were not up to date and documentation was not fully completed. This meant staff did not have appropriate records to show how they were meeting people's needs.

People's privacy and dignity was not promoted through staff practice. The care and support delivered to people was insufficient to meet their needs. We found people were left without appropriate personal hygiene care, which resulted in them being dirty and unkempt. People felt able to raise complaints with the service and the manager did look into these. However, any action taken was not effective as there remained poor care practices within the service.

Activities were taking place in the service, but these did not meet everyone's needs. People who remained in their bedrooms received little or no social stimulation through one-to-one interventions.

The lack of effective leadership, oversight and management within the service meant the quality assurance and monitoring processes were not used to drive improvement. The assessment, monitoring and mitigation of risk towards people who used the service was not carried out effectively. This included areas such as accidents/incidents, medicine management, hydration, bowel care, falls, pressure care and infection control

practices. This meant people's health and safety was put at risk.

We found a breach of Regulations 9, 10, 11, 12, 13, 15, 17, 18 and 19 during this inspection in relation to person-centred care, privacy and dignity, consent to care, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing and fit and proper persons employed. You can see what action we told the provider to take at the back of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 is not safe.

Staff recruitment processes were poor and not enough staff were employed, which impacted on all aspects of the service.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

The assessment, monitoring and mitigation of risk to people who used the service was not robust.

Infection control practices were not robust and this increased the risk of infection or cross infection.

Is the service effective?

Inadequate

The service is not effective.

Staff employed by the service did not have the skills, knowledge and abilities to deliver care in line with people's needs.

Competency checks of staff performance were not being completed and meetings with staff to discuss their work performance (supervisions and appraisals) were not taking place.

There was a lack of effective communication between the care staff and management team.

Decisions made on people's behalf were not made in a best interests forum as required and the principles of the Mental Capacity Act 2005 were not being followed.

Is the service caring?

Inadequate

The service is not caring.

People were not always treated with respect and dignity by staff. Care and support was rushed or delivered late, leaving people in an undignified state.

The care and treatment of people was not person-centred and did not meet their needs. Care staff were kind and patient with people, but lacked the time to give people the attention and support they needed.

Is the service responsive?

Inadequate

The service is not responsive.

People's care plans did not always clearly describe their needs and were not up to date. People's basic care needs were not being met and this was impacting on their health and wellbeing.

People were not always able to make choices and decisions about aspects of their lives. Staff encouraged people to join in with social activities, but the events on offer did not meet everyone's needs.

People were able to make suggestions and raise concerns or complaints about the service they received. The continued poor staff practices and lack of care indicated these were not always being addressed appropriately.

Is the service well-led?

Inadequate

The service is not well-led.

There were significant shortfalls in the way the service was led and multiple breaches of the regulations were found.

Delivery of good or high-quality care was not assured as there was a lack of governance and oversight of the service and little evidence of appropriate action being taken to make improvements.

There was no registered manager, which is a condition of the provider's registration.

Long Meadow 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 25 July, 7 and 20 August 2018 and was unannounced on day one. The inspection team on the first day consisted of an inspection manager, an inspector, an assistant inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had knowledge of older people and people living with dementia. The inspection team on the second and third day consisted of an inspection manager and an inspector.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams for their views of the service. They raised some concerns about low staffing levels in the service and a lack of engagement from the provider's management team with NYCC's quality monitoring team. We asked the provider to send us a provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used the information we held to help plan the inspection.

At this inspection we spoke with the provider, manager, business manager and eight staff. We spoke with 12 people who used the service and nine visitors over the three days of inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records, including their initial assessments, care plans and risk assessments. We checked medication administration records (MARs) for everyone who used the service and looked at a selection of documentation relating to the management and running of the service. This included quality

assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

We gave feedback to the provider, manager and business manager during and at the end of the inspection.

Inadequate

Is the service safe?

Our findings

At the last inspection we found there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to risk management and infection prevention and control. The provider gave us an action plan detailing how they would meet the requirements of this regulation.

At this inspection we found insufficient action had been taken to meet the requirements of the regulation. During the inspection we raised concerns around unpleasant odours in the service and dirty equipment in use. There remained issues with a lack of risk management with regard to falls, medicine administration and care practices. In addition, during this inspection we found issues in relation to medicine administration and management.

There were ineffective cleaning and infection prevention and control practices within the service. Walking around the service there were unpleasant odours in some areas, including the entrance hall, small lounge and six of the bedrooms we looked at. We noted that the provider had replaced the flooring in two rooms since our inspection in October 2017, but both rooms still had strong malodours in them. Further checks of the rooms showed that staff had left a full commode in one room and the other had a dirty, stained mattress on the bed. This meant people were living in an unpleasant and odorous environment.

People were left at risk of infection due to a lack of cleanliness and care. There were cleaning staff on duty each day, but we found evidence of stained commodes, pressure cushions, carpets and chairs throughout the service. For example, we noted unpleasant odours in the small lounge; when we went to check one chair we found the pressure cushion in it was sat in a pool of foul liquid. Discussion with the provider indicated that chairs were not cleaned by night staff and the domestic staff found it difficult to clean them during the day as people were sat in them. There were basic 'tick box' sheets of cleaning records kept by the domestic staff. However, we found no records of bed changes to indicate how often linen was sent for washing.

People did not always receive the care and treatment they required which left them at risk of neglect. The management team had admitted people into the service who had mental health needs as well as living with dementia or needing residential care. We found staff were unable to meet people's mental health needs, which had an impact on their wellbeing and that of others living in the service. A visiting GP brought the situation of one person to our attention. We found the person laying in their bed in dirty linen, with a foul odour within the room and no evidence in their care records to show when they last received personal care. This was brought immediately to the attention of the provider and manager who took action to refer the person to the community mental health team and assist them with personal care. The provider told us they realised that they could not meet the needs of some people and that they were being reassessed for alternative placements.

Accidents and incidents were being recorded by the staff and the manager, but there was a lack of action by the manager to report these to CQC or the necessary authorities when needed. When we brought this to their attention they assured us this would be done retrospectively.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. For example, the temperature of the medicine room was at, or exceeded, 25 degrees centigrade on four out of seven occasions in the week leading up to our inspection. This meant medicines being stored in the area may not have been fit for use due to the heat in the room.

We reviewed the Medicine Administration Records (MARs) and found staff did not always complete them correctly to reflect the treatment people had received. For example, we found two people had gaps in their MARs where staff had failed to sign or enter an appropriate administration code. Four people were not being administered their bowel medicines even though they were known to be at risk of constipation. A visiting GP told us that they were called out to attend to one person's bowel problems and our checks of the MARs showed the person had not received their bowel medicine in the weeks leading up to the visit or after.

One person had not received their medicine for dementia treatment on five occasions between 27 July 2018 and 6 August 2018. Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs were completed on a paper format by care staff to record the application of these medicines. We checked records for two people and found that in both cases staff had not applied the creams as they had been prescribed. This showed people were not receiving their medicines as prescribed and for at least one person this had impacted on their health and wellbeing.

The evidence above showed the provider had not ensured the risks to people's health and safety were being assessed appropriately, monitored and actions taken to reduce any risks identified.

There was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to low staffing levels and the ineffective deployment of staff. The provider gave us an action plan detailing how they would meet the requirements of the regulation.

At this inspection we saw we found that insufficient action had been taken to meet the requirements of the regulation. We saw people did not have their care needs met which had a detrimental impact on their health and wellbeing.

At the time of our inspection there were 33 people who used the service. Staffing levels were five care staff working during the day time and three care staff at night. We spoke with staff who told us, "There is no organisation or structure to our shifts, in the afternoon we just answer call bells. We come on in a morning and get told 'you two go and do doubles' (referring to a person who needs two care staff for personal care) one person helps out with breakfasts, the senior does medicines and one staff does singles" and "Night staff give the handover to the senior care staff. They just say 'settled night' and such, so no real information on how people are. If you have been off duty you really don't know what is going on."

We observed people were left in their bedrooms and calling out for assistance. For example, on the second day of inspection at 11.05am one person told us they were still waiting for staff to get them up. At 11.20am staff brought another person a warm drink and put it on their bedside table but did not tell them it was there. At 11.45am when we went back it was there untouched and cold. Between 11.30am and 12 midday on the first floor we saw multiple people ringing for attention and/or calling for staff. Some were crying out asking for the toilet. One person said, "Help me to get washed and dressed."

We went downstairs to the manager's office where the provider and manager were sat together and asked the manager if they would go and give hands on assistance to people calling for help on the first floor. We advised the provider that the service was insufficiently staffed and people's needs were not being met. They replied "What today – there are five on?" and started looking at the rota. We asked a number of times during the inspection for a copy of the dependency tool used to determine staffing numbers, but this was not given to us until the last day of inspection. The tool indicated that the number of care hours, determined by the information put into the tool by the provider, should be met by the five staff on duty. However, our observations during the inspection showed that this was not the case. There was a lack of oversight and monitoring of the staff hours, which if completed would have shown the provider that the numbers of staff on duty were not meeting people's needs.

This evidence shows there was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that when they raised safeguarding concerns with the manager, appropriate action was not being taken to improve things. We looked at information in the accident and incident records and checked this against the safeguarding file. We found evidence that the manager was not reporting appropriately to CQC or to NYCC safeguarding team. For example, we became aware that two people, who had a DoLS in place restricting them from leaving the service alone, had left the building without staff being aware. They had been eventually found and brought back unharmed. However, the appropriate notifications to CQC and NYCC safeguarding team had not been completed. We also found that there were two known instances of people not receiving their medicines for three or more days due to poor staff practice, these had not been submitted as a safeguarding alert. On looking at the complaints file we found written evidence of whistle blowing about alleged verbal abuse of a person who used the service. The manager had not referred this to the safeguarding team at NYCC. The manager did not provide an answer when we asked why these notifications were not made and we asked them to make retrospective alerts, which they subsequently did.

This evidence shows there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for three staff members and found some gaps and inconsistencies in the documentation within the files. For example, the records for one member of staff showed they had applied for a position in the kitchen and their previous work experience all related to them working in catering. On their application form there was a gap from education completion to work experience from 1985 to 2011, which had not been explored during their interview process. The member of staff had supplied reference details for a previous employer but these references were not taken up by the manager, instead two references were on file from a previous work colleague and friends. Neither of which corresponded to the names given as referees on the application form. The references were not sent on headed notepaper or with any evidence that they had been sent from a business or organisation.

One member of staff was working as a care worker and when we asked why, they told us the job in the kitchen had gone and so they were asked to work on the care side. There was nothing in the file to suggest that any further interviews or discussion had taken place regarding their experience and skills for care work. We asked the provider how they validated staff references and they said they personally did not have any input to recruitment. The provider said decision making around suitable candidates did take place but was not always well documented.

This evidence shows that robust recruitment procedures were not being followed, which put people at potential risk of harm.

This shows there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at documents relating to the servicing of equipment used in the home. These showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required.

Inadequate

Is the service effective?

Our findings

At the last inspection we found there was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to staff induction, training and supervision. The provider gave us an action plan detailing how they would meet the requirements of the regulation.

At this inspection we found that insufficient action had been taken to meet the requirements of the regulation. There was poor documentation of staff induction records, staff supervisions were brief and ineffective, and there was a lack of management oversight and monitoring of staff training and knowledge.

We looked at five staff files and found that the quality of the induction records was poor with little or no records kept. For example, one staff member's induction record had nothing recorded about the actual role they were employed to do and was signed by the member of staff but not by the inductor. The form did not show the date when sections of the induction had been completed by the member of staff or when they were assessed as competent.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. The records of staff supervision we saw were brief and ineffective as they did not address poor staff practice. The provider told us, "I think it is right that senior staff supervise the other care staff, but there is a lack of a team approach." The provider was unable to tell us what training senior staff had received to carry out this role and it was not clear which member of senior staff was mentor to the rest of the care staff. The manager told us that staff appraisals were overdue.

The staff training programme relied heavily on staff watching training DVDs and completing test papers on each subject. During our interviews staff informed us they lacked the time to look at the DVDs and although they might take them home they did not actually watch them. Staff also told us that other staff assisted them to fill in the test sheets in order to pass and get their training certificate. The manager informed us that there was a test paper at the end of the training when staff returned the DVD and this was done on site, but no one observed this being completed. The manager told us there were a lot of test papers that needed redoing due to poor scores and when we enquired further they said they thought staff were not looking at the DVD's but no action had been taken about this. We found that no competency checks of staff practice were being carried out apart from medicines.

Staff had not received training on end of life care or specific health conditions such as diabetes or Parkinson's disease, but were caring for people with these needs. This meant staff may have lacked the training or skills to deliver effective care. Checks of the staff training records indicated that six members of night staff had not completed first aid training or fire safety training. We asked the manager on day three of our inspection what action had been taken to ensure night staff were adequately trained but they were unable to answer this question.

People told us, "If you want something they will get it for you" and one visitor said, "Staff are around and helpful. I have seen them being supportive when my relative needs it. If my relative needs help staff come."

We found through talking with staff and observing care practices that there was an obvious desire to 'care' for people who used the service and a warmth shown towards people. However, the staff displayed a lack of adequate knowledge regarding the specific needs of people who used the service. For example, one member of care staff was unable to tell us which people required a special diet for diabetes or who had swallowing difficulties.

This evidence shows there was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 to 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 are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was not following the principles of the MCA as two authorised DoLS had expired and the manager had not made subsequent applications for renewal. There was no evidence in the care files that mental capacity assessments or best interests meetings had taken place for people who lacked capacity to consent to their care or make specific decisions. For one person whose care file we looked at, the lack of assessment and monitoring meant they had restrictions placed on their liberty without appropriate authorisation. They did not have a DoLS authorisation in place but were under constant supervision and could not leave the service unaccompanied. When we raised this issue with the manager they took action to submit the appropriate forms for all three people.

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

There had been some minor changes to the environment since our last inspection but the majority of the building remained unaltered. A large lounge to the front of the service had been redecorated and was used by people who lived in the service. Also the staff office, which had been part of the dining room, had been moved to an area in the new 'dementia' suite. The layout and design of the older part of the service presented as a 'maze' of rooms and corridors, with single bedrooms interspersed with bathrooms and toilets. The building was not easy to navigate, particularly for people who may be disorientated due to cognitive impairment, or have poor vision. The first floor had narrow corridors with some 'blind ends'. We mentioned in our last report that this type of layout could lead to people being socially isolated and potentially 'overlooked'. These concerns were validated when we observed at this inspection people left in bed calling out for assistance.

The area to the rear of the property was overgrown and the decking was worn. There was a lack of seating and no-one was using this facility even though the weather was warm and fine. We noted that there were unsafe flags in the inner courtyard, which the provider took action to secure straight away. The upper floor of the service was very hot and a number of people in bedrooms did not have access to a fan and were in distress. No room temperature checks were being done. This was discussed with the management team who arranged for fans to be supplied where needed and for staff to ensure people had access to drinks. By day three of our inspection bedroom temperatures were being monitored by the staff. The heat in the service and the unpleasant odours due to a lack of appropriate cleaning and decontamination of furnishings and equipment meant people were living in an unpleasant environment.

The evidence above shows that there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with three visiting health care professionals who all expressed concerns about care and support in the service. One professional told us, "[Name of service user] has told me they feel isolated in their bedroom. They would like to get out into the garden but find it difficult to use the lift. They were still in bed today when I visited, this was not their choice but due to a lack of staff support." A second health care professional said, "I have recently been in to visit one person who had not had a bath or shower for two weeks. I had to ask the staff to bathe them before I could give them the care they needed." The third professional told us they had raised concerns at care management meetings. They said, "I feel the service is short staffed, staff are good but not there are not enough of them. Staff are well meaning but too busy. I have been to see one person today and I have told the manager to raise a safeguarding about self neglect, I am surprised that staff have not asked me to visit before today. I have seen two other people today who show signs of poor hygiene which is affecting their health." The concerns raised by professionals meant the GP was now coming out to carry out a weekly monitoring visit instead of the usual fortnightly one.

People's care plans and monitoring charts were not being reviewed, updated or completed appropriately by the staff. For example, one person's care plan said they required a high calorie/fortified diet to maintain a healthy weight. They required a monthly weight check as they had a small appetite and needed encouragement to eat. The last time the care plan was reviewed was in February 2018. The last weight record was dated May 2018 and nothing about weight had been documented in the care file since that date. The poor quality of records meant we could not be assured that people had their nutritional needs met appropriately. Hospital passports were in place, but these were not dated and some of the information within them did not reflect people's current needs. This was fed back to the manager who said they would ensure the passports were updated.

The evidence above showed there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At 12.30pm we observed that the lunch time meal experience for people was not well organised and extremely busy. However, staff offered people appropriate support with eating and drinking. We did not hear or see staff asking people what they would like for lunch but we did see a menu on the wall outside the dining room. The food smelt appetising and there were ample portions. People told us, "I can have what I want" and "I eat in my room and they give me a choice for lunch. If I didn't like anything they would ask me what I would like and cook it for me. They do offer me snacks and my juice jug is filled up when I need it to be. They give me a choice of juice" A visitor thought the food was good and told us, "Staff make sure my relative eats properly. Physically my relative is not deteriorating so they are getting what they need." We observed staff cutting up food for people that required help. Spoons were given out to those who wanted them. We observed staff helping one person to eat; staff chatted away to them about the food and asked if they liked it. We only saw two staff serving and helping people and the lunch time period seemed very rushed for the staff. We passed the kitchen area at approximately 2pm and there were puddings on the hatch still waiting to be served. We asked four people if they had enjoyed their food and they all said they had.

We found no evidence that the service used any technology aids to assist people to maintain their independence. We also found no evidence of best practice being used with regard to complex needs such as dementia care.

Inadequate

Is the service caring?

Our findings

Although people who used the service said they felt the staff protected their privacy and dignity we found staff practices were not consistent in promoting this. People were left waiting to get up until late in the morning. For example, one person who we saw brought into the dining room for breakfast at 10.50am told us, "I rang at 8am this morning for them to get me up but they couldn't find two people to assist me." We observed another person was in dirty clothes at 10.30am and when we rechecked at 3pm they had the same clothes on. This person was dependent on staff to support them with personal hygiene care. Walking around the service we noted that several bathrooms and toilets did not have door locks on them for privacy. The provider took action to fit locks to the doors where needed once we spoke with them about this.

The provider had a policy and procedure for promoting equality and diversity within the service, but this was not always being followed in practice. The lack of care for people who could not speak up for themselves due to dementia or those reliant on staff for support meant there was inequality taking place. People were left isolated in their rooms and although staff tried their hardest to see to everyone, people's choices and decisions about their care were not always adhered to. Discussion with the manager indicated there was no system in place to enable people to vote in local elections. There was also no system in place to inform people or promote the fact that people had a right to access their care documents.

This evidence shows there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not receiving the care and support they required to meet their needs. For example, one person was neglecting themselves and staff were struggling to manage their behaviours. We observed the person was living in a bedroom that was extremely unpleasant due to foul odours. Their bedding was dirty and the appearance of their hair and skin indicated they had not washed or bathed for some time. Following GP advice, the manager made a referral to the community mental health team and the local authority safeguarding team. On the last day of our inspection we saw that the person had agreed to bathe and have their hair washed and cut. They had moved to another bedroom so staff could clean their original room.

Through observations and speaking with staff and visiting professionals we established that several people were not being supported appropriately by staff with changing their continence products. This left them smelling and sore. One person told us, "I can't be independent, I do wash myself but I rely on staff to support me."

We saw people were left in bed with lank hair that needed washing and the bathing records we looked at indicated that they had not received a bath or shower for several weeks. For example, one person whose care we looked at had a bed bath on 21 June 2018 and the next entry was on 28 July 2018 when they had a bath. We spoke with the staff on duty and between them they were able to identify that they had completed five baths in the last week, but could not recall if or when other people may have been attended to. Staff told us, "We get frustrated because we want to give good care but do not have the time", "Jobs don't get done

because no-one tells us what to do. Care staff have to make decisions and the lack of communication makes it difficult" and "This is like a 'free-for-all'. [Name of person] could do with a bath as their hair is greasy, but there are no plans to do this today." We discussed the poor bath and shower records and people being left in bed without the option of getting up with the management team. The manager told us, "One person is frightened of water and doesn't want a bath; a lot of people don't want baths or showers." We explained to them that this needed to be risk assessed on an individual basis and recorded in their care file as the lack of care was impacting on people's health.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some very kind and caring interactions between staff and people who used the service. For example, we saw staff help one person to move positions. Staff helped them move from their wheel chair into a dining chair encouraging them to be independent by helping them stand and then another staff gave the person a walking frame so they could steady themselves before moving the wheel chair away and offering a dining chair. The person sat down safely. Staff explained every move and only proceeded when the person agreed. We also saw and heard staff knocking on people's door and asking if it was alright for them to enter. We observed staff talking quietly and kindly towards people at all times.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the manager. An advocate is an independent person who supports someone so that their views are heard and their rights are upheld.

Staff we spoke with were aware of the need for documentation to be kept confidential and safe. We saw that care files were locked away in the staff office in the dementia suite. We asked people and visitors if they knew about or were involved in the care plans for themselves or their relatives. One person told us, "I am always consulted. If I wasn't happy the staff would listen and it would get sorted." A visitor said, "We sit together with my relative. The staff ask them, but I am there to support them. Social services come in and we discuss it together."

Inadequate

Is the service responsive?

Our findings

At the last inspection we found there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to poorly documented care files and record keeping. The provider gave us an action plan detailing how they would meet the requirements of the regulation.

At this inspection we found that insufficient action had been taken to meet the requirements of this regulation. We found that people's care plans and other care documents did not always clearly describe their needs or record the care being given.

We looked at five people's care files and associated care documents during the inspection. The records showed there were gaps and information missing about the care being given, which left people at risk of not receiving appropriate care to meet their needs.

The community nurse was visiting one person to assist them with continence care. The nurse told us they had asked staff to keep bowel monitoring charts for this person who was at risk of constipation, but no charts had been completed. We checked another person's care file and their continence care plan said to monitor their bowel movements. There were no charts kept by the staff and they were unable to tell us how they monitored this person's continence. Staff told us, "We don't have time to complete the charts. We have told management about this, but nothing has changed."

One person had recently undergone eye surgery in July 2018, but there was nothing about this in their physical health care plan only a note in their appointment records. This person's file also lacked reviews of their care plans such as their risk of absconding, even though the accident records showed they had left the service in the last month without staff knowing about this. They returned to the home unharmed. Their nutrition care plan said that staff would weigh them monthly but the last recorded weight was done in February 2018. The care file was last reviewed in June 2018 so had not been reassessed following the person's surgery.

Another person was receiving treatment from the district nurse for a skin tear to their leg, which was sustained in July 2018. Although we recognise that the district nurse recorded their treatment on a different system to that used by the service, there was no care plan to inform staff about the wound or the visits from the district nurse. No body map was completed by staff to show the position of the skin tear. The care file had last been reviewed and updated in April 2018 indicating that staff were not reviewing people's care needs even after an accident/injury.

This evidence showed that care staff did not have clear written guidance in respect of these people's needs. This left people at risk of harm.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans recorded when people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) in place. We saw that basic information on end of life care such as funeral arrangements and who to contact about these details were documented in people's files. One person who was receiving end of life care said they were very comfortable in their bed and staff were, "kindness itself" to them. Their relative also spoke highly of the care and attention given to their loved one.

At our last inspection we spoke with the management team about the need to develop accessible information for people who used the service. There were people who had visual and hearing impairments as well as those who had cognitive conditions. The information available to people was presented in small print, which would be difficult for some people to read and understand. At this inspection there was no evidence of accessible information in the service. We asked the provider about this and they said they had no idea about this and would look into developing this.

At our last inspection we reported that activities were low-key and left some people dissatisfied as they felt there was little for them to join in with. People cared for in their bedrooms did not receive one-to-one input and felt isolated and alone. Our checks at this inspection found there had been a lack of action taken to improve activities within the service. One development that had taken place was the introduction of a list of activities for July 2018 on the notice board. These included, for example, dominos, quizzes, play your cards right, music around the piano and a visit from an outside entertainer.

The activity worker was on duty from 1pm-5pm Monday to Friday. At weekends staff were on the activity schedule to carry out activities but they told us these did not take place as they lacked the time to do these. The activity worker told us, "I don't do one-to-one with people in bedrooms, I just record that they are watching television."

People told us, "Sometimes people come and sing. There is bingo which I am not keen on. I like to read and be on my own I like my alone time" and "You get a good laugh; I get involved now and again." However, we spoke to two gentlemen who lived at the service who told us they did not get involved in the activities as they were not interested in the events that were on offer. They both said, "It's what women are interested in I don't like bingo."

This evidence showed there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors and people living in the service confirmed that they were able to take part in church services in the home and individual arrangements could be made for visits from different clergy on request. One visitor told us, "I collect my relative on a Sunday to go to church then take them to my home for Sunday lunch. I bring them back around 3pm."

Despite the number of issues we have raised in this report several people who spoke with us were happy with the service. They told us they felt if they had a problem they would be listened to and most knew who to go to if they had a complaint. One visitor told us, "I would say something straight away to staff if I saw something I didn't like" and one person said, "You only have to say something to staff and it would be looked into." However, we received three complaints about poor care and support from people and families before and during our inspection. We used the information given to us to plan our inspection and have documented our findings in each section of the report.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to good governance. The provider gave us an action plan detailing how they would meet the requirements of the regulation.

At this inspection we found that insufficient action had been taken to meet the requirements of the regulation. There remained no registered manager in post and there was a lack of oversight and monitoring of the service with regard to risk, daily care, hygiene and staffing levels. We found evidence of poor communication between management and staff and between staff and people. This was impacting on people's health and wellbeing. Poor staff induction, training and supervision meant staff were not being supported, especially new staff. There was also a lack of structure and guidance for staff to follow.

The service had been without a registered manager since August 2017. There was a manager in post but they withdrew their application to register with CQC in July 2018. The provider told us they were recruiting a new manager who would start in post as soon as possible.

There was a dependency tool used to determine the number of staff and the range of skills required in order to meet people needs and keep them safe at all times. However, we found this had not been effective in ensuring people received appropriate care. We found people had to wait for attention from staff and some individuals did not receive appropriate support as staff struggled to meet everyone's care needs.

Staff training was not up to date and staff lacked the knowledge and skills to recognise risks to people's health and safety. We found that staff did not receive a robust induction when they commenced employment and the quality of supervision was poor. This meant we could not be certain that staff had the appropriate training and skills to meet people's needs. This had not been identified and acted upon by the manager or provider.

The quality of record keeping was inadequate with a lack of up to date care plans to guide staff in delivering effective support and care to people who used the service. Monitoring charts for baths and bowel movements were not well recorded and people did not receive the support and care they required to keep them clean, safe and well looked after. This was impacting on people's health and wellbeing.

People and relatives were aware of meetings with the management team, but not everyone wished to attend them. The provider sent questionnaires to people and relatives to seek feedback on the service. These were not dated, but we were told by the manager that they were from 2018. These showed that individuals had raised issues about the service, however we found little evidence to demonstrate that action had been taken to discuss and resolve these. For example, eight questionnaires raised concerns about the temperatures in the service and bedrooms being very high. When we inspected we found bedrooms were hot and lacked fans to cool them down. Room temperatures were not being monitored by the management team.

The provider had a range of robust policies and procedures but these were not being followed by the staff. We discussed this with the provider and spoke about the risk of staff not following these. For example, there was a policy in place instructing staff - not to wear jewellery below the elbow, due to the cross infection risk. We saw evidence of staff wearing wrist watches and rings with stones in. Staff practice needed to be monitored and the provider said that in the future the manager would go through each policy with staff on a regular basis.

During the inspection we found that systems and processes were not established and operated effectively to ensure the service was assessed or monitored for quality and safety in relation to the fundamental standards. This led to breaches of regulation in relation to person-centred care, privacy and dignity, consent to care, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing and fit and proper persons employed. This meant people who used the service were at risk of harm.

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

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had not informed us of significant events in a timely way. When we looked at the accident and incident records we found there were some that should have been reported to us as a notification. We will take action outside of this report to follow this up with the provider.

Work was required to improve the partnership working with other health care professionals involved in the care of people who used the service. The three professionals we spoke with raised concerns about the poor care and support being given to people who used the service. The local authority quality monitoring team told us they felt there was a lack of engagement with their offers of training and assistance to improve the service. These issues were discussed during and at the end of the inspection with the provider and manager when we gave both written and verbal feedback on the outcomes of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. People with distressed behaviours and those dependent on staff to get them up in a morning were left in undignified situations. Regulation 10 (1) (2) (a-c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that people who lacked mental capacity to make an informed decision where treated in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1-5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment as systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1-7)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment in the service was not always kept clean, secure and suitable for the purpose for which they were being used. Regulation 15 (1) (a-e) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively and did not ensure staff were qualified and competent for the work to be performed by them. Regulation 19 (1) (2) (3)