Norens Limited

Homecrest Care Centre

Inspection report

49-55 Falkland Road
Wallasey
Merseyside
CH44 8EW

Tel: 01516397513

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 20, 30 and 31 July 2018. The inspection was unannounced.

Homecrest Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home offers accommodation for people who require support with their personal care. There are 29 single bedrooms with a passenger lift enabling access to bedrooms on the upper floors. Four bedrooms are reserved for people who require emergency admission to the home or respite care.

On the day of our visit, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in January 2018 we identified breaches of Regulations 10, 12, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to dignity and respect, the management of risk, the safe recruitment of staff, staff training and the governance arrangements in place to manage the home. After the January 2018 inspection, the provider submitted an action plan to CQC outlining the action they intended to take to improve the service.

At this inspection we found that the provider had not taken sufficient action to address all of the breaches we had previously identified in accordance with their action plan. We identified continued breaches of Regulation 12 (safe and appropriate care) and Regulation 17 (good governance), and additional breaches of Regulation 9 (person centred care) and Regulation 13 (safeguarding of people from the risk of abuse and improper treatment). The concerns we identified during this inspection were serious and significant and we were concerned about people's immediate welfare.

We reviewed seven care records. Risks associated with people's care were assessed and staff had guidance on how to manage these conditions. Records showed that staff did not always follow the risk management advice in order to protect people from harm. One person's medical needs were not monitored in accordance with risk management guidelines and two people's challenging behaviours were not always supported appropriately. At times this had resulted in staff and the person sustaining physical harm due to the use of unauthorised restraint techniques.

We identified that a number of serious safeguarding incidents had not been appropriately reported, investigated or responded to by the manager or provider in accordance with local safeguarding procedures or CQC requirements. This meant that the manager and provider failed to take appropriate action to protect and prevent the risk of people experiencing abuse or improper treatment.

Some people's bedrooms smelt extremely offensive and it was difficult to comprehend that people still lived in these conditions. Some of the home's communal areas were also malodorous and unpleasant to be in but despite this no action had been taken by the provider to improve people's living conditions. The home's boiler frequently tripped which meant that at times people did not have access to hot water to wash in. On day one of the inspection, there was no hot water in the home when we arrived. Records showed that the temperature at which the home's water was stored was not sufficient enough to control the risk of Legionella bacteria developing in the water supply. This meant that risks to people's physical health and well-being were not mitigated against.

People's medication was stored securely but not always at safe temperatures. This meant there was a risk that some of the medicines were not safe to use. People's medication administration records showed that some people had refused their medication or were not given it because they were sleepy but there was no evidence that they were re-offered it at a later time the same day. This meant the medication was missed. We found that people's 'as and when' required medication was not given in a timely or effective manner in accordance with their 'as and when' required medication plans. This meant that people did not receive the medicines they needed to relieve discomfort or distress.

People got enough to eat and drink but people's opinions on the food and drink provided were mixed. Two people told us the quality of the meals had declined. At lunchtime, people's ability to choose and exercise control over what they ate and drank was not actively promoted and people's meals were served in a disorganised and chaotic environment. It was not conducive to a pleasant dining room experience. Some people were observed to need assistance to access the right cutlery or to eat their meals but staff either did not notice or were too busy to provide the support people needed. Inspectors intervened on two occasions to ask staff to support people.

People's opinions on the number of staff on duty were mixed. A staff member we spoke with felt the home was short staffed at times. When we checked the system the provider used to determine safe staffing levels, we found it was not robust. This was because the system in place failed to take account of people's psychological and emotional needs. During our inspection we observed this was a much needed aspect of people's care that was not adequately provided for. This did not show that the provider had considered all aspects of people's needs and care in the management of the service.

At this inspection we found that standards of care at the home had declined and the quality and safety of people's care placed them at risk of serious harm. This demonstrated the management of the service was inadequate both at provider and manager level.

We found that the provider's governance arrangements had either failed to identify the concerns we found during the inspection or had identified them but little action had been taken to address them. The day to day management of the service was observed to be reactive and complacent with regards to improving the service and people's quality of life. The lack of action and supportive involvement of the provider to make positive changes to the delivery of the service did not demonstrate that they were accountable or responsible for the care people received.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into '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.

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 from 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.

Risks in the delivery of care had been assessed but risk management advice was not always followed to protect people from harm.

Incidents of a safeguarding nature had not been appropriately reported or investigated and unauthorised restraint had been used by staff to manage people's behaviour.

Improvements to the management of medication were required to ensure people received the medicines they needed.

There was no evidence that parts of the premises and its equipment were safe and suitable for use.

Is the service effective?

Requires Improvement

The service was not always effective.

People got enough to eat and drink but the service did not always promote people's choice or control over what they ate at mealtimes. The environment in which people at their meals was chaotic and disorganised.

People's ability to make decisions was assessed in accordance with the Mental Capacity Act.

Staff had completed training and supervision in relation to their job role. Staff appraisals were not up to date.

People had access to a range of health and social care professionals with regards to their well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind when people required support but staff were task, as opposed to person, focused. Some staff members interacted with people in a child-like way which was not very respectful.

Staff had an understanding of 'the person' they cared for but at times staff did not always demonstrate that they were aware of people's right to privacy.

People's bedrooms were personalised with the things that were important to them.

People had access to advocacy services to help them understand their care and the choices available to them. This was good practice.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always met in a person centred way. Support for people's emotional and behavioural needs was not always appropriate or responsive.

People spent the majority of their day with little to occupy and interest them. Some activities were provided but we observed that most people spent the majority of their day with little to occupy and interest them.

People living at the home and the relatives we spoke with had no complaints.

Is the service well-led?

Inadequate

The service was not well led.

Standards of care and the management of the service had declined since our last visit in January 2018.

We found significant shortfalls in people's care and in the management of the service that placed people at serious risk of harm.

There was little evidence that the manager and provider were proactive in managing the service or that they were committed to providing good quality dementia care.

Homecrest Care Centre

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 20, 30 and 31 July 2018. The inspection was unannounced. The inspection was carried out by an adult social care inspector, an assistant inspector and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service. Prior to our visit we looked at any information we had received about the home and used this to plan our inspection.

During the inspection we spoke with four people who lived at the home, four relatives, a care assistant, a senior care assistant, the cook, the manager, the deputy manager, the maintenance officer, the activities co-ordinator and a visiting advocate. We also requested feedback on the delivery of the service from the NHS tissue viability service, the NHS infection control team, social services and community dietetic services.

We looked at the communal areas that people shared in the home and some of their bedrooms. We reviewed a range of documentation including seven care records, medication records, three staff files, policies and procedures, health and safety audits and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service in January 2018, the provider was found to be in continued breach of regulation 12 (safe care and treatment) and regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found that changes in people's needs were not always picked up and responded to in a timely manner which meant people did not always receive the support they needed to keep them safe. New staff employed to work in the home were not recruited safely. At this inspection we found that the provider had made some improvement to staff recruitment but the care people received remained unsafe. At this inspection we had serious concerns about people's safety at the home.

During our visit, we looked at the care plans belonging to seven people who lived at the home. We saw that people's risks in relation to malnutrition, falls, moving and handling, pressure sores and continence were all assessed. There were management plans in place to reduce any potential risks but we found that these plans were not always followed to protect people from harm. This placed people at risk on inappropriate and unsafe care.

One person had a medical condition that meant a clinical check of their well-being need to be undertaken twice a day. We saw that the results of these clinical checks determined what action staff needed to take to keep the person safe. Records showed that staff had not always taken this action when the person's clinical checks determined they must do so. This placed the person at significant risk of physical harm.

On day two of our inspection we found a person slumped in their wheelchair with their head below the table, holding onto the table cloth in the dining room. They had an uneaten bowl of porridge in front of them. We checked the person's care records. We saw that the person was at a high risk of malnutrition. Staff had been advised to ensure the person was fully supported at mealtimes as they were unable to eat and drink independently and were very frail. Despite this, no staff were present in the dining room to support the person to eat and to ensure they were safe. When we checked the person's food and drink chart, the information staff had recorded in respect of the person's breakfast intake was inaccurate and misleading.

Two people whose care records we looked at lived with behaviours that challenged as a result of mental health issues that they had no control of. Records showed that the support they received in response to these behaviours was poor and at times the way in which staff managed these behaviours escalated the person's distress. Some of the interventions used by staff to support people's emotional and behavioural needs had not been agreed with the manager or the provider as an appropriate risk management strategy to use with either person. As a result, staff members using these interventions had been hurt. People in receipt of the support were put at risk through the use of restraint, which at times had not been agreed for them and staff recorded bruising on a resident following the use of restraint.

These examples of people's care demonstrate a significant breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the care people received was not always safe as it did not mitigate risks to their health, safety and welfare.

We checked the arrangements in place for the management of medication. We saw people's medication was stored safely in a locked medication room. Some medication can become ineffective or unsafe to use if stored above 25 degrees centigrade. We saw that staff took the temperature in the medication room daily but found little evidence that appropriate action was taken when temperatures exceeded 25 centigrade. This meant there was a risk that the quality and safety of some of the medicines in use may have been affected.

We found that some people had 'as and when' required medications prescribed for them such as painkillers, medications to reduce agitation and eye drops. Staff had guidance on how and when to administer these medications but records showed that this guidance was not always followed. For example, one person was prescribed 'as and when' required inhaler medication to help relieve episodes of breathlessness. On day one and day two of our inspection, we observed that the person was breathless. On day two of our inspection we spoke with the manager about the person's breathing and asked whether the use of their 'as and when' required medication was needed. The manager agreed and immediately gave the person their inhaler medication. We were concerned that staff had not noticed that this person was breathless. We checked the person's medication administration record to see how often the person had received this medication. We saw that despite the person's inhaler medication being prescribed in May 2018, there were no recorded administrations of this medication prior to our visit. We asked the manager about this. They were unable to explain why the person's records showed that they had not received their 'as and when' required medication at any other time.

We also saw that staff members failed to ensure that people's 'as and when' required medication for agitation was administered in a timely and effective manner in order to reduce the person's emotional distress or to prevent the risk of harm to the person or others. People who were sleepy were always given their medication and some people regularly refused their medication with little evidence that any adequate action had been taken by staff to address this or seek medical advice.

On checking a sample of people's medication administration charts for regular medication, we found that one of the medications we checked did not match what had been administered. We asked the manager about this. They were unable to explain the discrepancy. We saw that people's medication administration records did not record the actual time people's medicines were administered. Handwritten entries on people's medication records were also not always double signed by another member of staff to confirm their accuracy. Poor record keeping with regard to the administration and management of medication increases the risk of medication errors being made.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have robust systems in place to ensure the proper and safe management of all medicines in the home.

Weekly health and safety checks were completed by the maintenance officer but the required safety certificates for the home's electrical installation, emergency lighting and moving and handling equipment were not available during the inspection. Some of the home's electrical equipment had not been tested to ensure they were safe to use. We gave the provider extra time after the inspection to provide these certificates. Following our inspection the provider sent us a copy of maintenance and safety records, including for the testing of portable appliances and lifting equipment. However, we had also requested a certificate that confirmed that the condition of the electrical installation throughout the home was satisfactory. Neither during our inspection, nor in the additional documents the provider sent was this made available.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the premises and its equipment were safe to use.

We looked at three staff files. We found that staff members were recruited following an application and interview process. Improvements had been made to investigate and verify any gaps in the employment history of staff members but we found that the recruitment of staff still required improvement. This was because some of the previous employer references we looked at had been returned to the manager without any evidence they had been completed by a referee with the authority to do so. For example, some references had not been stamped with the previous employer's company stamp or returned on the company's official letter headed paper to indicate the reference was authentic. The criminal record check of a newly employed member of staff had also not been fully completed before they were permitted to work unsupervised in the home.

People we spoke with had mixed views on whether there were enough staff on duty to meet their needs. One person said "Staffing varies but there is not enough at night". Another said "When the staff go for breaks they go in twos which means you are two staff down". A staff member told us "We are often short-staffed. People come and go." During our visit we noted that staff were very busy with practical aspects of people's care and had little time to provide reassurance to people who had become upset or who needed reassurance. This aspect of service delivery required review to ensure that the number of staff on duty was sufficient to meet all aspects of people's physical, social and emotional needs.

We asked four people who lived at the home if they felt safe. Three people said that they did. One person told us "I don't feel safe. People come into my room at night."

We looked at a selection of care records. We found that there were incidents of a safeguarding nature that had not been appropriately identified, investigated or reported to the local authority or CQC. We saw that one person had been subject to physical restraint and following this staff had recorded bruising. Physical restraint is sometimes used to maintain the safety of the person concerned and other people but its use must be necessary and proportionate. The registered manager told us they had not investigated the use of this restraint as a potential safeguarding incident to check whether the use of this restraint was appropriate and lawfully applied. The registered manager had recorded referral to the local authority, but did not inform CQC of this as a potential safeguarding matter, but as a police incident. Staff had also attempted to physically remove items from another person's hands which had resulted in the situation escalating to a physical confrontation. There was no evidence that this incident had been investigated, referred to the local safeguarding team or reported to CQC.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have robust systems and processes in place to protect people from abuse and improper treatment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that the manager had not always ensured that new staff had received appropriate training to do their job role. This meant regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been breached. At this inspection, we saw that sufficient action had been taken to improve the completion of staff training. For example, the majority of the staff team had completed training in the safeguarding of vulnerable adults, moving and handling, dementia awareness, fire safety, infection control, end of life care and food hygiene. Senior staff had also completed training in medication administration.

Further action was needed to ensure that all staff completed the provider's first aid, mental capacity, positive behaviour support and nutrition and hydration training. Some training sessions were noted as 'not applicable' for some staff. The provider told us after the inspection that dysphagia and diabetes training were delivered as mandatory to cooks but not kitchen assistants. The provider told us, "Kitchen assistants work under the direction of the cook and they are not responsible for menu planning or for the food prepared each day. They are also not involved in assisting residents to eat/drink."

We found however that one of the two cooks had not completed this training, neither had eight other out of the 20 staff that had to complete this training as they were involved in assisting residents to eat and/or drink.

One staff member told us "They do a lot of training, a couple times a week but not so much recently. I am still trying to get through my Care Certificate. I did not get to do mine as I had to go on support".

New staff received an appropriate induction into their job role. The induction covered infection control, the rota, code of conduct, confidentiality, emergency situations, certificates, training, and the role of the Care Quality Commission.

Staff members told us they had regular supervision with the manager. The manager's supervision schedule confirmed this. Staff appraisals to assess their competency in their job role were not up to date but were a work in progress.

People we spoke with had mixed views about the support they received. Some thought the support was good, others did not. People's comments included "The girls are lovely, no problems, no complaints they are brilliant"; "I am treated like a child" and "I hate this place I lost everything when I came in here". During our visit we identified concerns with the support people received.

We observed lunch. We saw that people had the choice of eating their meal in the dining room or in the lounge. A handwritten menu was displayed on a blackboard with two meal choices. There was also a set of picture menus available to help people choose what they would like to eat but these were not used in any meaningful way. We did not see people being asked what they would like to eat before their meal was served. We asked the deputy manager about this. They said that staff did not ask people what they wanted to eat beforehand as people often forgot what they had chosen. They said staff chose people's meals based

on what they knew about the person's likes and dislikes. They said that if the person did not like what was served to them, they would then be offered an alternative. This was not good practice as it did not promote the person's choice and control over what they ate and drank. There were no cold drinks offered with the meal or available on the table, but tea was served after the meal. Some people had their food served in bowls all mashed together. This did not look very attractive or pleasant to eat.

The environment plays an important role in how much a person enjoys their meal. It can affect how much the person eats. A relaxed, social atmosphere at mealtimes can have a positive impact on a person's health and well-being. We found that people's mealtime experience was disorganised. The tables in the dining room were not set before people sat down to eat which meant that the tables were set by staff whilst some people sat waiting. Other people were being brought into the dining room by staff at the same time. The push to get everyone seated and the tables set was rushed and chaotic. It was not an experience that promoted good dietary intake.

People's opinions about the food and drinks on offer differed. Two people told us that lately the quality of the food had declined. People's comments included "I had the fish. I enjoyed lunch"; "The food's ok"; "The food was very good but has deteriorated" and "The quantity and quality (of food) has deteriorated".

We saw that people were served drinks and biscuits at set times throughout the day. One person told us "It's always biscuits and they are always the same ones". We asked this person and another person if they ever had cake or chocolate biscuits and they both laughed. We took this to mean they didn't. We saw in people's diet and fluid charts that staff had recorded offering residents things such as chocolate cake, scones, teacakes or cheese sandwiches.

The cook said they had up to date information on people's special dietary requirements and confirmed people's meals were made accordingly. We saw that homemade milkshakes and a fortified diet were provided for people at risk of malnutrition to promote their calorie intake. During our inspection we contacted a community dietician for their feedback on the nutritional support provided to people with weight loss issues. They told us that that the action taken by staff at the home in response to people's weight loss had improved. They said people were now referred to dietetic services appropriately and that people received a fortified diet to prevent further weight loss whilst waiting for a dietetic assessment. This was good practice.

Records showed referrals to other services were made as and when required. For example, people's care records contained evidence that referrals to mental health, falls prevention team, district nurses and specialist medical teams were made when needed. Care plans contained information on people's health and medical conditions and gave staff information on the signs and symptoms to spot in the event of ill health.

We looked at the care files belonging to seven people who lived at the home. The care files we looked at indicated that some people lived with varying degrees of memory loss and confusion. Some people lived with dementia. Where people lived with dementia or short term memory loss, their care plans contained sufficient information about how these conditions impacted on their day to day life and their ability to consent to any care decisions made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We checked whether 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 some elements of good practice with regards to the MCA. For instance, the manager had ensured people's capacity to consent was sought and a best interest decision making process followed when specific decisions about people's care needed to be made. This good practice needed to be further developed to ensure that any decisions made in people's best interests were not made solely by the manager and in isolation from the person and other relevant persons.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we found that people's privacy and dignity were not always respected. This meant that the provider was in breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found that sufficient improvements to meet the requirements of Regulation 10 had been made. Further action was needed to ensure these improvements were consistently applied and sustained by all staff members.

Staff we spoke with had an understanding of the people they cared for and were able to tell us about people's day to day support needs. We observed that staff were very busy during the day completing practical tasks. They did not have time to sit and chat to people in any meaningful way or to provide people with the emotional support and reassurance they sometimes needed.

Staff knew people by their preferred name and interacted with people pleasantly but at times some staff members interacted with people in a child- like or school- like way. This was done with the best intentions but staff needed to be mindful that the people they were caring for were adults and deserved to be treated as such.

We saw that people's bedrooms were personalised with their personal belongings and items that were important to them. On our tour of the home, we saw that one person kept two budgies in their room. Staff told us that the budgies were very important to the person.

During our visit we spoke with staff members about the care people received. One staff member explained how they recognised when a particular person needed to go to the toilet. They told us, "When I am on shift they will just come to me." After this conversation, the staff remember returned and stated, "Guess who just came to me" and walked the person they had just talked about in to meet inspectors. The staff member did not introduce the person and simply indicated to inspectors that the person now needed the toilet. This was not appropriate. It did not show that the staff member was aware that the person may have been uncomfortable with this public disclosure or that they were mindful of their dignity and right to privacy with regards to such matters.

We saw that relatives were able to visit without restriction throughout the day. One relative we spoke with said that "We are given tea and coffee on a tray." whereas another visitor said "I always visit before lunch time sometimes I get I drink and sometimes I don't".

Both relatives said staff were good at keeping in touch about their loved one's progress and well-being. One relative said "We have had a couple of talks to discuss progress and they tell me if they (the person) need any more clothes." The other relative said "They feedback every day" about the person's well-being.

Records showed that people had access to advocacy services to help them make decisions about their care and treatment. Advocacy services help by representing the person's views and ensuring the person's rights are respected during discussions about their care. This was good practice and showed that the service cared

that people's wishes and best interests were promoted.

Inadequate

Is the service responsive?

Our findings

During our visit, we observed multiple instances where people who lived at the home required support and reassurance with regards to their behavioural and psychological needs. We saw that staff were in the main task focused and records showed that people's agitation and distress sometimes escalated without any evidence of appropriate or timely intervention from staff to diffuse or de-escalate the situation. There was also a lack of any meaningful interaction between people and staff and very little to interest or occupy people for the majority of the day.

We observed that most people were encouraged to remain in the communal lounge. People sat for prolonged periods in seats around the room, with the television playing in the background. No-one paid much attention to the television. We noticed that one person, who was unable to mobilise, sat in their moving and handling sling in the same chair all day. When people left the lounge, they were actively encouraged by staff back to the lounge to the same seat they had just left. This gave the impression that most people were 'contained' in one area for most of their day. Some people congregated in the communal corridor by the manager's office or by the front door, anxious to leave the home. Staff had little opportunity to respond to people's anxiety as they were too busy completing practical tasks or completing paperwork in the communal lounge.

There was an activities co-ordinator in post for 20 hours a week, but on the day we visited the activities provided were minimal. For example, on day one of the inspection the activity provided was adult colouring books and a quiz in the afternoon. The activities provided on day one of the inspection did not match the activities listed on the activities board for that day. This would have added to people's confusion with regards to the activities on offer and the days of the week. On days two and three of the inspection, the activities co-ordinator was on annual leave, so no activities were provided at all.

At our last visit to the home in January 2018, records showed that people regularly went on trips out but at this inspection people and their relatives told us that this had stopped. They said they had not had any trips out for some time. There was no evidence of people's hobbies being supported. One person spoke of their love of golf but that they could no longer follow this. One relative said "Not enough entertainment here". The deputy manager told us that they no longer held a budget for activities or trips out and that staff were not paid to support people on trips out. They said this had impacted on the ability of the service to organise for trips out for people who lived at the home. The provider informed us following our inspection that there had never been a designated budget for external trips out and this had always been funded by residents as an extra.

A lack of social and cognitive stimulation can have a negative effect on people's well-being especially for those people who live with dementia who may need extra support to communicate or have a good quality of life. This was concerning as the service mainly catered for people who lived with varying degrees of dementia.

We saw that the residents' meetings took place on a monthly basis. At these meetings the activities

coordinator or manager asked for activity suggestions. At a recent meeting, people had requested a gazebo for the garden as they were finding the garden too hot to sit in during the summer. At the time of our inspection there was no gazebo to indicate that this suggestion had been acted upon, and we did not see any of the people who lived at the home using the garden. This area appeared to be 'off limits' in terms of free access. This did not demonstrate people's needs, wishes or suggestions were responded to.

We observed that some people who lived at the home looked unkempt. The clothes of some people also smelled. We looked at the records maintained in respect of the personal care people received. We found limited evidence that people had access to regular bath or showers. This meant that some people were at risk of neglect with their personal care.

For example, one person had no record of receiving a bath or shower for 19 days during July 2018. Another person had come to live at the home 12 days prior to the inspection but had only received one bath during that period. We asked the deputy manager and manager about this. They told us some people were resistive to receiving assistance with their personal care. People's records did not reflect that people had been offered and refused baths or showers on a frequent basis. We saw that a bath and shower schedule was in place that determined what specific day of the week each person was to be given a bath or shower. The manager told us that people could have a bath or shower outside of this schedule but we did not see any evidence of this. This did not demonstrate a person-centred approach as it did not give people any choice or control over an important aspect of their personal care.

At lunchtime we observed that the support some people received was poor and not person centred. On day one of the inspection we observed one person trying to eat spaghetti bolognaise with their fingers and on day two trying to eat mince and mash with a knife. Staff had not noticed the person struggling and inspectors had to intervene to get the person help to use the cutlery they needed to eat in a dignified way. Some people were trying to eat large pieces of food, such as a piece of garlic bread as one whole piece as this had not been cut up into a manageable size.

Some people's bedrooms smelled extremely offensive and were unbearable to be in. Despite this, people still lived in these rooms. This was especially concerning as at the time of our inspection there were other empty bedrooms in the home which people could have been relocated to in order to ensure they lived in clean, pleasant and comfortable surroundings. During our inspection we spoke with the manager about the smell in these bedrooms. By day two, the manager had responded to our concerns and moved people, with their consent, into other suitable bedrooms. It should not have taken inspectors to point out the unsuitable and unpleasant living conditions some people were living in before action was taken.

The manager told us that the home catered for emergency unplanned admissions. We found that the process for emergency admissions was unsafe. This was because the manager had not always ensured that people's needs were robustly assessed prior to, or on admission to the home. For example, one person had not been properly assessed prior to their admission and shortly after their arrival, this person's mental health and behavioural needs were such that other people and staff were placed at risk of physical and emotional harm. Staff were unable to meet the person's needs and it was clear that this person was an inappropriate admission to the home.

Another person was admitted to the home a few days prior to the CQC inspection. There seemed to be some confusion amongst the staff team as to how long the person's admission was for. There was no evidence that the person's needs had been robustly assessed by the manager prior to their admission which meant that the manager could not be confident that staff were able to meet their individual needs.

These examples indicate that people's care failed to be person centred. People's needs were not always properly assessed prior to or on admission. Some aspects of people's care were institutionalised. People's social and emotional needs were poorly supported and the conditions that some people lived in were detrimental to their quality of life. This meant the provider had breached Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For those people who had lived at the home for some time, we saw that their care files contained information about their person's needs and preferences. There was information about the person's life history which gave staff an understanding of the person they were caring for. Staff spoke warmly about the people they cared for and were able to tell us about people's likes and dislikes. Staff told us that where people struggled to communicate verbally they interpreted their facial expressions and body language to help them understand the person's needs and wishes. People had end of life care plans in place. These plans were limited and required further development.

No formal complaints had been received by the manager in respect of the service since our last inspection in January 2018. We asked people who lived at the home and their relatives if they had every made a complaint. None had. We asked what they would do if they had a complaint. One person told us "I wouldn't tell the staff anything" and another person said "I never complain". The relatives we spoke with said they would discuss any concerns they had with the deputy manager or the manager of the home.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2018, we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance systems in place to ensure the service was well-led were ineffective. At this inspection, the necessary improvements to the management of the home had not been made. Furthermore, at this inspection we found standards of care at the home had declined further. This meant we had significant concerns that people who lived at the home were at serious risk of harm.

During our visit we found that the standards of cleanliness, infection control and maintenance of the home were poorly managed. A range of environmental audits was completed by the maintenance officer and the manager to monitor and manage the quality of people's living conditions. We saw that both the manager and the maintenance officer had identified a number of serious concerns with the home's environment over a period of several months. These concerns were reported to the provider but no action had been taken.

For example, some people's bedrooms were extremely malodourous and it was hard to comprehend that people were still living in these conditions. This had been reported to the provider but no action had been taken. The provider had been advised that the home's communal lounge and communal hallway smelt offensively but no action had been taken to address this.

The provider had been informed that the home's boiler was not fit for purpose. This meant that people who lived at the home did not always have access to hot water and on the day of our inspection there was no running hot water in the home due to the boiler tripping. The maintenance officer had also reported that water storage temperatures were not hot enough to control the risk of Legionella bacteria developing in the home's water supply. Despite this, the provider had taken no action. This did not demonstrate that the provider was proactive or accountable with regards to the management of the home. Fortunately a test carried out on 9 July 2018 revealed there were no legionella bacteria present at the time.

The provider following our inspection sent us information that the boiler has now been replaced. The provider also sent us pictures of the flooring having been replaced in the linen room and several bedrooms, including those rooms that previously smelt extremely offensively.

Other cleanliness and infection control issues identified during our visit had not been picked up by the environmental audits in place. This raised concerns about their effectiveness. For instance, the audits had failed to identify that some of the showers in people's en-suite bathrooms did not work, or that people did not have any hand towels in their bedrooms to enable them to observe good hand hygiene for infection control purposes. Faecal stains were found on a chair in the lounge, as well as in some bathrooms. On the day of inspection, one person's commode had not been emptied and remained in the person's bedroom. Radiator covers were loose and unsecure in some areas.

The method used by staff to clean people's continence aids such as commodes was inadequate. There was no separate sluice facility in the home and staff cleaned continence aids in people's toilets by emptying the

bowl, then washing the bowl in clean toilet water before spraying with disinfectant. This practice was inadequate for infection control purposes.

Records showed that the governance arrangements in place for safeguarding incidents failed to be effective in mitigating risks to people's safety. The systems in place also failed to ensure that these incidents were reported to CQC in accordance with the provider's conditions of registration.

Medication audits and checks were ineffective and insufficient. They failed to identify that people's PRN (as and when required) medication was not always administered appropriately; medication was sometimes missed; or that record keeping of medication administration was not always accurate.

There were no adequate systems in place to check the accuracy of record keeping or to ensure that records were kept contemporaneously in respect of each person who lived at the home. During our visit we found that staff members completed and signed care records on behalf of others. The deputy manager told inspectors that "I do all the diary pages (daily records) for each person. Staff come to me and I write it down. Staff tell me what has been done". This was not safe or accountable practice.

A staff member told us, "If there are three of us, then one will do the diary pages (daily records) for all of the residents, one will do the [personal care] charts and one will do the turn charts". They told us that they then signed the initial of the staff member reporting the activity to them. This meant people's daily records and care charts were based on the word of mouth of other staff members. We questioned the accuracy of this method of recording as it meant there was no written record of the exact care provided by staff at the time it took place. This meant there was a risk that the records were not accurately reflective of the care provided or signed by the staff members who provided it.

During our visit we observed that some people who lived at the home needed constant staff support and reassurance due to distress, agitation or challenging behaviours. This impacted on staff time and their availability to support service users in other areas. When we looked at the dependency tool used by the provider to plan safe staffing levels, we found it was not fit for purpose. The dependency tool focused solely on people's practical support needs and failed to consider the emotional and mental health needs of people who lived at the home, despite this being a significant aspect of people's dementia care. At times during the inspection, we observed people's emotional needs were not met and that people had little meaningful interaction with staff to maintain their emotional well-being. There were no audits in place to monitor and assess the quality of people's day to day care or their living experience. This meant that issues with the lack of person centred care and good dementia care were not picked up.

This evidence demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the management of the home was poor both at provider and manager level. The systems in place to monitor and mitigate the risks to people's health, safety and welfare were inadequate.