St. Helena's Residential Homes Limited

St Helena's

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 2, 4,5 October 2017. The first day of our visits to the service was unannounced. Prior to the inspection we received information of concern around care and safety of people who used the service. We looked at those concerns as part of this inspection.

At the last comprehensive inspection 4, 5 and 12 May 2017 we found a breach regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance systems were not effective. We issued the provider with a warning notice requiring them to become compliant with this regulation by 18 September 2017.

We also identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always managed safely and people's environment was not safely monitored. After the inspection, the registered provider wrote to us to inform us of the action they would take to meet legal requirements.

At this inspection found improvements had not been made and further concerns were identified. The CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

St Helena's is registered to provide accommodation and personal care for up to 33 people who require support with their personal care. They specialise in supporting older people. At the time of our inspection there were 24 people living at the service who were living with a range of age related conditions including dementia.

There was no registered manager in place. The last registered manager left the service 12 May 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. The day to day management of the service was being overseen by a manager who had started working at the service 7 July 2017.

The provider had not addressed the shortfalls identified at the last inspection. They had no effective internal quality assurance systems in place to assess and monitor the service provided identify shortfalls and drive improvement. In addition action plans given to the provider to address shortfalls identified by external agencies in relation to the management and safe administration of medicines, fire safety, and care planning had not been fully completed. There was no clear plan in place for when, how and by whom actions would be addressed. Records were not properly maintained to make sure they were accurate and fully complete. Care plans did not always contain accurate information regarding people's care needs and failed to record the guidance provided by health care professionals involved in their care.

Action had not been to ensure the management of medicines was safe. Staff did not have access to specific guidance for when PRN (as required) medication, including pain relieving medicines, could be administered to individuals or for how long before medical advice should be sought. Medicines were not always stored in line with good practice guidelines and medicine records and audits were not accurate.

People's privacy was not always ensured or their dignity respected. Staff opened toilet doors when people were using the toilet, in view of others. People's rights were not always upheld. People who had expressed the desire to vote had not been supported to register to do so.

Risks to people's health and safety were not always safely managed. Staff were not always aware of and did not always use the equipment people had been assessed as needing, when supporting them to move or transfer. The provider had not ensured the risks of experiencing falls were kept under review when their needs changed and appropriate steps taken to mitigate the risk of them experiencing another fall.

The provider had not ensured that staff understood and always worked within the principles of the Mental Capacity Act to gain lawful consent for people's care and treatment. Decision specific capacity assessments had not been completed and best interest decisions recorded as required. Despite this people were supported throughout our visits to make a number of choices regarding how they received their care and we observed staff seeking consent from people before initiating care interventions.

People and their relatives were not always listened to. Complaints were not recognised recorded or investigated appropriately.

Recruitment checks were not safe. Required identity and security checks had not always been completed before staff started work. There was no evidence that new staff and agency staff had completed an induction to the service before working unsupervised. Staff had not received the training and support they needed to meet people's assessed needs effectively and keep up to date with current good practice. Staffing levels were not always sufficient to protect people from the risk of harm. People in communal areas of the service were left unsupervised for prolonged periods of time.

The CQC had not been notified about incidents of potential abuse and deaths as required.

People were not always provided with the opportunity to participate activities they found enjoyable and stimulating to help them maintain their physical and psychological health. People enjoyed the food on offer but were kept waiting for over half an hour for their food before being served.

People and their relatives were invited to attend meetings to offer their views and discuss any changes or improvements needed around the service. People and their relatives were complimentary about staff who they described as "Kind" and "Caring". Family members described the service as "Clean".

Health care professionals visited the service on a regular basis to review, monitor and treat people's health needs.

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 registered provider's registration of the service, will be inspected again within six months.

The expectation is that registered 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 registered 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 registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

The management of medicines was not safe.

Appropriate steps had not been taken to reduce the risk of people being placed of harm. Staff did not always use safe moving and handling techniques.

Routine checks had not always been completed to ensure equipment was safe and working properly.

Action required to ensure fire safety had not been always been completed.

Staff recruitment procedures were not safe and the deployment of staff was not always sufficient to ensure communal areas of the service were supervised and people's needs were safely met.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive support from staff who had completed the training they needed to undertake their role and provide safe and effective care.

Staff lacked understanding of and did not always work within the principles of the Mental Capacity Act.

Some people experienced delays in receiving the healthcare support they needed.

People enjoyed the food provided but the mealtime experience needs to improve.

Is the service caring?

Requires Improvement

The service was not always caring.

Peoples rights to choice, privacy and dignity was not always maintained.

Information relating to people was not always stored securely.

Staff were kind and caring.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was centred on their needs and reflected their preferences. Care plans and risk assessments did not reflect people's current care needs or provide staff with the guidance they needed to provide safe and effective care.

People were not provided with the opportunity to participate in activities they found enjoyable and stimulating.

Complaints had not been recorded and responded to.

Is the service well-led?

Inadequate

The service was not well led.

The provider did have systems and processes in place to effectively assess and monitor the service people received and drive improvement.

The provider had failed to ensure that records relating to the delivery of care and management of the service were accurate up to date and complete.

The provider had failed to inform the Care Quality Commission of notifiable events that had occurred at the service.

Roles and responsibilities of management and staff were not clearly defined.

St Helena's

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 registered 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.

We visited the service unannounced on 2, 4 and 5 October 2017. The inspection team consisted of two adult social care inspectors on the first and second days and one inspector on the third day.

Before the inspection, we received anonymous concerns regarding the provision of care at the service. We had also received information of concern about the management of medicines from the Clinical Commissioning Governance (CCG) Medicines management team and the delivery of care from local authority.

We spoke with six people who lived at the service and four people's relatives. We also observed the lunch time experience of four people and undertook individual Short Observational Framework for Inspection (SOFI) observations in the communal lounge of five people. SOFI is a specific way of observing care to help us understand the experience of people who were unable to give us their views. We observed general interaction between people and staff and observed staff providing people with support to move.

We spoke with six care staff, an agency staff member, the provider, manager and administrator. We also spoke with 12 health and social care professionals who visited the service whilst we were there.

We looked at the care records of 10 people living at the service, which included, care plans, daily records and medication administration records. We also looked at records relating to the management of the service including staff rotas, accident and incident records, medication audits, staff recruitment files, records of the dates of staff training and supervision and the staff communication book.

Inadequate

Is the service safe?

Our findings

Some people felt they were safe living at the service. One person told us "I feel safe living here". People told us and our observations confirmed that staff responded quickly when they used the call bell. One person told us "I get my tablets on time, more or less. You can get overlooked, but you get them in the end".

During our last comprehensive inspection in May 2017 the provider was in breach of Regulation 12 and improvements were required in relation to the management and administration of medicines, the completion of risk assessments and health and safety checks. At this inspection we found these breaches had not been addressed.

The administration of medicines that had been prescribed to people on an as and when needed (PRN) basis was not safe. There was no guidance to indicate under what specific circumstances PRN medication, to help manage people's anxiety or pain could be administered or for how long before GP advice should be sought. Therefore the provider could not be assured that people were receiving their medicines safely and in line with their individual needs and preferences. When PRN medicines had been administered the reason for this had not been recorded. Therefore the provider had no way of monitoring the effectiveness of the medicines.

Medicines had not always been administered as they were prescribed. There were gaps in people's medication administration records (MAR) where there was no signature to indicate whether their prescribed medicines had been administered. Some medicines were prescribed to be given before food however some people were being given these medicines with their breakfast. One person's medicines should not be administered with caffeine however they were drinking coffee at the time the medicines were administered. Some medicines prescribed to be given on set days had been administered before their due date. As part of the medication audit a handwritten list of medicines and the quantity stated on the electronic MAR that should be in stock were recorded. The actual quantity of each medicine in stock was also recorded. However these did not always tally. For example medication audits carried out September 2017 of 13 people's medicines showed the stock of 24 medicines did not tally with the records. The records did not record any explanation for this or of what action had been taken in relation to these errors. Therefore the provider could not be assured that people had received these medicines as prescribed.

The instructions on the box of one person's pain relieving medicine stated that they were to take two tablets when needed. However the MAR for this person showed that on some occasion's staff only administered one tablet. The instructions on the box of another person's pain relieving medicine stated two tablets three times a day however the MAR for this person showed this medicine as being a PRN medicine. Therefore the provider could not be assured these people were receiving their medicines as prescribed and intended.

At the last inspection medicines no longer in use by people that were to be returned to the dispensing pharmacy were not stored in line with good practice and the items for return had not been recorded. At this inspection we sound this issue had not been addressed. Medicines for the return to the pharmacy were stored in open baskets in the medication room and there were no records to indicate what they contained. Therefore there was no clear account of what medicines were being stored in the service. There were also a

large amount of other medicines stored in baskets on shelves. Some medicines need to be stored in a fridge at specific temperatures. The temperature of the fridge was being recorded however records showed that temperatures had exceeded the recommended maximum temperature and no action had been taken to address this issue.

Some medicines have to be recorded in a register. The index of this register was not accurate and up to date. Therefor it was difficult to navigate find the appropriate page for recording the administration of the medicine. There were missing signatures to indicate whether one medicine had been administered. These issues had been identified as part of a medication audit undertaken by an external body in August 2017 but had not been addressed.

The provider had not ensured they had a proper and safe system in place for the management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always follow safe moving and handling guidelines. Staff told us and records confirmed that one person who used a wheelchair to move, had been assessed as needed two staff to support them to stand using a stand aid. Stand aids are designed to support people who may not be able to fully weight bear to transfer from a sitting to a standing position. We observed two members of staff supporting this person to stand without using a stand aid. We observed two other members of staff manual lift another person up the bed to reposition them. This person had been assessed as needing to be moved using slide sheets.

Some people had bed rails in place to protect them from falling from bed. Bed rails did not cover the full length of the bed and so there was a risk that people could slip out of the end of the bed however bed rail risk assessments had not been completed to mitigate this risk. There was no cover on the bed rail at one side of one person's bed which placed them at risk of becoming trapped in the rails or hurting themselves on the rails.

The risks of people falling were not assessed and managed appropriately. Where people had experienced falls, their risk assessments had not been reviewed to establish whether the risks to them experiencing another fall could be reduced. Record showed that there had been 17 falls at the service since 1 July 2017 and none of the fall risk assessments or care plans for the people that had fallen during this time had been reviewed or updated. A number of people had experienced multiple falls in the last few months. A history of falls in the past year is the single most important risk factor for falls and is a predictor of further falls. If there is concern that a person is at risk of falling, they can be referred to, or advised to see, a healthcare professional or service to further assess their risk. However there was no evidence that relevant referrals had been made for people who had experienced multiple falls.

Safety checks the provider's records stated should be completed weekly such as fire extinguisher checks, the temperatures of the water outlets and call bells tests had not been undertaken for over a month. There were no checks in place to check that bed rails were safe. Therefore the provider could not be assured that this equipment was working properly. We also observed the height of the bannister at the top of a flight of stairs to be low and could pose a risk of people falling over it however no risk assessment had been completed in relation to this.

We observed some fire doors did not close fully, others had excessive gaps or were ill-fitting in their frames and some fires seals around door frames had been painted over. Some of these issues had been identified on a fire risk assessment the provider had commissioned in April 2017 and by the fire safety officer in May 2017 but had not been addressed. At the last inspection we found an area close to a set of stairs was

cluttered with equipment which could cause a hazard for people having to access the stairs in an emergency. This issue had not been addressed.

The provider had not ensured that at all times people were protected from the risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a thorough and robust approach to safeguarding people from abuse. Since August 2017, 15 safeguarding concerns had been raised many of which were in connection to people not receiving their medicines as prescribed. Although some of these concerns had been raised by the provider, others had been reported to the local authority safeguarding team by visiting health and social care professionals and had not been recognised by the provider. During this inspection further safeguarding concerns were identified and reported by a visiting social care professional which had not been identified by the provider as safeguarding concerns. Information received from the local authority was that the provider had not taken sufficient action to safeguard people from abuse and safeguarding plans designed to protect people had not been followed.

The provider had not ensured people were always protected from abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three care assistants, one senior care assistant and as a temporary measure one agency staff to administrator medicines from 7am to 7pm. There was also a care assistant from 7am to 11am. There were two care assistants and one agency staff to administer medicines from 7pm to 7am. The manager was on duty 9am to 4pm Monday to Friday and on call out of office hours.

Staffing levels were not always sufficient to supervise communal areas and provide support to people when they needed it. Staff told us that there were six people who needed two staff to support to move some of whom needed to be transferred using a hoist. One staff member commented "We've always been told three carers is enough. We have problems when someone has to go in a hoist. It could leave us with only one carer". Another staff member told us "Sometimes there could be 20 people unsupervised". Relative's told us that from 7pm communal areas were left unsupervised for long periods. They told us they frequently had to go and find staff when people were calling for assistance to go to the toilet or trying to stand or walk on their own. One relative commented "We've asked before for staff to be in the lounge but they're not doing it. Residents will attempt to go to the toilet themselves if they can't see anyone, which is dangerous". Another relative told us they has seen a person fall when trying to get up on their own when there were no staff in the lounge.

The provider had not ensured staff were deployed in sufficient numbers at all times to meet people's individual needs and protect them from harm. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment of staff was not always safe. The recruitment file for one member of staff contained a copy of a disclosure and barring service (DBS) check issued when working for a previous employer. A DBS check incudes searching police records and barred list information, it helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. A new DBS had not been applied for and there was no risk assessment in place to mitigate the risk this posed. The employment history for two members of staff was incomplete and there was no evidence of photographic identity in two files. On the first day of inspection there was no information available to confirm the required checks had been completed for agency staff. By the third day of the inspection the manager had obtained this information for some agency staff.

The provider had not ensured the recruitment of staff was safe. This is a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection personal emergency evacuation plans (PEEPs) could not be located. PEEPs detail the support and guidance an individual needs in the event of having to leave the home in an emergency. On the second day of inspection a PEEP for each person had been printed out. However these were lengthy documents and information pertinent to the evacuation of the person was not easily accessible.

Equipment such as hoists and electrical and gas installation had been serviced. Some action had been taken to address shortfalls identified in relation to fire safety such as the replacement of fire doors. The environment was clean and bright and people's rooms were cleaned on a regular basis.

Requires Improvement

Is the service effective?

Our findings

The provider had not ensured that all staff had completed training and received the support they needed to meet people's needs and carry out their role. At the last inspection not all staff had received up to date moving and handling, first aid or Mental Capacity Act (MCA) 2005 training and we were told this was in the process of being arranged. At this inspection we found staff had not been addressed and we identified concerns in relation to poor moving and handling of people by staff and a lack of understanding of the MCA.

At the last inspection we were told that plans were in place to introduce the Care Certificate training to newly recruited members of staff. The care certificate is a nationally recognised set of standards that care staff are expected to meet within their practice. At this inspection we found this had not been introduced and we saw no evidence that new staff or agency staff had been provided with an induction to the service which prepared them for their role and provided them with the skills they needed prior to working unsupervised.

At the last inspection staff told us they had not received formal supervision for their role. Supervision gives staff the opportunity to sit with their supervisor and discuss their role and identify and development needs. At this inspection records showed that 13 staff had received supervision since the last inspection. However the remaining staff had not and no staff had received an annual appraisal of their performance. A relative commented "There's no one helping the staff improve and do their jobs and enjoy them. They need to be updated with their skills. They've got really good carers here they just need support".

The provider had not ensured that people received the training and support they needed to undertake their role and deliver safe and effective care. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

Records demonstrated that the majority of staff had received training which included equality and diversity, dignity in care, safeguarding people and food hygiene. Thirteen staff also held a nationally recognised qualification in care. Nine of which were at level two and four at level three.

The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). 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.

Applications had been made appropriately to the local authority on behalf of six people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations. However the provider had not ensured staff were aware of and always followed the principles of the MCA. Some staff told us one person had fluctuating

capacity to make decisions for themselves ; however the mental capacity section of this persons care plan stated 'I am able to make my own decisions and fully understand the consequences of my decisions'. Therefore there was a risk that this person would not receive the support they needed to make decisions.

We saw a message in the staff communication book in relation to the completion of forms for the consent of people to have flu jabs stating 'Can get verbal consent from next of kin and managers signature on all'. A member of staff told us they would ask the relative to give their consent for this treatment. They explained the person lacked capacity to give consent themselves, however the family members did not have the legal authority to give consent. We did not see any records to show that decision specific mental capacity assessments had been completed for anyone living with dementia or poor memory for this or any other decisions.

There was a secure entry system to the service to which people did not have the key code to. Therefore they were not able to come and go as they pleased without asking staff to let them in and out of the building. There was no evidence to show that people had consented to this. Some people had bed rails in situ but there was no evidence that they had consented to this. None of the staff had completed up to date training in the MCA that took into account recent court rulings. Therefore the provider could not be assured that staff were following current legislation and people were not being unlawfully restricted.

The provider had not ensured staff who obtained consent of people who used the service were familiar with and acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Consent for people's care and treatment had not always been provided by a relevant person. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of understanding in relation to the MCA staff told us they would not make people do anything they did not want to and understood the importance of seeking consent from people before initiating care interventions. For example we observed on most occasions staff asked people if they were ready to be supported to move or go to the toilet.

Each person was registered with a GP and had access to the community nursing staff linked with these practices however our findings in relation to health care support was mixed. Records also demonstrated that people had regular access to the local district nursing team and routine visits to the service by an optician and podiatrist. However relatives told us that on some occasions there had been a delay in referrals being made. One relative commented "I'm concerned about the handover of information and continuity of care. Staff asked if mum should have a flu jab. They had already asked her and I agreed, but she still hasn't had it after three weeks. They've obviously got a communication book that nobody reads".

At the last inspection we recommend that the provider reviewed people's mealtime experiences and choice of menu. At this inspection we found some improvements had been made but others had not. People told us the food was good and their comments included "We get a good choice. I'm just having sandwiches today". "Food is very good. We always get enough. We can get tea whenever we want". "Lunch was nice today". "The food is alright. Staff tell you what's on offer and it's up on the board". Tables were laid with cutlery, crockery and fresh flowers. The menu was displayed on the wall however not everyone could see this. The menu specified a choice of sandwiches or soup but did not specify that an alternative meal was available on request or that fruit or yogurt were available for dessert. We observed the portions were small but more food was provided to those who asked.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that they felt staff were kind and caring. One person told us "I talk to the staff. They're smashing". Relatives comments included "Carers on the whole work very hard and they all seem kind but they are always in such a rush the little things get lost along the way". "People are well looked after. The staff are dead friendly," and "Mum loves it here and the girls love her". Despite the positive feedback we received about the caring nature of staff we also identified areas of practice that required improvement.

People's privacy and dignity was not always protected and promoted. On two occasions we observed staff, who were supporting people to use the toilet in the reception area, opened the door when people were sat on the toilet in view of other people present. We noted that the doors to rooms where people who were sleeping or resting in bed during the day were open. Staff told us these people wanted their doors open however we could not see any evidence in the records to indicate whether people had been asked if they wanted the doors open or not. Therefore the provider could not be assured that people's wishes on privacy were being considered or respected.

One person was receiving end of life care. However only one staff member had completed end of life care training and the person's care plan did not provide staff with any guidance on what support this person wanted or needed at the end of their life. Staff told us the person had said they wanted to die at the service however this had not been documented. Therefore there was a risk that this person's wishes would not be respected.

People's preferred times for going to bed and getting up were recorded. However relatives told us that sometimes people had to wait to be supported to bed because staff were busy. A relative told us and records confirmed their family member who was living with dementia, usually went to bed between 8pm and 9pm however on some occasions recently they had not been supported to bed until 10.45pm. There was no reason for this documented and staff were not able to provide an explanation for this. Therefore the provider could not be assured that people's choices of when they wished to get up and go to bed were being respected.

At the last inspection four people had told us they would like to vote but had not been supported to register to do so. We recommend the provider reviewed the systems to promote people's rights to vote. At this inspection we found this had not been addressed. Therefore the provider had not ensured people's rights to vote were being upheld.

Most records were stored confidentially however some were not. Paper records relating to people were stored within lockable storage cabinets and records stored on computer were password protected. Only staff who were authorised to do so could access these records. However a general communication book was in use in which staff had recorded information relating to people's emotional and physical health, medicines and health appointment outcomes. The contents of this book did not protect individual's personal information because different people's notes were written on the same pages. The issue of ensuring that

people's personal and confidential information was managed appropriately was raised at the last inspection and had not been addressed.

The provider had not ensured that people's rights to choice, privacy and dignity were always respected. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection improvements were needed as to how meal times were planned for people so they promoted choice and freedom of movement of people. At this inspection improvements were still needed. People were supported to the dining table to be seated well in advance of 12.30 when the meal was planned to be served. However people did not receive their meals until 1pm. This meant people had waited over half an hour to be served. In addition to this it was difficult for people to have a conversation because music was playing loudly in the background.

Staff demonstrated a caring approach to people. For example, staff addressed people in a gentle manner and offered a reassuring and comforting hand or arm when needed. It was evident that staff knew people and that positive relationships had been formed. People received care from some staff that had worked at the service for many years and knew and understood their needs. These staff were able to describe people's character, routines, personal preferences, health and support needs. We heard staff explaining to people what they were going to be doing before offering support and laughing and joking with people.

Meal times were protected and visitors were asked not to come to the service during these times. However relatives told us they felt they could visit their family members or contact the service at any time of the day. Throughout our inspection we observed family members and other visitors being welcomed to the service. People had their own bedrooms and had been encouraged to personalise them with their own memorabilia. This helped people to be comfortable and feel that their room was personal to them.

Inadequate

Is the service responsive?

Our findings

The provider had not ensured people always received support that responded to their changing needs. At the last inspection we recommended that the provider reviewed the systems in place for the reviewing and updating of people's care plans. This was because they did always contain up to date information that reflected people's current care needs and preferences. At this inspection we found this issue had not been addressed and further improvements were required.

An electronic care planning system was in place which enabled information relating to people's physical and psychological health, finances, medical and medication needs to be recorded. The system gave the opportunity to record and calculate risks relating to individuals and to produce a plan of care which included how a person's identified needs were to be met. However, we found people's care plans did not reflect people's current care needs and had not been updated when significant changes had occurred to people's needs. Therefore staff did not have access to the guidance they needed to ensure people received safe and effective care that met their needs. One member of staff told us when they had started work at the service "People had to tell me what to do". Another staff member commented, "The care plans need updating. There's some person-centred information in the files. We're not involved in reviews of care".

Where changes in relation to people's care needs such as mobility, eating and drinking and continence had occurred, reviews had not taken place to reassess and plan for how people's needs should be met. When we arrived at the service we were told that no one had been assessed as needing a soft textured diet. However information in the staff communication book showed that a speech and language therapist (SALT) had advised that one person should continue with a soft diet. This information had not been transferred onto this persons care plan and although staff told us this person usually ate soft food they thought this was because it was their preference and were not aware of the fact that guidance to eat a soft diet had been provided by a SALT. Therefor there was a risk that this person would be provided with food that was not suitable for them.

The incontinence risk assessment for one person dated 29 December 2016 stated 'Continence nurse advised to monitor for further four weeks and to contact with update'. The risk assessment had not been reviewed since that time and the associated care plan contained no details of the outcome of the monitoring or whether the continence nurse had been contacted. Therefore the provider could not be assured that this person was receiving care that met their needs.

Concerns about the availability of incontinence pads available to people who needed them had been raised by the Care Quality Commission (CQC) with the provider on 1 September 2017. The provider had told us there had been problems with stocks running low but had given assurances that the issue had been resolved. On the first day of our inspection relatives and staff told us the stock of incontinence pads, supplied to individuals, frequently ran low. One person only had one pad in stock and staff told us they would use someone else's pads for this person until new stocks arrived. Staff explained stocks ran low because they were being used for people who had not been assessed as needing them. They told us this was because they felt some people were incontinent and needed to be reassessed by the incontinence team.

However, there were no records in place to show when these people's needs had changed or whether relevant referrals had been made. Therefore the provider had not ensured the needs of these people had been kept under review.

The mobility section of another person's care plan dated the 21 June 2017 stated the person used a wheelchair for general mobility and staff should assist them transferring. Under the 'Action' section it stated 'Awaiting assessment from an occupational therapist'. Staff told us this person was receiving end of life care and no longer used a wheelchair because they spent all their time in bed. They also told us the person had been assessed as needing to be repositioned using slide sheets. This person's care plan and associated risk assessments had not been updated to reflect this and not all staff were aware of the need to support the person to move using slide sheets. Therefore the provider had not ensured staff had access the guidance they needed to meet this person's assessed needs.

People were not always provided with the opportunity to take part in activities they found stimulating and enjoyable. Care plans provided limited information in relation to people's interests, hobbies and how they liked to spend their time. When we asked people, their relatives and staff about activities on offer and how people were occupied during the day staff told us there was no structured activities programme in place. One person commented "I don't do anything. There's not much to do. I watch telly now and again". A relative commented "They don't do anything during the day. I think that people go to the toilet so they can talk to someone". Another relative echoed this and told us "Staff don't seem to do anything but take people to the toilet". We saw that that a lot of people spent time watching television or sleeping in chairs in the lounge or conservatory. The volume of the television in the lounge was very loud which made having a conversation difficult for anyone wishing to socialise with others. We were told the provider was in the process of recruiting to the post of activities organiser and in the meantime care staff were expected to provide activities. We observed bingo was provided on one day but we did not observe any other activities taking place. A relative told us "There's no activities co-ordinator anymore. Since they left the carers are stepping in. They were singing yesterday and mum loved it. Sometimes there's bingo but there's not much else".

The provider had not ensured that at all times people received appropriate care and treatment that was centred on them, met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of inspection a senior member of staff told us referrals had been made to the incontinence team for people to be assessed and an order of incontinence pads had been received.

At the last inspection we identified that although some complaints had been recorded, the action taken in response had not and improvements were needed to ensure that all complaints were managed appropriately and monitored. At this inspection we found action had not been taken to address this issue and further improvements were required. The provider had a complaints policy and procedure in place, a copy of which was provided to people and their family members when they moved into the service within the service user guide. The manager told us there had been no complaints since the last inspection. However two relative's told us they had raised concerns with the manager about the care of their family members and about the staffing levels at the service which had not been addressed. The manager told us they had not considered these concerns as complaints therefore had not recorded them. They were unable to tell us what action had been taken to address the issues the relatives had raised.

The provider had not ensured they had an effective system in place for receiving and acting on complaints. This is breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place. The previous registered manager had left the service on 17 May 2017 and a newly recruited manager started 6 July 2017. In the interim period the provider had placed a member of staff employed to work in the office in charge of the day to day management of the service. This person had also overseen the management of the service when the manager had taken three weeks leave.

At the last inspection in May 2017 the provider had failed to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the breach had not been met and the provider had continued to fail to meet these requirements.

The provider had no internal quality assurance systems to assess and monitor the service provided identify shortfalls and drive improvement in relation to care plans, care records, risk assessments, accidents and incidents, falls, safeguarding concerns, complaints, MCA assessments, staffing levels, staff training, supervision or recruitment records. Therefore the provider had not identified areas that needed to improve and had missed the opportunity to take corrective action.

Despite the lack of the providers own quality assurance systems visits to the service had been undertaken by a range of external agencies that had highlighted areas that needed to improve. These agencies had given the provider action plans to complete to address their findings. These action plans covered the management of medicines, staff recruitment, the completion of care plans, risk assessments and fire safety. However the majority of the actions needed to be taken had not been completed and the provider did not have a clear plan in place as to how and when these issues would be addressed or by whom. Therefore the provider was failing to take action to ensure people received a safe and effective service.

There was a lack of oversight of the maintenance of records and staff practice. Risk assessments and care plans had not been updated when people's needs had changed and that they contained inaccurate and out of date information. There had been no analysis of trends, patterns and actions taken in response to accidents and incidents, including falls that had occurred. Feedback and guidance from healthcare professionals had been recorded in the communication book and had not been transferred into people's care plans. Complaints were not always recognised and recorded so it was not possible for the provider to analyse them and learn by their mistakes. There was a lack of management oversight of issues relating to consent and the need for mental capacity assessments to be completed. Staff practice did not ensure people's privacy and dignity was always respected and safe moving and handling techniques were used and this had gone unchecked. The failure of the provider to take action to identify and address these issues meant areas of poor practice were being allowed to continue and people were not always receiving safe and effective care.

The registered provider had continued to fail to assess, monitor and improve the quality of the service and ensure the service people received was safe, effective and responsive to peoples changing needs. These failings placed people at significant risk of receiving inappropriate care and treatment and constitute a

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

The provider had not ensured that the Care Quality Commission (CQC) had been informed of significant events affecting the health and wellbeing of people who used the service, by way of a statutory notification as is required. The CQC had not received any statutory notifications including those relating to potential abuse that had occurred since the last inspection. The local authority told us that there had been 15 incidents of potential abuse of people since August 2017. However the provider had not submitted statutory notifications in relation to any of these events.

The provider had failed to notify the Commission without delay of any incidents of potential abuse. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider is also required by law to notify the CQC of the death of people who use the service. We were told that one person who used the service had recently died however the CQC had not received a statutory notification in relation to this death. This is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Although there was a management structure in place, areas of responsibility were not clearly defined. For example, the person who conducted the routine safety checks was not at work but no one could tell us who was responsible for completing these checks in their absence. The manager told us they thought someone else was notifying the CQC of deaths and staff were unclear about who was responsible for making referrals to the incontinence team and ordering incontinence aids.

The manager had recognised there were no processes in place for them to receive supervision and support in their role and told us they were in the process of arranging for an external agency to provide this support. They also told us they were in the process of recruiting a deputy manager, a senior care assistant and a care assistant.

Relatives told us they felt the manager was approachable and had informed them of improvements they proposed to make in relation to the way the service was run at residents and relatives meetings. However they also raised concerns about their visibility within the service and that their family members were not all aware of who the manager was. They also raised concerns about the number of changes in management there had been at the service and the unsettling affect a change of manager had on people and staff.

At the last inspection we recommend the provider sought guidance from a reputable source regarding the then proposed implementation of CCTV and audio equipment within the service. At this inspection the provider told us that the plans to introduce this monitoring system had been put on hold and there were no plans for this to be introduced in the near future.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify the Commission of the deaths of people who used the service.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay of any incidents of potential abuse.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that at all times people received appropriate care and treatment that was centred on them, met their needs and reflected their preferences.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people's rights to choice, privacy and dignity were always respected.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

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 staff who obtained consent of people who used the service were familiar with and acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Consent for people's care and treatment had not always been provided by a relevant person.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people from the risk of harm. Systems in place for the management of medicines were not safe.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were always protected from abuse.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure they had an effective system in place for receiving and acting on complaints.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had continued to fail to assess, monitor and improve the quality of the service

and ensure the service people received was safe, effective and responsive to peoples changing needs.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure the recruitment of staff was safe.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were deployed in sufficient numbers at all times to meet people's individual needs and protect them from harm. The provider had failed to ensure staff received the training and support they needed to undertake their role and deliver safe and effective care.

The enforcement action we took:

We issued a Notice of Proposal to cancel the Registered Provider of the service.