Cuerden Developments Ltd

Cuerden Developments Limited - Cuerden Grange Nursing

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of Cuerden Developments Ltd – Cuerden Grange Nursing on 12, 13 and 14 August 2015. The first day was unannounced.

Cuerden Grange Nursing Home provides nursing care for up to 48 people with nursing needs. At the time of the inspection 33 people were accommodated in the home. The home is purpose built and accommodation is provided over two floors in single occupancy rooms. A passenger lift provides access between the floors.

Summary of findings

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 9 and 10 December 2014, we asked the provider to take action to improve staff recruitment and record keeping. On this inspection we found the necessary improvements had been made to staff recruitment processes, but we found there were continuing shortfalls with record keeping.

During this inspection we found the provider was in breach of eight regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. These were in relation to person centred care, dignity and respect, safe care and treatment, safeguarding people from abuse and improper treatment, meeting nutritional and hydration needs, good governance and staffing. You can see what action we have asked the provider to take at the back of the full version of the report. We also found a breach of one regulation of the Care Quality Commission (Registration) Regulations 2009 for non-notification of incidents. We are dealing with this issue separately.

People's safety was compromised in many areas. We found risks to people's health, safety and well-being had not been mitigated, and staff had not followed risk management strategies set out in people's care plans. This meant people were at high risk of unsafe care. The majority of the staff had not received recent vulnerable adults safeguarding training and lacked insight into institutional abuse and neglect by omission of care. We also found shortfalls in the management of people's medication.

Whilst staff were safely recruited there were not enough staff to meet people's needs. We found the majority of the staff had not completed training in many key areas. This meant staff did not have updated knowledge to ensure they carried out their role effectively. Staff told us morale was very low in the home and they felt stressed. We noted that although some staff had received an appraisal of their work performance, none of the staff had received a supervision during 2015.

People were not given appropriate support at mealtimes and staff focussed on tasks rather than interacting with people they were supporting. We witnessed unsafe practices at meal times and throughout the inspection, which left people at risk of choking. People told us they felt rushed.

Staff were not responsive to people's healthcare needs and did not act promptly on advice given by external healthcare professionals.

We found the majority of the staff had not completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Whilst we saw applications had been made to the local authority for DoLS and some assessments had been carried out of people's mental capacity, we found some information in people's care plans was out of date.

We observed some staff practices which showed a lack of respect for people and did not promote their privacy and dignity. We had to intervene on several occasions to ensure people received safe and appropriate care. There were few opportunities to engage in activities and people were seen sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place.

Whilst people had an individual care plan there was no evidence people or their families had been involved in reviews of their care. We also found care plans had not always been updated in line with changing needs and staff did not follow the plans when delivering care. This meant people were at risk of harm because the service failed to respond promptly and appropriately to their care needs.

The management of the service was inconsistent and lacked continuity. There were no effective systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

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

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Within a few minutes of arrival at the service a director of the Company operating the home contacted us to inform us of the intention to close the home. He told us that he was unable to recruit nursing staff and the service was unsafe. He submitted an application to remove the location from the provider's registration the next day. During the inspection the director and the covering managers worked closely with relatives and external organisations to support people's transfer to their new homes. The home is now closed and the service provider is no longer admitting people.

Summary of findings

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 provider did not have measures in place to promote the safety and well-being of the people living in the home.

When risks to people had been identified guidance to reduce the risks had not been followed. People were at increased risk of choking, developing pressure sores and injury due to poor practice.

People were at risk of not receiving the care and support they needed as there were not enough staff on duty.

People were not adequately protected against the risks associated with the unsafe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

People were not provided with appropriate care and support to ensure their nutritional and hydration needs were met.

Systems were not in place to ensure there was an appropriate response to people's changing healthcare needs. There were delays in people receiving professional advice and treatment.

Staff had not received suitable training and supervision to enable them to deliver care and treatment to people in the home safely and to an appropriate standard. The majority of the staff had not completed Mental Capacity Act training.

Is the service caring?

Inadequate

The service was not caring.

People were not supported and cared for in a dignified and respectful way. Staff focused on carrying out tasks and there was little social interaction between them and people living in the home.

Care records did not show how people and/or their relatives were involved in planning their care and support needs.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving a person centred service. The delivery of care did not meet their needs and reflect their preferences.

People were left unattended in the lounge or in their bedroom for long periods of time without any meaningful or stimulating activity.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There were no effective systems or processes in the home to ensure the service provided was safe, effective, caring, responsive or well led.

The service lacked leadership and management support. This meant the staff team did not have the day to day support they needed so they could provide safe and appropriate care.

Records did not evidence people's care needs were met.

Notifications had not been made to the Care Quality Commission for recent safeguarding incidents.

Cuerden Developments Limited - Cuerden Grange Nursing

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12, 13 and 14 August 2015 and was carried out by four adult social care inspectors, an inspection manager and two specialist pharmacy inspectors. The first day of the inspection was unannounced.

Before and during the inspection we sought information from representatives of the local authority, the Midlands and Lancashire Commissioning Support Unit and Chorley, South Ribble and Greater Preston Clinical Commissioning Groups. We also reviewed the information we held about the service, including notifications. A statutory notification is information about important events which the provider is required to send to us by law.

During the inspection, we spoke with ten people living in the home, five relatives and a visitor, two visiting healthcare professionals, five staff, the two covering managers and a director of the operating company.

We looked at 11 care files which belonged to people living in the home. We also looked at other important documentation relating to people living in the home such as 13 medication administration records. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. This included three staff recruitment files, the training records, staff rotas, supervision records for staff, minutes of meetings with staff and people living in the home, quality assurance audits and menus.

Inadequate

Is the service safe?

Our findings

People spoken with told us they were generally satisfied with the service. One person told us, "It's a good place" and another person commented, "Living here is alright". Relatives and a visitor spoken with had mixed views on the care provided, one relative told us, "In the main care is good" and a visitor confirmed they had no concerns about their friend's care. However, relatives also told us about their observations during their visits. One relative stated, "Everything feels very procedural, people who live here have to fit into a routine" and another relative told us staff had to be constantly reminded about important aspects of their family member's care.

We looked at how the provider managed risk. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included, moving and handling, nutrition and hydration, falls and pressure ulcer formation. However, we found gaps within care records and saw risk management strategies did not correspond with care delivery. We noted a visiting healthcare professional had specified the frequency of pressure relief and dressing changes for one person, who was at risk of pressure ulcers. However, the person's records indicated their dressings had not been changed in line with this advice. We also noted the person's pressure ulcers had not been assessed each time they were dressed. It was therefore difficult to ascertain the state of the wounds or the grades of the pressure ulcers. We asked a nurse on duty how they graded a pressure wound and found they were not aware of guidance to evidence was type of wound it was. This meant there was a high risk that people at risk of developing pressure sores or with pressure sores already in evidence were not monitored and cared for appropriately.

We further noted one person's continence care plan stated they needed to be assisted to use the toilet "regularly during the day", however we observed the person sitting in the same position for over six hours without being assisted to the toilet. We intervened and asked staff if the person had been provided with appropriate care. This then prompted them to assist the person to the toilet.

During lunchtime on the first day we observed two people were given food to eat whilst lying flat in bed. We noted one person's care plan stated they required "full assistance" of staff at mealtimes, however, we found the person alone in their room in a distressed state trying to chew their food, without having any dentures in place. We immediately asked a covering manager to provide the person with assistance, as stated in their plan. We were concerned about the potential of risk of choking for both people.

Staff told us there was sufficient and appropriate equipment for use in the home. However, we observed members of staff moving people in wheelchairs with no footrests and on two occasions dragging people in recliner chairs backwards with their feet scrapping the ground as they moved. We also saw that on one occasion staff used an inappropriate technique to transfer a person from a chair to wheelchair. This placed the person and the staff at risk of injury. On another occasion we observed a person sliding out of their chair. We alerted the staff and noted they tried to encourage the person to move back. This caused difficulties for the person and we overheard the nurse saying to staff, "Don't move him whilst she is there", referring to our inspector.

During the afternoon on the first day we observed a person was sat outside in the sun for a considerable time with no head protection. We alerted staff to this situation and noted they pushed the person back inside the building with no footrests on the wheelchair and no lap belt to secure the person whilst they were being transported.

The provider had not mitigated risks and had failed to provide people with safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at how the service protected people from abuse and the risk of abuse. Before the inspection we received detailed information from the local authority's safeguarding team. The information received highlighted a number of concerns about the safety of people using the service. The concerns were considered as part of the inspection of the home.

We discussed safeguarding procedures with staff during the inspection. Safeguarding procedures are designed to direct staff on the action they should take in the event of any allegation or suspicion of abuse. Staff spoken with understood their role in safeguarding people from harm and could describe the different forms of potential abuse. However, in practise, our observations found they lacked insight into what constituted abuse and, in particular, there appeared to be a lack of understanding of institutional

Inadequate

Is the service safe?

abuse and neglect by omission of care. According to the staff training records many of the staff had not completed safeguarding training. This meant we were not confident all staff would know how to respond if they encountered any concerns.

The provider had failed to ensure people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to staff the home on the first day of our visit. Members of staff spoken with told us the home was understaffed and one member of staff said "We are trying our best, but staff morale is horrendous" and another member of staff commented, "We are constantly short staffed." We looked at the staff rota on arrival and noted there were two nurses on duty and seven care staff. A covering manager told us this was slightly below the usual level of two nurses and eight care staff. The rota demonstrated that some staff were going off sick or absent and this was not being followed up to ensure they would be arriving for their next planned duty. A director of the company explained he had difficulties in recruiting nursing staff and securing nurses from agencies, this meant there had been occasions when only one nurse was on duty in the home. This affected the quality of care in the home.

A relative spoken with voiced concerns about the level of staffing and told us, "I don't think there's enough staff on. He (family member) has to decide an hour before he wants to go to the toilet." Throughout the inspection we noted people were left in the lounge areas unattended for long periods of time. Staff could not monitor people living in the home effectively and they were over stretched with the work load. We heard call bells often left for five minutes before being cancelled and there were delays in assisting people with meals and the delivery of personal care. There was no interaction between staff and people living in the home other than during the delivery of care. We discussed our concerns about the lack of staff with the covering managers at the end of the first day. They agreed with our concerns and offered to make arrangements for more members of staff to be placed on duty.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

From the second evening of our inspection, the level of risk to people's safety was mitigated by additional staff organised by the Local Authority and the local Clinical Commissioning Group (CCG).

Concerns that regular audits of medication were not being completed and that prescribers had not been advised about a medicines error were reported to us prior to this inspection. We were also notified of a delay in making recommended changes to one person's medicines and that a second person experienced poor pain control due to their medication being 'out of stock' at the home. A third person who had missed doses of medication required hospitalisation.

We spoke with the covering managers about medicines handling at the home. The managers explained that a medicines audit had not been completed in July 2015 because the Medicines Lead Nurse had left; a new lead had now been identified. An action plan had been developed in response to CCG concerns.

We looked the storage, recording and handling of medicines for thirteen people. All medicines were administered by qualified nurses. We spoke with an agency nurse who confirmed that they received orientation to the home and information about the medicines rounds before beginning their first shift. Photographs of people living in the home were in place to assist with positive identification when administering medicines.

We observed part of the morning medicines round. The medicines administration records were completed at the time of administration to each person, helping to ensure their accuracy. However, the written individual information used to support decision making about the use of 'when required' medicines was missing, or in need of review, in five of the records we viewed. Additionally, consideration had not been given to the Parkinson's UK recommendation that alarms were used to remind staff about medicines due at different times from set drug rounds. This increases the risk that these medicines will not be given at the right times and that people's symptoms will not be well controlled.

We found that advice from visiting healthcare professionals was not always promptly acted upon. For example, a hospital letter dated June 2015 recorded that one person was struggling to swallow their medicines and had requested that their treatment was reviewed. Notes made by nurses at the end of July recorded that this person did

Inadequate

Is the service safe?

not wish to take any medicines at night time. However, GP advice had not been sought and records showed that this person had missed doses of night-time medicine for two weeks. Medicines were administered covertly (hidden) to a second person. A written care plan was not in place and healthcare professional advice to avoid administering medicines in hot drinks had not been followed.

Arrangements had been made for supporting the application of creams by care workers. However, contrary to the homes medicines policy carers applying creams had not completed a written competency assessment. Individual written guidance and body maps used to assist carers when applying creams were not completed for two of the four records examined. One person had creams in their room that were not included on their cream record and a second had a cream listed that was not in stock at the home. This meant it was not possible to tell whether prescribed creams were being used correctly.

We found that medicines, including controlled drugs, were stored safely but contrary to a recent NHS England patient safety alert fluid / food thickening powder was not kept out of reach, in order to reduce the risk of asphyxiation from accidental swallowing. Nurses told us that adequate stocks of medication were now available to ensure continuity of treatment but managers told us that adequate supplies of thickeners were not available prior to their intervention in July 2015. Additionally, we saw that one person had missed two days doses of one medication due to a lack of stock.

The provider's arrangements for managing medication did not protect people against the risks associated with medicines. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On the third day of the inspection, the risks to people's safety found in respect to the management of medication were mitigated by a full audit undertaken by the local CCG's Medicines Management team. This meant prompt action could be taken to address any shortfalls.

At the last inspection on 9 and 10 December 2014, we found the provider had not operated an effective recruitment procedure. This meant appropriate checks had not been carried out before staff commenced working in the home. This was a breach of Regulation 21 of the Health and Social Care (Regulated Activities) Regulations 2010, which were applicable at the time. Following the inspection the provider sent us an action plan which set out the action they were going to take in order to meet the regulation. At this inspection we noted the necessary improvements had been made. We looked at three staff files and found all appropriate checks and documents had been obtained before the staff started working in the home.

Inadequate

Is the service effective?

Our findings

People spoken with had mixed views on the food provided. For instance one person told us the meals were "not so good" and felt there was not much choice and variety offered. A relative also told us "The food is terrible. He says it is cold all the time." However, another person commented "The food is very nice."

We observed the arrangements over lunchtime on the first day of our visit. The menus were on a four week cycle and were displayed in small print on the wall. We noted there was a choice of food options. The normal food was presented appropriately and portion sizes were adequate. However, some people were served mashed food, which had been liquidised together and brought to the dining room in plastic jugs. The jugs did not keep the food warm and were partially covered with cling film. The liquidised food looked unappetising and we saw much of it went to waste, as it had not been eaten by people served this food.

We saw swallowing guidelines on people's care plans indicating the consistency of the food recommended, amount of thickening agent to be put in liquids and the type of drinking cup best suited to the person. The kitchen staff were advised about special diets when people were admitted into the home. We noted from one person's care plan they were at risk of aspiration and should eat mashed food under supervision. However, we saw the person alone in their room eating lumps of food, which posed a choking risk. According to the person's records they had lost weight and the dietician had recommended fortnightly weights and fortified foods. We saw they were being weighed monthly. We also noted another person's care plan stated they should have thickened drinks in an open beaker. We observed they were given a spouted beaker, which made it difficult for them to sip the thickened liquid. From records seen, we noted the person's fluid intake was poor and there was no evidence the staff had contacted external healthcare professionals for advice.

We observed some people's drinks were out of reach. For instance a drink was placed out of reach of one person sitting in the lounge, 30 minutes later the person tried to pull the table closer in an attempt to get the drink. They were finally assisted ten minutes later by a member of staff, by which time the drink was cold. This meant the person had to wait 40 minutes for a drink. At lunchtime we observed the person had to wait longer than other people for lunch and had to sit watching others eat. They shouted out "Nurse please" three times, but were ignored. They were given no explanation for their wait and when the staff member brought their food, they again placed the drink out of reach. Later in the day we observed the person drinking a cup of tea unsupervised. The drink was spilling down their chin and onto their clothing. We quickly alerted staff due to the risks of scalding.

One person told us they felt rushed at mealtimes and stated, "If I don't eat it fast, they will take it away." Further to this, we noted one person was sat in a chair with a small table in front of them. They were given a bowl of soup. None of the staff offered any support and the bowl was taken away without consent.

The provider had failed to ensure the nutritional and hydration needs of people were met. This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We noted there was little or no interaction between the staff and people living in the home during the meal time. For example we saw one member of staff feeding a person on a pureed diet and throughout the whole task the staff did not speak once. We also observed a member of staff enter the lounge with plastic gloves on from a personal care intervention; they moved a drink from one person to another person then disposed of the gloves. There was no communication with either person.

During the inspection we found serious concerns regarding the management of people's health care needs, the timeliness of seeking professional advice and the poor arrangements for ensuring staff were following any professional advice and direction provided.

Several people's care plans included oral care because they were PEG (Percutaneous endoscopic gastrostomy) fed. This meant people received their dietary intake by means of a tube inserted into their stomach. We saw one person had poor oral hygiene, with their mouth heavily crusted with debris. We noted another person's care plan stated they required mouth care twice a day. This recommendation is not in line with CNS (Certified Nutritional Specialist) standards which recommend hourly oral care. We observed the person's relatives carrying out oral care, however, none of the staff were seen performing this task. A further relative told us they had purchased mouth freshener packs so they

could assist their family member, because staff did not carry out oral care. This meant people's needs were not being met and they had to rely on relatives to support this aspect of their care.

A relative expressed concern that staff had not made GP referrals in a timely way. They had noticed a change in their family member's condition and they told us that they had to constantly remind staff over a period of time before a GP referral was made. Similarly we noted from looking at another person's records their healthcare condition had deteriorated, however, there was no evidence staff had made an appropriate referral to a GP. We alerted a covering manager who made contact with a doctor. We also found one person had been assessed by their GP to be at the "end of life" and was prescribed anticipatory medication. However, there was no evidence to indicate any action had been taken in response to the GP visit. Staff were unable to explain the rationale for placing this person on end of life care.

We noted staff had received advice from visiting healthcare professionals, however, there were often delays in implementing advice or it was not carried out all. For instance we noted a visiting nurse clinician had advised staff to maintain a pain chart to track one person's level of pain, however, there was no record made until six days later. We also noted a hospital discharge letter dated February 2015 recommended a person's blood was tested once a month, we found no evidence to indicate this had been arranged or completed.

The provider had failed to respond to people's changing healthcare needs. This was a breach of Regulation 12 of the Health and Social Care (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw a record had been made following an assessment of some people's mental capacity, which included the four stage functional test. We also noted the assessments were supported by a mental capacity care plan and records of restrictive practice. The latter considered the least restrictive care and support options. Where appropriate, this had been followed by applications to the local authority for a DoLS. We saw evidence of the applications on people's files. We noted that where the person was assessed to have a lack of capacity decisions had been recorded in their best interest. However, we noted one person was described in their care plan as "pleasantly confused", but we saw that no mental capacity assessment had been completed. We also found that mental capacity care plans had not been updated in line with changes. For instance one person's record of restrictive practice indicated they received their medication in a covert way. However, the nurse on duty told us this was no longer the case.

We looked at staff training records and noted the majority of staff had not completed MCA training. This meant there was the increased risk that staff would not be aware of the principles of the MCA.

The staff training records demonstrated a large proportion of the staff team had not completed the training programme and some staff had not had recent refresher training in key areas such as risk assessment, caring for people living with dementia, incontinence care and diet and nutrition. This meant staff were not equipped with the necessary knowledge and skills to meet the needs of the people they cared for.

We found little evidence of senior staff supervising and monitoring staff competence in carrying out their role. Whilst records indicated some staff had received an appraisal of their work performance, none of the staff had received a supervision during 2015. Staff spoken with said there were so many different managers working in the home that it was difficult to follow their directions and they felt undervalued and demoralised. A nurse spoken with also told us about the pressures they were working under and told us it was difficult to cope.

The provider had failed to ensure staff had received appropriate training and supervision to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

From the second evening of our inspection, the overall level of risk to people's safety and well-being was mitigated by

Inadequate

Is the service effective?

additional staff organised by the Local Authority and the local Clinical Commissioning Group. The additional staff remained in place until all people were supported to move out of the home by 24 August 2015.

Inadequate

Is the service caring?

Our findings

We asked the people living in the home if the staff were caring. Most people responded positively. One person said, "The staff are perfect. Good people. They try to please me" and another person commented, "All the staff are very good to me and everyone else." During the three days we spent in the home we saw some instances where staff demonstrated a caring approach to people, for instance we observed a nurse was kind and gentle when communicating with people.

However one person living in the home told us some of the staff "are very kind and others are not." The person added "They don't show much affection". The person gave a recent example of calling for staff during the night to request assistance to adjust their pillows. The person told us the staff member didn't want to help and they "practically had to beg" before the staff member eventually agreed to assist.

Staff did not protect people's privacy and dignity. One person told us they felt their privacy was compromised because staff didn't knock on their bedroom door before entering. We observed several instances during our visit when we had to ask staff to adjust people's clothing to ensure they were appropriately covered. Whilst staff responded quickly to our requests we would expect these matters to be addressed without our intervention.

A relative expressed concern about their family member who prior to moving into the home enjoyed at least one shower a day. However, since moving into the home the staff supported the person to have showers three times a week. The relative explained personal hygiene was very important to the person and they knew this situation would distress them. The relative was also concerned about their family member's night wear, as despite approaching the staff on numerous occasions to explain the importance of this to the person, they had never received a response from the staff.

We observed staff interactions on both floors throughout the inspection. By the third day there was a considerable difference in staff interaction with people and the general atmosphere in the home, due to additional staff organised by the Local Authority and the local Clinical Commissioning Group. However, on our first two days we noted there was very little social interaction. We noted staff often sat at the dining tables together completing care records. We also observed staff routinely walked past people and carried out tasks without speaking to them. On one occasion we observed staff discuss the person's needs whilst standing over them, without asking the person for their views and wishes.

Whilst walking down the corridor, we overheard a person shouting from the bathroom. Shortly after this a staff member said in a stern and uncaring tone, "Stop shouting you are only having a wash". The staff member then added, "Have you finished now?" There was no further conversation and the person was offered no explanation about the personal care tasks being carried out. We reported this incident to a covering manager who immediately went to see the member of staff concerned.

We observed people were left in their rooms for long periods of time. We found one person in their room with dried faeces on their fingers and another person was sat in their room with a commode full of faeces and urine, which was causing a malodour in the room.

The provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Relatives spoken with told us they had discussed their family member's support needs, choices and preferences at the time of the preadmission assessment. They said they had not been involved in the care planning process since their family member moved into the home. None of the people spoken with were aware of their care plan. We found no evidence in the care plans to demonstrate people had been involved in the care planning process. This meant staff may not have been aware of people's wishes and aspirations.

We noted one person's care plan placed emphasis on the importance of social interaction and stimulation. On our first day we observed the person was in the lounge from 8.30 am until 10.30 am. During this time, we saw staff walking past them many times without speaking. The person's daily notes stated they were distressed, so they were taken back to bed. However, we saw no signs of distress during our observations. We noted the person was then left alone in their bedroom with the radio playing. During the afternoon we found the person crying and asked the nurse to attend to them.

Inadequate

Is the service caring?

People were provided with information about the service in the form of a service users' guide. However, the information was inaccurate and out of date. At our last inspection carried out 9 and 10 December 2014, we were told the service user guide would be reviewed and updated. However, this had not been work had not been completed. This meant people did not have access to up to date information about the home.

From the second evening of our inspection, the overall level of risk to people's safety and well-being was mitigated by additional staff organised by the Local Authority and the local Clinical Commissioning Group. The additional staff were in place until all people moved out of the home by 24 August 2015.

Inadequate

Is the service responsive?

Our findings

At 11am on the first morning of the inspection, we heard a person shouting "help" from their bedroom. The person told us they had been waiting since 9 am to be assisted out of bed. They explained they had pressed the nurse call and a member of staff had responded, but they had turned the call bell off and had not returned to help them. The person pointed to their incontinence aid which they said had not been changed since the previous night. We immediately sought staff support to assist the person. We went back to check the person at 12 midday and found them lying on their bed fully dressed, still waiting for staff to assist them to get up.

We looked at 11 people's care files and found each person had an individual care plan. We saw the initial care plan was produced by the nurse following a pre admission assessment. All care plans we reviewed contained a pre admission assessment, which covered an assessment of needs and notes on preferences for food, preferred routines, personal hygiene and appropriate forms of communication. The care plans were kept in locked cupboards on each floor. Members of staff spoken with told us they were encouraged to read the care plans and were given information about people's care needs at handover meetings.

We noted the care plans were written in a person centred way. The plans were divided into sections according to area of need and included risk assessments. They also provided details about how the person could best be supported and what was important to them. We noted people's care files contained life biographies, but these were frequently incomplete. This information is important for staff in order to facilitate meaningful conversation. Whilst there were records to demonstrate the care plans had been reviewed, there was no evidence people or their relative had been involved in the review process. We also noted one person's care plan contained out of date and inaccurate information about their physical condition. We asked for further clarification about this issue and were given conflicting information by the staff. This meant staff were not fully aware of the person's condition. We also noted one person's care plan stated they needed to change position every two hours, but their care notes indicated they were on a four hourly schedule.

A member of staff spoken with told us people were allocated a keyworker. This practice links people using the service to a named staff member who has responsibilities for overseeing aspects of their care and support. However, they added that the keyworker allocations were constantly changing and they had "not got a clue" who they were keyworker for. This meant people's care was not being overseen and monitored by a specific member of staff.

We spoke with a visiting healthcare professional who told us staff did not follow instructions given. They told us, "The staff never follow your guidelines. They will tell you they are doing one thing and do entirely the opposite." We noted many examples throughout the first two days of the inspection where staff failed to respond to people's needs in the way identified in their care plan. This included assistance with eating and drinking, pressure relief and personal care. A relative also told us, the Occupational Therapist had recommended an exercise programme for their family member, but staff at the home had "never followed this through".

We reviewed the bath /shower records and noted only three people out of 16 had been assisted to have a bath or shower that week. This meant people's personal hygiene needs were not being met.

We noted one person's social and emotional wellbeing care plan stated they were at risk of social isolation and should be included in social events in the home. However, we observed the person was left alone in their room for many hours during our inspection. We checked the activities log and found there were 11 days in June 2015 where the activities coordinator had recorded "Had a chat" or "Put music on" and apart from two entries in July there were no further records.

We spoke with relatives about their views on the activities provided. One relative told us they had witnessed their family member and other people "stultifying" due to the lack of stimulation. Another relative said the staff had agreed to assist their family member into a wheelchair, so they could go out for a walk with the family, but this "never happened" because staff left the person in a recliner chair.

The activities coordinator told us she provided a variety of activities including quizzes, armchair dance, cookery, arts and crafts, hand massage and ball games. We observed the activities coordinator chatting to people and throwing a ball. However, for the majority of our first two days in the

Inadequate

Is the service responsive?

home people were sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. We saw the lounges were left unattended by staff for long periods of time as there was insufficient staff available to support people.

The provider had failed to ensure people received person centred care which met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at how the provider managed complaints. We noted there was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. From the records seen we noted the previous registered manager had received five complaints during 2015. We saw there was a record made of the investigations and outcomes. However, three relatives raised concerns during the inspection which they felt were on-going and unresolved. One relative told us, "I don't know who to complain to because there is no manager anymore."

From the second evening of our inspection, the overall level of risk to people's safety and well-being was mitigated by additional staff organised by the Local Authority and the local Clinical Commissioning Group. The additional staff were in place until all people moved out of the home by 24 August 2015.

Inadequate

Is the service well-led?

Our findings

Staff and some relatives spoken with expressed concern about the way the home was organised and managed. One staff member described the situation as "terrible" and a relative was concerned about the high turnover of managers. We found the staff lacked leadership and management support and staff morale was low. At the time of the inspection the home was being managed by managers from other homes owned by Cuerden Developments Ltd. They acknowledged they did not have the necessary skills to provide clinical leadership to the nurses in the home.

At our last inspection on 9 and 10 December 2014, we found some records were incomplete and inconsistent. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which were applicable at the time. The provider sent us an action plan and told us what action they intended to take to ensure the regulation was met. However, on this inspection we found continuing shortfalls in record keeping. For instance care plans had not always been updated in line with people's needs, some risk assessments were incomplete and diet and fluid charts had not always been fully completed. It was therefore difficult to determine if people had received safe and appropriate care.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider is required to send the CQC notifications of incidents which affect the safety and wellbeing of people living in the home. We found there had been at least six occasions since June 2015, when safeguarding incidents had occurred, which required a notification to CQC. However, our records indicate we had not received them, despite a reminder being sent to the provider to submit these to the Commission. Notifying the CQC of incidents which affect the health and welfare of people who use the service enables us to check with the provider how these are being dealt with. It also alerts us to any emerging patterns or trends as part of our monitoring of the service.

The provider had failed to notify the commission of safeguarding incidents in the home. This was a breach of Regulations 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). We are dealing with this issue separately.

The quality monitoring programme at the service was ineffective. We found checks on how the service was operating had not been completed. The covering managers told us they had focussed on the daily operation of the service and therefore had not had time to carry out routine audits. We noted from the records seen that audits had not been completed for over six weeks.

We found there were no effective systems in place to ensure people's needs were properly monitored and reviewed to inform their care planning. We found care plans were not followed by staff in the delivery of care. Neither were there any systems in place to check monitoring charts, for areas such as food and fluid intake or pressure relief had been completed and any concerns had been acted on. We found evidence that people's care needs were not being met.

Following residents and relatives' meetings, people and their families were asked to complete a short satisfaction questionnaire. We noted questionnaires were last completed in March 2015, however there was no action plan seen to address any suggestions for improvement.

The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager left the service on 3 July 2015 and was closely followed by the deputy manager and a permanent nurse. The provider had recruited another manager, but the person was unable to take up the position. At this point, he informed us he had voluntarily suspended new admissions to the home until a new manager could be appointed and we received written confirmation of this. A new manager was recruited, but they were unable to take up the post for three months. In the meantime, the home was being managed by a director and managers from other homes in the group. This meant there was no continuity of leadership.

On 28 July 2015 a director of the operating company informed us he had problems recruiting nurses and there

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Is the service well-led?

was now a heavy reliance on agency staff. He told us he was considering closing the service, but was concerned about the people, some of whom had lived in the home for many years.

Within minutes of our arrival on 12 August 2015, the director informed us of the decision to close the home. He told us he was not able to secure nursing staff and people were no longer safe in the current situation. Relatives and staff were then informed of the decision to close the home. Following this announcement a number of nursing and care staff did not return to the home to work their planned shifts, placing additional pressures on the diminishing staff team. The registered provider submitted an application to remove the location from the provider's registration. During the inspection the director and covering managers accepted and acknowledged the standard of care was unacceptable and they worked closely with relatives and external organisations to support people to move to their new homes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not mitigated risks and failed to provide people with safe care and treatment. (Regulation 12 (1) (2) (b))**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had failed to ensure people were protected from abuse and improper treatment. (Regulation 13 (1))**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had failed to deploy sufficient numbers of suitably qualified, competent skilled and experienced staff. (Regulation 18 (1))**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider's arrangements for managing medication did not protect people against the risks associated with medicines. (Regulation 12 (2))**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The provider had failed to ensure the nutritional and hydration needs of people were met. (Regulation 14 (1))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to respond to people's changing healthcare needs. (Regulation 12)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure staff had received appropriate training and supervision to enable them to carry out their duties. (Regulation 18 (2) (a))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had failed to ensure people were treated with dignity and respect. (Regulation 10 (1))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider failed to ensure people received person centred care which met their needs and reflected their preferences. (Regulation 9)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment. (Regulation 17 (1) (2) (c))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. (Regulation 17 (1) (2))