Coverage Care Services Limited

Lightmoor View

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 30 and 31 October 2017 and was unannounced. At the last inspection completed in November 2016 we rated the service as requires improvement, the provider was meeting the regulations. Lightmoor view is a residential and nursing home that provides personal care and accommodation, diagnostic and screening procedures and treatment of disease, disorder or injury for up to 75 older people some of whom are living with dementia. At the time of the inspection there were 75 people using the service.
During this inspection we identified four breaches of the Health and Social Care Act 2008. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

People were not supported by sufficient numbers of staff. People were not always supported to manage risks to their safety. People were not always safeguarded from potential abuse. Accidents and incidents were not always managed effectively. People were not always safely supported with their medicines. People were supported by staff that had been recruited safely.

People were not always supported by staff that were knowledgeable and staff did not always have the skills to meet people's needs. People did not always receive the support they needed with their dietary needs. People were not always supported to maintain their health. People had their rights protected by staff that understood and could apply the principles of the MCA. People had a choice of food and drinks.

People did not always receive support in a way that maintained their privacy and dignity. People received support from staff that were caring in their interactions with people, however people sometimes experienced uncaring support due to staff not having the time to interact with them. People were involved in decisions and had their choices observed by staff.

People had their needs and preferences for care and support met by staff that understood them. However care plans lacked detail about people's preferences. People could not always follow their individual interests or take part in social activities. People understood how to make a complaint and complaints were responded to.

The systems in place to monitor peoples care delivery were not effective. The registered manager did not always respond to and act on feedback about the service. The registered manager had failed to make required improvements following the last inspection. Notifications were submitted as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not receive support from sufficient numbers of staff.

People were not supported to manage risks to their safety.

People were not always safeguarded from potential abuse.

People did not always have their medicines administered safely.

People received support from staff that had been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff that did not always have the knowledge and skills to meet their needs.

People's rights were protected by staff.

People's nutrition and hydration needs were not always monitored effectively.

People did not always receive support to monitor their health.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always maintained.

People were supported by caring staff, however staff did not always have time to spend with people.

People were involved in making decisions and choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always able to follow their interests or spend time doing activities they enjoyed.

People received a response to their complaints and felt they were addressed.

People's needs and preferences were understood by staff but care plans lacked personal preferences.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor care delivery were not effective.

People and staff did not feel supported by the registered manager.

The registered manager notified us of incidents.

Lightmoor View

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 30 and 31 October 2017. The inspection team consisted of three inspectors, a pharmacy inspector to look at people's medicine administration, a specialist registered nurse advisor to look at nursing practices and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Why we inspected – The inspection was prompted in part by a notification of a safeguarding incident in which a person using the service received inadequate care. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of risks and staff communication. This inspection examined those risks.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service. We also contacted the Local Authority Safeguarding Team for information they held about the service.

During the inspection, we spoke with four people who used the service and 21 visitors. We also spoke with the registered manager, the quality manager, four nurses, four senior care workers, 15 staff.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of 17 people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, staff rotas, meeting notes, monthly audits, and medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last inspection on 17 November 2016 we found there were not always sufficient staff to support people in a timely manner, risks were not always appropriately assessed and managed. At this inspection we found the registered manager had made some changes to staffing, however this had not had the required impact and whilst some risks were assessed and managed safely this was not consistent and people were left at the risk of harm.

People were not supported by sufficient numbers of staff. People and their relatives told us they did not feel there were enough staff to support people when they needed it. One relative said, "The problem is there are not enough of them [Staff] and I don't think they [staff] get any support from the management team". Another relative said, "The staff are really good here but they don't have enough time. They never have time to sit and talk to people". Another relative said, "The staff just have enough time to do the task whatever that is and they do that well". Another relative said, "I come at lunchtime as I know my [relative] will eat the food if I feed them. They do their best there just aren't enough of them". Staff had mixed views about the staffing levels; some felt there were enough staff, whilst others told us people had to wait for their care. Staff told us for example, where people were cared for in bed, or were resistant to personal care, they sometimes had to wait until the evening to have personal care when staff had time. The registered manager told us they were working to increase staff numbers.

The registered manager recognised there was not always enough staff to support people. They described improvements to staffing since the last inspection including recruiting additional staff, and deploying staff at different times. Training had been given to ancillary staff to support people at lunch time. We saw this was effective and people had an improved lunchtime experience as staff stopped carrying out their other duties at lunchtime and assisted people with their meals. However, this was insufficient to address all the concerns about staffing as it was not consistent throughout the day.

We saw from the rotas there were less staff during the evenings. The registered manager told us they did not have a system in place to allocate staff hours, this was historically how staff were deployed. One relative told us they had witnessed someone fall and they felt this was because staff were unable to monitor people in the evenings. We looked at records of falls and found there were a high number of falls during the evening. For example, we saw one person had fallen during the evening and night on multiple occasions. However, we were unable to determine if staffing levels had been a factor in the persons falls as the incidents had not been reviewed effectively. This was because the registered manager had not analysed the falls to identify why the person was falling or if the staffing was a factor.

People were left at risk due to insufficient staff. We found there was a staff presence in communal areas at all times, however staff were not always able to follow the guidance for minimising risks. One person required monitoring when eating; the staff could not sit with this person as they were helping someone else. This meant the person was left with a potential risk of choking. In another example, staff were unable to monitor one person that was at risks of falls in line with their care plan, the person was walking in the corridor and almost fell over a wheelchair that had been left by the wall, despite the care plan stating the corridors

should remain clutter free. We found staff understood peoples risks but there was insufficient staff to ensure peoples plans were followed. The staffing had not been determined based on people's needs. This meant there were insufficient staff to manage risks to people's safety.

People had to wait for their care and support. We saw one person wait for an hour to have support from staff to eat their breakfast. The meal had gone cold and the staff member had to replace it. We looked at the rotas and they confirmed the allocated number of staff per shift was available. We saw people had their dependency assessed to find out how much support they needed. However when we spoke to the registered manager they confirmed this was not used to determine the number of staff that were allocated to each shift, this was based on standard staffing hours allocated by the provider. This meant the provider had failed to ensure there were sufficient staff to provide support to people at the times they needed it. The quality manager told us on day two of our inspection that the provider had agreed to increase the standard hours for the location to make improvements to staffing.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

People were not always supported effectively when they displayed behaviours that challenged. We found plans lacked guidance for staff. For example one person displayed behaviours which could place people and staff at risk. We found there was no guidance for staff on what triggered these behaviours or what signs to look for. We found there had been a large number of incidents of the behaviour recorded. However the incident records lacked any detail which would enable staff to understand what triggered the behaviour. There had been no analysis of these incidents undertaken. We found there had been no external health support requested to see if there was more staff could do to manage these behaviours. This meant people and staff were left at risk from the person displaying the behaviours.

People were not always supported to manage risks to their safety. Risks to people were not always assessed and plans put in place to protect people. One person had been identified as being at high risk of developing pressure ulcers. We found there was no prevention plan in place; we confirmed with staff that there was no plan. We did see a skin integrity chart which stated the person's skin should be checked twice daily. We found records showed on multiple occasions the checks had not been recorded as complete or records were missing. The person had not experienced any breaks in their skin however and staff told us they would report any concerns to the nurse. This meant the person was at risk of developing pressure ulcers.

People's plans were not always evaluated following falls or incidents. For example, one person had a risk assessment in place behaviour that challenged. We found the risk assessment had not been reviewed or updated despite multiple incidents of behaviour being displayed and recorded in a behaviour chart where the person had incidents of physical contact with staff members. This meant staff and others continued to be at risk from the behaviours the person displayed. In another example, one person had two falls their risk assessment was not evaluated and updated following the falls. Another person had a risk assessment in place relating to them being in an upstairs room and a risk associated with the balcony. The person had moved to a ground floor room but the risk assessment had not been updated to reflect the change in this risk. This meant staff may not have the up to date information about how to support people to manage risks to their safety.

Peoples risk assessments were not always updated following the advice of health professionals. For example, one person had been seen by a dietician who had suspended the use of a Percutaneous endoscopic gastrostomy (PEG). A PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach to provide them with food when oral intake is not sufficient or possible. The person's risk

assessment and care plan had not been updated to reflect they were now eating and drinking normally. We spoke to nursing staff and they said this would be updated immediately. This meant the person was at risk of receiving care and treatment which had been suspended.

The provider could not be assured peoples medicines were administered as prescribed. The provider used an electronic operating system to record the receipt, administration and disposal of medicines. We found it was not possible to complete a reconciliation of medicines. This was because the receipt of medicines was not always recorded accurately. This meant the provider was not able to have an accurate record of medicine stock or demonstrate people were receiving their medicines as prescribed. We found, out of the nine people audited four of them had not received some of their medicines during October 2017 because the stock was not available to administer. For example, one person who had been prescribed an analgesic tablet did not receive their prescribed dose for three and a half days because there was none in stock to administer. We spoke with the nursing staff about the electronic system, one nurse said "It is a pain, it makes us vulnerable". Another nurse said "It makes the administration round very time consuming…. you sometimes don't realise something is out of stock until it is too late."

We looked at how controlled drugs were managed. We found one person was prescribed a controlled drug for pain relief to be administered every 12 hours. We found the medicine was not administered at the correct time. This medicine needed to be administered every 12 hours in order to gain the maximum analgesic effect. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. The person had also been prescribed analgesic medicine for breakthrough pain on an as required basis. We saw this person had been receiving this medicine on a regular basis this may have been required on a regular basis due to the incorrect administration of the analgesic patches. We could not be assured this was not as a result of the incorrect times of administration.

We found that analgesic skin patches were being changed after the prescribed time interval but some were not being rotated correctly around the body. Analgesic patches should be rotated to reduce the risk of unwanted side effects. This meant people were placed at risk of experiencing unnecessary side effects.

Where people had to have their medicines administered by disguising them in food or drink (covertly) we found the provider did not have all the required guidance in place for staff. We looked at four records and found healthcare professionals were involved in best interest decisions, there was advice from a pharmacist about how to safely prepare medicines however that there was no written information to tell staff how to carry out this process safely and consistently.

Medicines that had been prescribed on a when required basis had written information in place, however we found the information was not comprehensive enough to support staff on when and how these medicines should be administered. For example, we saw care plans identified medicines that were to be used to treat conditions like anxiety or aggression but there was no guidance for staff about the symptoms that would be experienced by the person or when to administer the medicine. This meant people were at risk of not receiving or receiving too much of this medicine.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People and their relatives told us they felt safe using the service. Staff had received training in safeguarding adults and could describe the signs of potential abuse. Staff could tell us about the action they would take if they observed an incident or activity they felt was potential abuse and how to contact the local authority safeguarding team if the situation was not investigated. Staff told us that they felt able to approach the

registered manager if they had concerns. This meant people were supported by staff who understood how to safeguard them from potential abuse.

However we found investigations were not always carried out and incidents were not referred to the local safeguarding authority. For example we found four incidents which had not been investigated these included where people had sustained injuries and been assaulted by other service users. We spoke to the registered manager about these and they were unable to explain why the incidents had not been reported to the safeguarding team. The registered manager told us they would refer them to the safeguarding team straight away. We were notified this had been done the day after the inspection. This meant people were not always protected from the risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding people from harm.

People told us, they felt supported to stay safe. One person said, "I have just started to walk again, one of the staff come in to give me support whilst I walk a little way along the corridor, all the staff have been excellent and if it wasn't for them I wouldn't be walking at all". Staff told us they understood the risks to people and could give examples of how they supported people. For example how equipment was used to keep people safe and how they monitored people.

Where people needed to have their medicines administered directly into their stomach through a tube we found the provider had ensured that the necessary information was in place to ensure that these medicines were administered safely and consistently. We found that the provider had written protocols in place to inform staff on how to prepare and administer the medicines, which promoted safe administration. All medicines were being stored securely and at the correct temperature. Controlled Drugs were stored correctly and their administration was recorded accurately.

People received support from safely recruited staff. We saw the provider ensured checks had been carried out before new staff started work, which included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the service was effective. People were supported by knowledgeable staff and had their rights protected. People had their needs and preferences for food and drinks met and received support to manage their health conditions. At this inspection we found the service required some improvements in how people were supported to manage their health conditions.

People and their relatives felt there was a good choice of food and drinks. One person said, "The food is lovely and you get options for dinner and for pudding, there are lots of vegetables too". Another person said, "The food was delicious and I am full to bursting". One relative said, "I have sampled the food and it was very tasty, my relative is enjoying the food also". We saw menus were in place which showed pictures of the meals which were on offer, we saw staff using these to find out what people would like to eat. People had their nutritional and hydration needs assessed and care plans were in place. Staff could describe where people had specific needs for food and drinks. They understood the risks associated with food and drinks. For example where people had a risk of choking they could describe the advice given by the Speech and Language Therapy Team (SALT) and how they followed this. We saw staff follow the advice and confirmed this was correct in peoples care plans. We saw records which showed staff recorded what people ate and drank. However this was not consistent and staff were not always following the care plans in place. We found one person required their weight monitoring as they were at risk of malnutrition, this had not been completed for four weeks. There was no sign of weight loss or impact for this person. This meant that whilst staff understood people's risks and the plans in place to support them they were not always following the guidance for keeping people safe.

People and their relatives told us staff supported people to meet their health needs. One person said, "Doctor comes to see me when I need them to". A relative said, "[Persons name] had a fall, they fell backwards coming in off the balcony, and had a gash on the back of their head and was taken to hospital". Staff told us they supported people to manage their health conditions and could give examples. One staff described how a person's blood sugar was monitored due to their diabetes. Another staff member told us about acute care plans being used to identify where someone had an illness or infection to guide staff in providing support. We spoke to a visiting health professional and they felt there was inconsistency in the management of health concerns and things may be missed. They told us they felt this was because there were insufficient numbers of staff.

We observed staff seek support from a medical professional for one person. The person was diagnosed with a chest infection and staff put an acute care plan in place straight away. We saw these had been effectively used for people with a range of presenting health conditions and the staff had followed these for people to ensure their health needs were met. However we found external health professional support had not always been sought. For example one person was struggling to remain in an upright position in a chair. Staff had tried various different approaches to assist the person to remain upright but these had not been successful. We found there had been no support sought to assess this person's needs from any health professionals. When we spoke to the registered manager about this they arranged for a health professional to see the person. In another example a person was falling over frequently, staff felt this was due to the person's

dementia, however no health advice had been sought for this person and they continued to have falls. This meant people were not always supported to seek advice from health professionals.

People and relatives told us staff were skilled in their role. Staff told us they received training in aspects of their role. One staff member described receiving training in supporting people when they displayed behaviours that challenged and safeguarding. Another staff member told us they received spot checks to test their competency for areas such as medicines administration. Staff confirmed they had an induction and this was effective, the records we saw supported this. Staff told us they received supervision and this helped them to understand their role. One staff member described how they had attended an "awareness of dementia" course and how this had taught them simple ways of supporting people more effectively. They described how using different techniques to reduce the noise levels for people with dementia. We found staff were considerate about noise and people were calm and relaxed. We saw there was a training plan in place and staff had received training in safeguarding, fire safety and moving and handling for example. We observed staff were using the skills they had learnt to support people safely for example when supporting people to move and be repositioned. This meant people were supported by suitably skilled staff.

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

People told us staff asked for their consent when giving care and support. Staff understood the principles of the MCA and could describe how to seek consent and how they made decisions in people's best interests where they lacked capacity. We observed staff ask for consent before carrying out care and support tasks. For example, we observed staff seek consent where people needed assistance. For example, staff used terms such as "Can I help you with that" when supporting with care. They asked people, "Are you comfortable", when repositioning people.

When people may not have capacity to consent an MCA assessment had been carried out for the decision required. Best interest meetings were held with the appropriate people attending and decisions were recorded for example where people were required to have their medicines administered without their knowledge. In these cases discussions had been held with doctors, pharmacists and family members. This showed people received support in line with the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw where people had been deprived of their liberty applications had been made to the local authority. Authorised DoLS were in place and understood by staff and care plans reflected the information from the approved DoLS. This meant where people's liberty was restricted it was done in line with the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found people's privacy and dignity was not always observed, staff were not always caring and people could not always make choices and decisions for themselves. We asked the provider to make improvements. At this inspection we found they had made some improvements but because of the lack of staff available this sometimes impacted on staff being able to be caring in their approach and impacted on people's dignity.

People and their relatives told us they felt the staff were kind and caring. One relative said, "Some of the carers are so fabulous, kind and so caring". Another relative told us, "The staff are all lovely and they do care. The problem is they can't do everything". Staff told us, they understood people's needs and took time to get to know them. We observed staff having positive interactions with people throughout the inspection. We saw staff using different ways of communicating with people that had difficulties, such as touch and visual prompts. Staff ensured they were at eye level with people who were sitting down and altered their tone of voice. We saw staff interacting with people whist they were giving them their care and support, offering explanations for what they were doing and giving reassurance. However due to having insufficient staff there were times when staff were unable to provide support which was caring. For example, one person was anxious and walking around the corridors, they were visibly upset. The staff were busy supporting other people and could not immediately support this person. Staff made every effort to get to them and we saw once staff spent time with the person they calmed down and relaxed. In another example, one person was sitting alone at the table for breakfast. The person became withdrawn and eventually fell to sleep without eating their breakfast. The staff member tried hard to engage the person but they were busy supporting another person to eat. At the same time a further three people were waiting for support from staff. Staff provided encouragement eventually to the person and they ate their breakfast. This meant that whilst staff were kind and caring, sometimes people experienced delays in getting the support they needed due to the lack of available staff which was distressing for them.

People were not always treated with dignity. We found two people had been left in undignified positions during the inspection, both were soaked in urine. The registered manager said they would investigate these concerns. Staff told us with one person they had not noticed the people had been left with urine on their clothing. This meant peoples dignity was not always maintained as there was insufficient staff to ensure people's needs were met. However we did receive positive feedback about dignity and privacy. One relative said, "I am more than happy that the carers are respectful of [my relatives] privacy and dignity". We also found staff understood how to support people with dignity. For example, A staff member told us about one person that had been reluctant to sit and eat their meals and would keep getting up and walking away. The member of staff sat with the person at a table and ate their meal at the same time. We saw this was effective in encouraging the person to sit and eat their meal. We made some observations that staff treated people with dignity and respect. For example, we saw staff were discreet when people needed assistance. They offered people reassurance and responded calmly and sensitively when engaging with people. We observed staff knocking doors and ensuring doors were closed when helping people with their personal care. We saw staff were sensitive when using distraction techniques. This meant staff considered people's privacy and dignity when people received care and support.

People were supported to make choices about their care and support and maintain their independence. People and their relatives told us they were able to make decisions for themselves. Staff told us they offered people choices and supported them to maintain their independence. We saw staff gave people specialist plates and spoons at lunchtime so they were able to eat their meal without support. We saw staff offered people choices throughout the inspection. For example people were given a choice of hot drinks, juices and milk shakes throughout the day. We saw staff supporting people to choose their meals using pictorial menus. Staff offered people a choice of joining in activities that were taking place and where they would like to spend their time. We saw one person was supported to eat snacks from the kitchen work surface. Staff explained this was how they preferred to have their food. The person was happy standing to eat their snack and smiled at staff when they placed the snack in front of them. This meant people were able to make choices and retain their independence.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found people received support from staff that understood their needs and preferences. People's complaints were not always responded to and people did not always have an opportunity to follow their interests. At this inspection we found complaints were responded to and the provider had employed staff to support people's interests, however this was limited and further improvements were required.

People and their relatives were involved in assessments and care planning. One relative told us, "I was involved with my husband's care planning and I check it regularly to see if his needs are up to date". Staff told us they had an opportunity to read care plans and they used these to follow what support people needed. We found people had their needs assessed and care plans were put in place to support people to meet their needs. We saw records were completed which showed the daily care that had been delivered and where appropriate people had charts in place for repositioning or their fluid and food intake. However, we found this was not consistently followed by staff. We saw one person had a repositioning chart as they were at risk of pressure sores. The chart showed staff had not repositioned the person at the frequency set out in their care plan. We saw fluid charts which recorded a target for fluids, when one person had not met the target we found no action had been taken to review the person's needs. Reviews were recorded as having taken place on a monthly basis however the reviews did not indicate how people's views or the views of others were included in the review. Some care plans lacked the detail required to support people effectively. For example, one person had a PEG feed in place; whilst the plan was clear about emergency situations there were no records in place for daily cleaning to prevent infection. We saw the site had become infected treatment had been sought by staff, however the plan was not reviewed at this point or in the two months since the infection occurred.

People's preferences were understood by staff. One relative told us, "I do feel they know my relative well. It is quite disruptive for [person's name] when they change the staff round, consistency with care is better. [My relative] is fond of a lot of the staff and gives them a kiss when they recognise them. We were asked to do a life history book and I know the staff have looked at it". Another relative told us, "The staff are great, lovely and caring. They are interested in their life history, I found a paper cutting with an article about [my relative], and I have bought it in so the carers can have a look". Staff told us they understood people's needs and preferences and could give examples of how they established what people wanted. For example one staff member said, "Some people can't tell you what they want or what is wrong, but you can tell by the little changes in their behaviours". We saw staff understood people's routines and could offer people their care in a way that they preferred. Staff demonstrated an understanding of people's likes and dislikes. This meant staff offered personalised care. However we found care plans lacked this detail, they were task orientated and focussed on problems rather than people's individual health and wellbeing. We found assessments and care plans were in place for people's sexuality. However these had been used to document preferences for clothing and makeup, which the registered manager confirmed was not the intention of the care plan. We found care plans lacked information about how the staff would support people with protected characteristics. The registered manager told us the provider was looking at reviewing care plans and this would be addressed. This meant improvements were needed personalise peoples care plans.

People were not always supported to follow their interests and spend time taking part in social activities. One person told us, "I don't want to go to the lounge if there are things going on, I am happy with my word search, I can't be doing with the TV or the radio either, the staff always come and ask me if I want to come up and join in though". One relative told us, "There are three activities staff but I don't know what they do exactly, the other day the activity was for a staff member to carve a pumpkin, that's it. There has been a 40's weekend where people dressed up, there has been a singer and they do play bingo occasionally". Staff told us there was little time to support people with their interests. Staff felt some of the activities on offer were not suitable for the male residents. They explained they felt many of the male residents would benefit from having more to do. Staff described plans to raise funds to provide a shop in the grounds manned by volunteers as this would enable the men to purchase a newspaper. The staff were hopeful this would be accepted by the management team. We saw activities coordinators had planned a programme of activities for people. However many people were not able to participate in the planned activities and although information had been gathered about what people liked this did not appear to influence the activities on offer. We saw two people were sat with two activities staff and were being encouraged to use crayons to colour a picture. Both people seemed not interested in the activity. We found those people being care for in their bedrooms had very little stimulation and were at risk of isolation. This meant improvement was needed to how people were supported to engage in meaningful activity.

People and relatives told us they felt confident their complaints were investigated. One relative said, "I complained about staff not positioning my relative correctly and it has improved". We saw one relative make a complaint to the registered manager on the day of the inspection. The relative was taken to a private area to discuss their concerns, which the registered manager documented and said they would investigate. We saw records of complaints which showed how the complaint had been investigated and there was a copy of the response given to the complainant. This meant people understood how to make complaints and these were investigated and responded to.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the registered manager could not be assured peoples care records were completed robustly. We found the quality audits were not always effective at identifying issues and driving improvements and the registered manager did not have a system in place to check there were sufficient numbers of suitably trained staff. At this inspection we found improvements had not been made and some further aspects of the management of the service were not effective.

The provider had failed to ensure there were sufficient numbers of staff available to support people. The registered manager told us the dependency assessments carried out for people were not linked to the staffing available to support people, these helped to understand the level of support people needed individually. Staffing was determined by the number of hours available and the budget in place. The registered manager had taken action to deploy staff differently at lunchtime. The registered manager had identified there were insufficient staff and was in the process of undertaking recruitment and looking at how to deploy staff differently. However we found this had not addressed the concerns we found during this inspection which left people at risk of not having their care and support when they needed it. The provider told us during the inspection that this would be addressed immediately and additional staffing would be made available.

The impact of having insufficient staff meant people were not always receiving a caring service. The registered manager did not have effective systems in place to identify these issues and plan for improvements. For example, people were not consistently supported in a way that maintained their privacy and dignity and staff were sometimes unable to offer caring support. The systems in place to look at the quality of the service people received had not identified these concerns. This meant the registered manager had not taken any action to address these concerns.

The registered manager carried out management audits to check the quality of the service people received. We looked at these audits and found they had not identified the concerns we found during the inspection. For example, the care plan audit system had not identified the concerns we found with people not receiving their care and support in line with their care plan and people were left at risk of harm. In another example, risk assessments were not being followed by staff and had not been reviewed following incidents and changes to people's needs. This left people at risk of harm.

People were not being supported to seek advice from health professionals when they needed it and the audit systems in place had not identified this to enable action to be taken. Medicines audits were not effective in identifying the issues we found with medicines, this was despite the management team carrying out daily audits to check people had had their medicines and stocks were not running low. The medicines audit process took considerable time to complete and this meant there was less management time for other aspects of peoples care.

The registered manager did not have systems in place which were effective in assessing and monitoring the quality and safety of care or to mitigate risks. There was no action taken to analyse accidents and incidents.

We found one person had experienced multiple accidents. The registered manager confirmed no action had been taken to analyse the accidents. Action was taken immediately after the inspection to seek an external review for this person. Failure to review accidents and incidents could lead to preventable incidents taking place. We found four separate incidents which we prompted the registered manager to report to the safeguarding authority following the inspection. The registered manager notified us after the inspection that they had reported the incidents as requested. The registered manager had failed to investigate safeguarding incidents and report them to the appropriate body. The registered manager understood what the requirements were and was unable to explain why these had not been reported.
People and their relatives told us the registered manager did not always listen to or act on their concerns. Relatives told us they had raised their concerns about the insufficient staff available to support people but no response was given and no action was taken. Relatives felt the management team did not really get involved in the units and listen to what people had to say. One relative said, "It is always the staff that contact us if something unusual happens and we need to be notified". We spoke to the management team about this and they told us they spent time on the units. However, staff told us, the management team were supposed to assist with the nursing tasks, but this did not always happen and staff were concerned as this meant there were sometimes insufficient nurses to meet people's needs. One staff member told us, "I don't feel supported by the management team, they are not approachable, I feel they do not acknowledge the staff and spend no time with us". We saw the deputy manager was available to support with nursing tasks during the inspection. This meant people, relatives and staff found the management team were not always responding to their concerns.

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

The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with the law. Services that provide health and social care to people are required to tell us about important events that happen in the service, we use this information to monitor the service and make sure the service is keeping people safe.