Quality Care UK Limited

Bay View

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

Overall summary

This inspection took place on 10 December 2014 and 5 February 2015 and it was unannounced. At our last scheduled inspection on 16 April 2014 the service was in breach of regulations 15: safety and suitability of premises and 10: assessing and monitoring the quality of service provision. We visited the service again on 23 September 2014 where we judged the service to be compliant with the breaches in parts of the premises that people used and because improvements had been made to the quality assurance system. However, we judged that the service required more time to further improve and sustain compliance in both regulations, and therefore planned to visit the service early in our inspection programme using the Commission's new methodology for inspection, under the five domains.

Bay View is registered to provide care and accommodation to a maximum of 23 older people who are vulnerable because of their age and illness only. There are 21 single occupancy bedrooms and one shared occupancy bedroom on three floor. There are two lounges and a dining room for people to use. There is a passenger lift to the upper floors.

At the time of the December 2014 visit there were four people living there permanently and one person staying there on a respite basis. At the time of the February 2015 visit there were four people living there permanently and four people staying there on a respite basis, but one of these was in hospital.

Summary of findings

There is a registered manager in post who has managed the service since it was registered under Quality Care UK Limited in August 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not safe because of unsuitable premises, poor care practices related to people's mobility and care that was not guided by clear care plans and risk assessments. It was not safe because of minimum staffing levels on duty, with no ancillary staff employed, because infection control practices were poor, fire safety systems were lacking, staff recruitment practices were inconsistent with regulation requirements and medication systems were incomplete.

We saw that the premises had not been made safe in all areas of the service, despite the registered provider having been given more time to ensure it was upgraded and repaired to a safe standard since September 2014. The provider had failed to ensure gas, electric and fire maintenance certificates were up to date, which put people at risk of harm from incidents relating to fire safety. There was an en-suite toilet door hanging from one hinge, which could have fallen on anyone at any time. There were two unlocked bedrooms with stored, stacked furniture in them, which could have fallen on staff or people that used the service and there were wardrobes without safety fixings which could also have fallen onto staff or people.

We saw staff carry out a banned lifting technique to transfer a person from their wheelchair to an armchair. We saw that care plans and risk assessments were statements of need without clear action plans (or information) to instruct staff on how best to care for people to meet their needs and to reduce the risks they faced because of frailty and illness. Care plans and risk assessments were not being properly followed to ensure people received the care and support that they had been assessed for.

We saw that there was only two care staff and no ancillary staff on duty in the service, to care for people, cook and clean, which meant when they were both assisting people with mobility, or in the bath, other people were left unsupervised. We saw that people with nutritional requirements were not having their needs met through use of monitoring of food/fluid intake and taking action to involve dieticians and specialist healthcare professionals.

Infection control practices were lacking: there were no paper towels for people to use, headboards, seat cushions, mattresses and duvets were all permeable and non-washable. Floor surfaces were damaged and difficult to keep clean, a communal fabric bathmat was in use and clean towels were stored in the main assisted bathroom.

We found that fire safety systems were not being maintained to ensure people's risk from fire, because there was no fire risk assessment in place, no personal emergency evacuation plans available, no annual check of the fire detection system carried out and at least one bedroom fire door was ill fitting and would not have held a fire back in the event of such an emergency. There were combustible materials and equipment stored in two bedrooms on the first floor and under both stair cases on the ground floor of the property.

We found that the service had not followed a robust recruitment procedure and had taken on staff that met the criteria under our regulation on 'requirements relating to staff'. Staff had started working at the service without proper security checks (Disclosure and Barring Service clearance and references). Staff hadn't properly completed job applications, the registered manager had no records of staff identities, their recruitment interview or details of their conduct and performance in their last job. The registered manager told us they had spoken to the previous employers of staff in an effort to obtain details of their suitability to work with vulnerable people, but we knew as fact that these employers had been non-operational for some two years.

The registered manager's fitness under regulation 6: Requirements relating to registered managers, in respect of their integrity and the skills to carry out the management of the regulated activity were in question.

We found that in the provider was in breach of eleven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in total (one of them twice). These were in relation to care and welfare, staffing, safety and suitability of the premises, infection control, requirements relating to workers, management

Summary of findings

of medicines, supporting workers, respecting and involving people, meeting nutritional needs, cooperating with other providers and assessing and monitoring the quality of service provision.

You can see what action we told the provider to take at the end of the full version of the report.

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. At our site visits people were not assisted safely with their mobility, staffing levels were inadequate to meet people's needs, the premises did not meet safety requirements, recruitment practices were poor and medication was not handled safely. There were breaches of regulation in all of these areas.

The provider was in breach of six regulations: 9, 22, 15, 12, 21 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This meant that people who used the service were at risk of harm or injury from unsafe transfers, inadequate staffing levels, unsafe premises, unsafe recruitment of staff and unsafe medication management systems.

Is the service effective?

Inadequate

The service was not effective. People received care from staff that were inconsistently inducted, not fully trained and poorly supervised. People's rights to be independent and autonomous were not always upheld and people were not fully included in the decisions about their care and treatment. People's nutritional needs had not always been satisfactorily addressed.

The provider was in breach of three regulations: 23, 17and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This meant that people were at risk of receiving poor care from poorly supported staff, they were unable to be fully autonomous and they were at risk of harm from poor nutrition.

Is the service caring?

Requires Improvement

The service was caring. People were spoken to respectfully by staff and staff made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions.

This meant that people who used the service were treated kindly but did not always experience independence and autonomy in their daily lives.

Is the service responsive?

Requires Improvement

The service was not responsive. We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information to help meet people's needs. The complaint procedure was not readily available to people and cooperation with other organisations was inadequate so that people did not always receive the care and treatment they required in a timely manner.

The provider was in breach of two regulations: 9 and 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

This meant that people who used the service were at risk of not having their needs met safely, their complaints heard or their health care needs met by other providers, in particular healthcare professionals.

Is the service well-led?

Inadequate

The service was not well-led. The registered manager had not used quality monitoring systems to ensure service delivery was safe or effective. There was no vision and no clear values for staff to aspire to. The registered manager indicated to us that they did not fully understand the responsibilities of their registration or role. They did not fully demonstrate good integrity and honesty. There was poor and inaccurate information available to people.

The provider was in breach of one regulation: 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This meant that people who used the service did not have the benefit of a service that was well run, well managed or well delivered, and so their needs might not be met safely in a situation where staff aspired to improving the quality and safety of care.

Bay 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 checked 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.

The inspection took place on 10 December 2014 and on 5 February 2015 and was unannounced. Our first site visit identified several areas of concern that we judged to be putting people at risk of harm. Our second site visit was to establish whether or not the provider had made any improvements in the safety and quality of the care provided, the safety of the premises and the staff selection procedures. All of these, and other areas had been identified as either an actual or potential risk to people that used the service. These concerns are listed in our summary inspection report but can also be found in full detail in this inspection report.

The inspection team consisted of two Inspectors and an Expert-by-Experience in December 2014, and two inspectors in February 2015. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The area the Expert-by-Experience is experienced in covers care of older people who have dementia.

We had not requested a 'provider information return' as the service was inspected according to need based on our previous scheduled inspection in April and the follow up inspection in September 2014, on information we had received from a member of the public and on information we had received from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department.

The Expert-by-Experience spoke with all five people that used the service, our Inspectors spoke with two people that used the service, a relative and two staff (one was a senior), as well as the registered manager, in December 2015. Our inspectors spoke with staff and the registered manager only in February 2015. We did not use a Short Observational Framework for Inspection as all of the people that used the service had capacity and we were able to communicate with them.

In December 2014 we observed some of the care and support staff provided to people and we listened to the interactions between people and staff. We also looked at records held in the service; three about people and their care, three staff recruitment files and those records pertaining to the running of the service (quality assurance documentation, maintenance certificates, policies and procedures and the Statement of Purpose, for example). We also looked around the premises with people's permission.

In February 2015 we looked at two care files, two staff recruitment files, all of the quality assurance system documents presented to us and details of a recent Humberside Fire and Rescue Service inspection. We also looked around the premises. We spoke with a visiting District Nurse employed by Humber Mental Health Trust to obtain information and we later contacted the East Riding of Yorkshire Council Contracts Monitoring Department.

The officer of the ERYC who we spoke with told us they had been monitoring the service with regard to staffing levels and care and welfare of people that used the service. Between the times of our two site visits we were informed by ERYC that they had issued the service with an 'improvement order' and placed a restriction on placements to the service. Following our site visits ERYC provided us with information about a safeguarding alert they had made.

Inadequate

Is the service safe?

Our findings

The service was not safe. At our site visits people were not assisted safely with their mobility, staffing levels were inadequate to meet people's needs, the premises did not meet requirements, recruitment practices were poor and medication was not handled safely. There were breaches of regulation in all of these areas.

10 December 2014.

People we spoke with told us they felt safe living at Bay View. They said, "I have no qualms whatsoever, I feel very safe here", "I feel safe to an extent" and "Yes, it's lovely. They're (staff) very nice." One person told us they had recently had some money missing, which we mentioned to the registered manager and staff. They told us the person often had staff looking for things that had gone missing. Staff acknowledged this was upsetting for the person and that it was important they were respected at these times. One of the staff we spoke with said, "Staff are very kind with the people here who can be a bit confused at times. I'm a trained nurse and I've never seen anything that would worry me."

We saw that people had risk assessments in their care files to reduce the risks to them when being cared for by staff. They referred to managing people's medical conditions, mobility, falls and transfers from one place to another.

One person had a risk assessment for when staff transferred them with the use of a lifting hoist. It stated all transfers were to be carried out by two staff using the hoist. However, we observed two care staff manually lifting the person using an unsafe lifting technique. This was brought to the registered manager's attention who had informed us earlier that the person was assisted to move using lifting equipment. The registered manager gave further explanation that the person refused to be moved using lifting equipment and said this had been a difficult situation to address, as occupational therapist and physiotherapist advice had been sought unsuccessfully.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We were told by the registered manager that staffing levels were reduced to a minimum of two staff on duty throughout the day and night (with one waking and one sleeping at night). The registered manager told us they worked three days a week (Monday to Wednesday inclusive) managing, during which time they also assisted with some care and cooking. The rosters showed that on Mondays, Tuesdays and Wednesdays there was only one care staff on duty from 9 am to 5 pm. We therefore concluded that the registered manager was the second staff member on duty those days and when we asked the staff they confirmed this. A senior care staff confirmed they always worked the same shift as the registered manager, when there was the two of them on. Rosters showed there was a minimum of 336 hours, manager and care combined, provided each week, which was the equivalent to two staff on duty over 24 hours, 7 days a week.

We were told by the registered manager there were no ancillary staff employed. The rosters confirmed this. Therefore staff completed all cleaning, cooking and caring tasks within the service. This meant people that used the service had insufficient care hours allocated to them to ensure their needs for social activities were met at any time. It meant care and other needs were not met when staff were cooking or cleaning or providing two to one care, as when helping people to transfer or to take a bath.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

On the day we inspected there were four staff in attendance because people that used the service were going out for their Christmas party. Four staff and five people vacated the premises at lunch time, as did the inspection team, and the premises were locked up. This was not a typical day at Bay View. Normally there were two care staff on duty, one of these could have been the registered manager.

Entrances to the premises were kept locked at all times when people and staff were in the building. Locks were operated by digital key pads. People and visitors were not given the codes routinely.

On looking around the premises we found there were some aspects of the environment and infection control that were a risk to people that used the service.

Environment risks included a bedroom en-suite door hanging dangerously from one hinge, which the registered

Is the service safe?

manager was told by us to have repaired as a matter of urgency, because the bedroom was occupied. The registered manager told us the occupant did not use the en-suite independently, but we had serious concerns for their safety.

There were also risks to people's safety because of the stacking of eleven unused armchairs and an unused lifting hoist stored in an unoccupied bedroom, which was not locked. There was a broken toilet cistern in this room so it was not fit for use. Other bedrooms which were unlocked were also used for storage of beds and other unused items of furniture.

There were wardrobes in use in people's bedrooms without wall fixings which were at risk of falling forward onto people. One bedroom had a badly fitting fire door, which meant there was a risk to people in the event of a fire. There was a split in the carpet on one of the landings, which was a trip hazard to everyone. When we asked the registered manager for a copy of the most recent passenger lift maintenance certificate this was not provided to us as the manager was unable to find one.

We saw that there were other issues with the environment: these included a constantly dripping cold water tap, a broken light pull, old and worn floor coverings in bathrooms and toilets, and broken toilet seats. Two bedrooms had badly fitting window frames which meant outside air leaked in, making them very cold rooms. One bedroom had a noisy toilet extraction fan and another bedroom had a broken toilet extraction fan. One bedroom had an en-suite toilet that was unfit for use (suite not plumbed in and light removed from the ceiling in a state of disrepair). All of these issues meant people did not have suitable premises in which to live.

We were told by the registered manager that there was no fire risk assessment in place for the service. They said people that used the service did not have 'personal emergency evacuation plans' in place. When we asked to look at a current five year electrical safety certificate this was not supplied as the registered manager told us they could not find one. The most recent evidence of a fire alarm safety test carried out by a competent person was dated 10 February 2013.

There was a lack of a fire safety risk assessment, no plans in place to aid people to evacuate the building, no current electrical safety certificate and a fire alarm safety test that had last been completed twenty two months ago significantly raised the risk of people being harmed in the event of a fire. We passed this information to an officer of the Humberside Fire & Safety Rescue Service, who undertook to carry out a fire safety inspection.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

Infection control practices within the service also raised concerns so that risks included fabric headboards on beds (in vacant rooms and in four of the five that were occupied), non-washable, seat cushions, mattresses and duvets, absence of paper towels in toilets (linen towels in use), suspected communal use of bathroom toiletries, stains under the bath seat, communal use of a fabric bathmat, clean towels being stored in the bathroom and broken tiles in the bathroom. All of this meant people were at risk of cross infection from poor infection control management.

We saw in correspondence from the Environmental Health Officer (EHO) that a food safety inspection had been carried out on 16 September 2014 when a rating of 3 from 5 had been given, 5 being the best rating. Contraventions of the food safety standards had been found; cleaning schedules were not completed, some food was past its 'use by' date, fridge temperature was too high, the freezer store was not clean and cooked foods were touching raw foods in the freezer. We saw no documentary evidence that any action had been taken to ensure these issues had been corrected and we did not check to see if these findings were still on-going. Our discussion with the registered manager revealed there was only them and one other staff with a valid food hygiene certificate, but all care staff handled food in the kitchen when they were on duty.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We found staff files contained evidential information that staff were not recruited safely. Two files contained Disclosure and Barring Service (DBS) checks that had not been carried out by the provider for the staff to work at Bay View. We put this to the registered manager who told us they thought DBS checks were transferrable. DBS checks

Is the service safe?

are only transferrable if they meet certain criteria; which we understood the registered manager and provider were aware of, as the registered manager had shown us an email print out in September 2014 making this clear.

One of the DBS checks held by Bay View was for a new staff member that had worked in the building under a previous provider and it was dated 2011. Their application had no details for referees and there were no references. The registered manager explained the person had not yet begun working at the service but we saw in their file that they had already completed an induction dated 9 December 2014 and their name was on the roster to work on the 18 December 2014.

A second staff file showed the person had a DBS dated 2014 for a position with another organisation working with children, which they had not secured. There was no information about references on their application form but one reference had been obtained from a previous employer and was satisfactory. The other reference was obtained via the telephone from a friend and after the person had started working at Bay View.

A third staff file showed the person had a DBS dated 4 December 2013 for a position working with children, but the references available were from an employer they had not worked for since 2010 and one from a friend. The registered manager told us the date that one staff had started working, and we saw that this was six days before they had completed and signed their application form.

This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We looked at the service's records, procedures and practices for handling medication. We found there were no controlled medicines held and taken by people that used the service so there was no need for a controlled drug register. There were risk assessments in place for individuals for managing the taking of medication.

A medication trolley was kept in the office and a medicines refrigerator was available in the office for drugs and creams requiring cold storage, but there were no checks made on the temperature of the room. This did not help to ensure medicines held in the trolley were stored at a safe temperature.

A monitored dosage system was used which helped people to receive the correct medication doses at specific times and there were medication administration record (MAR) charts for recording when medicines had been administered. MAR charts were appropriately completed but had not been completed for lunch time on the day we inspected. This was because all five people had gone out for Christmas lunch and it was planned they would take their medication later. This was an exceptional circumstance that happened rarely.

We were told by staff that one person self-medicated and kept their tablets in their bedroom. However, we found there was no lockable facility for them to keep medicines in, they had no MAR chart in place and there was no risk assessment in place to show they had been assessed to self-medicate and risks had been reduced.

We saw there were no photographs of people held with MAR charts to help staff identify people when administering medication and so there was a risk that people might have been given the wrong medication.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

The registered manager told us there was no written 'business continuity plan' incorporating emergency procedures for staff to follow in the event of an emergency. They said, "Staff know what to do in an emergency." They offered no evidence to support this. This did not ensure staff had clear guidelines to follow in the event of any emergency and so people could be at risk at such times.

We looked at accident records for people that used the service and found they recorded insufficient detail to evidence that the right action had been taken with people following an injury. Records showed what staff saw when they attended to people following an accident, what injury they had sustained and what staff did to assist them from the floor, for example. Records did not state what care, attention or treatment people had received, particularly where one person had sustained a cut to the elbow. This did not show that people were treated appropriately following an injury.

We saw in staff files they had completed level one and two training in Safeguarding Vulnerable Adults (SOVA) in May 2014. Discussion with staff revealed they understood the

requirements of safeguarding procedures and knew how to pass information to the appropriate organisation. The registered manager told us they had completed the local authority's safeguarding training for managers, but had not yet completed their new 'safeguarding threshold tool' training.

The safeguarding records held by the service showed there had been one safeguarding referral made to the local authority's safeguarding adults' team in July 2014 which had been addressed.

Further discussion with the staff followed and they told us they knew about whistle blowing. One staff member said, "If I was unhappy about something to do with the residents and had spoken with the manager, but it had not had been resolved I would then speak to CQC."

05 February 2015.

At our site visit in February 2015 we found there had been some improvement to service delivery.

Slight improvements had been made in that care plans and risk assessment had been reviewed, photographs of people had been taken to add to documentation and the manager had become supernumerary on her days at work. We saw that there was evidence of hoist maintenance carried out on 7 September and 18 December 2014. Two gas engineers visited the service on 5 February 2015 between 3:22 and 3:40 pm to service the gas boiler. They issued a landlord's gas safety certificate, which we saw.

People were still not assisted safely with their mobility in every case, staffing levels were still inadequate to meet people's needs, the premises still did not meet safety requirements and recruitment practices were found to be worse than before.

We asked the registered manager if the person that had been lifted unsafely in December 2014 had been assessed by the occupational therapist (OT) since the visit and were told this had taken place on 4 February 2014 when they had been assessed for a different type of hoist sling, which the OT had advised should be used. We heard the person ask staff to change their position in the armchair and observed two staff members manually assist them with a positional change using a blanket they were sitting on. We observed another person finding it difficult to transfer independently from their wheelchair to an armchair and after three attempts and the introduction of the person's walking frame to pull up on, they managed it. Staff stood close to assist if needed but did not manually lift them.

We saw on the rosters that when the registered manager was on duty another staff member had been added to work on shift, which meant there had been an improvement in staffing levels to enable the registered manager to carry out more managerial tasks. However, there was no improvement in ancillary staff and so staff were still completing the same responsibilities they had in December 2014.

We found that the premises still had no fire safety certificate and no electrical safety certificate.

When we asked the registered manager about a fire system safety certificate they showed us the letter they had received from the Humberside Fire & Safety Rescue Service following their visit carried out on 30 January 2015. We explained this was not a maintenance safety certificate, but a list of recommendations by the fire officer in order to achieve compliance with fire safety regulations.

We found that the premises were still in a state of disrepair because of poor maintenance, decoration was poor and in some areas the premises were dirty. Of the first six bedrooms we inspected (four on the ground floor and two on the first floor) one had a dirty toilet bowl and two had unpleasant odours in the en-suite toilets (both were wet, presumed to be urine in one because of the odour and the other looked like there was a leak from the plumbing). One bedroom had remnants of faeces in the commode pan and one bedroom had some stains on the bed linen. Bedrooms had not been vacuumed and so they looked dirty. One bedroom had a six foot set of step ladders open ready for use, there was a five foot fluorescent strip light bulb propped behind the door (the one in the ceiling did not work) and the furniture looked old and worn (the bed was not of a cleanable and therefore infection control friendly material).

Of the next six bedrooms we inspected two were used for storage of beds and furniture as at our visit in December 2014, one had a noisy extraction fan in the en-suite toilet and the wardrobe was still unsafe, one bedroom (registered for single occupancy) had two beds in it, as the person had been allocated the use of a profile bed. This bedroom had personal possessions in it but looked to be

unoccupied as the profile bed was deflated and not in use. The electrical wire to the profile bed was loosely and dangerously in place across the room from socket to bed over which staff would have to step to give support to the person in there. We concluded this bedroom was occupied by one of the people that was staying at Bay View on a respite basis but was in hospital. It was very cold as there was no heat coming from the radiator. Another bedroom was very cold with no heat coming from the radiator, though this bedroom was vacant. The last of these bedrooms was occupied and was acceptable in terms of safety.

Of the next six bedrooms we inspected on the second floor one was used as the staff sleep-in room, one was very cold, one was shared occupancy (though vacant) and had insufficient wardrobe space for two people, one had plain glass in the large window in the en-suite toilet so people could be observed using the toilet if they did not close the curtain in there, one had a noisy extraction fan in the en-suite toilet and the last one, which had been very damp at our visit in December 2014, was now dried out but had a very dirty toilet bowl and the fitted wardrobe door was hanging dangerously from its hinges.

We saw that in the second floor assisted bathroom, which we were told by staff was used regularly to bathe people, we found that there was still a communal linen bathmat in place and communal toiletries and hairbrush. The underneath of the bath seat was dirty, as at our visit in December 2014, and there was a topical medicine named for a person that used the service sitting on the shelf. The bath sides had been fitted badly so they did not meet properly and there was a sharp corner that anyone (people that used the service or staff) was at risk of cutting their leg on.

This lack of evidence that fire safety systems and electricity systems were working safely, and the continued poor maintenance of the premises left people who lived at, worked at or visited the service, at risk or at potential risk of harm should there be a problem. The provider was still in breach of regulation 15.

We found there had been a small improvement in infection control: the registered manager had supplied hand sanitizer in strategic places for staff to use. Other areas had not improved: there was still an absence of paper towels in toilets (linen towels were in use), suspected communal use of bathroom toiletries, stains under the bath seat and communal use of a fabric bathmat.

With regard to food hygiene, there were still two care staff providing all of the caring, cleaning and cooking tasks in random order without a change of uniform. Staff were providing personal care to people one moment, handling laundry and then dealing with food in the kitchen the next. The only protection methods they used were different coloured plastic aprons and hand washing. We were told that two staff had completed basic food hygiene training, which meant others that handled food were not trained in safe food handling. The provider was still in breach of regulation 12.

We asked if any new staff had been recruited since our visit in December 2014 and were told that none had been. We looked at two of the most recent staff recruitment files which included the file for one particular staff whom we had asked about in December and whom had been listed on the roster for 18 December 2014 and the registered manager had told us would not start working if their security checks and references had not been received by then.

We saw that they had one written reference dated 20 January 2015 from their most recent employer. The reference recorded that they had been “dismissed due to poor standards.” There was evidence that a DBS first check had been received on 13 January 2015. It was established at this inspection that the staff member had commenced work on 18 January 2015 before the security checks had been received. We were able to establish this as it was clear that, without the person being on the staff roster, there would have been insufficient numbers of staff on duty, and when we asked the registered manager if the person had actually worked 18 December 2014 they did not give a reply. Both the DBS first check and the reference had been received approximately one month after the staff member had commenced work at the service. The provider was still in breach of regulation 21.

We checked medication management systems again and found that although photographs of people had been attached to the MAR sheets there were still issues with safe management of medicines. Hand written entries where people had been prescribed medication mid-way through a cycle of the monitored dosage system, had not been

Inadequate

Is the service safe?

signed by two staff, there were no codes used to show when 'as and when' medication had not been required, the unused medication returns system had not always been used properly and staff were not dating topical creams and eye drops on starting a new packet. The provider was still in breach of regulation 13.

Inadequate

Is the service effective?

Our findings

The service was not effective. People received care from staff that were inconsistently inducted, not fully trained and poorly supervised. People's rights to be independent and autonomous were not always upheld and people were not fully included in the decisions about their care and treatment. People's nutritional needs had not always been satisfactorily addressed.

10 December 2014.

People we spoke with told us they felt that they were cared for by people who knew what they were doing. One person said, "The staff have the knowledge and skills for what I require. I've observed and received great care." Another said, "The carers are very good, they're on top of the job." However a third person said, "The care is adequate, some of them (staff) know what they're doing, some don't. They don't listen to you. I asked them not to put this jumper on and I've been complaining all day." This person made these comments at 10.30 a.m. and had changed tops a couple of times by then. Staff were observed and overheard trying to make sure the person was satisfied.

We observed that staff used basic caring skills to provide support to people that used the service. People were assisted with their mobility needs, provided with meals, were supported with personal hygiene and comfort and were given their medication. No one required any support with memory impairment, symptoms of dementia or complex care needs. The dependency levels of people were attributed to their physical needs in the main.

We found there was no central record kept for staff training, only certificates to evidence the courses staff had completed. This did not help to ensure staff training was kept up to date. These certificates showed that some staff had completed some training at Bay View and the rest while working in other positions in care, as the names of other services were written on some of them. For one staff member safeguarding of vulnerable adults (SOVA) and Mental Capacity Act 2005 (MCA) training took place in 2013 before they worked at Bay View. They confirmed this was the case when we spoke with them. A second staff member had completed medication administration, SOVA and moving and handling training early in their employment at Bay View.

For a third staff member we saw evidence in their file that they had completed medication administration training with a well- known pharmacy only four days after completing a job application form at Bay View, early in 2014. There was no evidence of their having secured the position when they completed the training. Moving and handling and SOVA training were completed later when the person had acquired the position. These examples did not evidence that the provider had an effective training programme in place and that they followed it.

We saw that one staff induction had been completed and signed off all in one day. When we asked the registered manager about this they said the staff member's induction only took one day completing all of the paperwork and one day working on shift alongside the registered manager, because they had already worked in the caring profession. Another staff had applied for their position in July 2013 but their file contained interview records from a previous provider dated July 2012, not from the provider at Bay View. Their induction papers were signed February 2014. We acknowledge the service was not providing care to people until early 2014 but documentation did not provide evidence that staff were consistently inducted or trained.

We saw from staff files that staff had received some appraisals but these were not consistently carried out. Records given to us by the registered manager showed that four staff had their 'performance reviewed' in May and June 2014 and all had been awarded a score of '3=excellent'. The registered manager said staff were supervised every three months, but there were no other records given to us to check this. When we spoke with staff about supervision meetings they explained, "To be honest I haven't had one. I was off work when they were done and so missed it" and "I see the manager every shift that I work, so I get supervision then." Supervision was not consistent to ensure all staff received the appropriate support they required in order to carry out their responsibilities.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We found no evidence to show the registered manager and staff followed best practice guidelines for caring for older people. We asked the registered manager if there were any models of care adopted or followed to ensure people received the best care possible and they told us, "No."

Inadequate

Is the service effective?

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA legislation which is designed to ensure that any decisions are made in people's best interests. We were told by the registered manager there had been no best interest meetings held and no applications made using the DoLS approach since the service began in early 2014. We found that one person had been prevented from using their mobility equipment which could have required the application of a DoL in determining a legal stance on the situation, if they had been assessed under the MCA as having no capacity.

However, because the person had capacity, a DoL was not applicable. We therefore looked at the regulation on 'respecting and involving service users' (regulation 17) and we found the provider and registered manager had not treated the person with respect and consideration with regard to their independence and their right to make decisions about their care. They had withheld information from the person about the whereabouts of their mobility equipment and had not enabled them to make their own decisions with regard to its use on a daily basis.

When we asked the registered manager why the information had been withheld from the person they told us this was because they had considered the person would be unsafe using the equipment and it was better that the person did not know where it was. The registered manager told us they had made a referral to an occupational therapist regarding the person's mobility needs, but no outcome had been achieved.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

The registered manager told us they had completed MCA and DoLS training, but had not updated their knowledge of this in April 2014 when changes were made in how the legislation is applied.

People we spoke with told us they had mixed views about the food provision, with views being more negative than positive. They said, "It's very good, I get what I like but if it's something I don't like they'll give me something else" and "I'm not keen, there's no choice. You get enough but I'm not impressed." We saw that the 'Statement of Purpose' document, which should be given to people that use the service, said 'A choice of full English cooked or continental breakfast was available.' However one person told us, "They (meals) vary from time to time, they're very basic really. Main meal can be good or not so good. Breakfast is very disappointing, as you don't see bacon often enough. You can get a sandwich for tea but it can be just beans or tinned tomatoes on toast." Another person said, "The meals are adequate. The trouble is I'm a very faddy eater and if I say I like something I get it forever."

We understood from information given to us by staff that because there were no kitchen staff employed in the service meals were supplied by a 'ready meals' company. Staff told us they ordered a number of meals for delivery that were then stored in the freezer. People could choose from whatever was in the freezer on a daily basis. This meant there were no set or planned menus for people to choose from or be aware of. While we understood that staff used this system of 'ready meals' because staffing was at a minimum, we did not believe it was a suitable way of providing nourishment or choice to older people in care who may have been used to home cooked food prepared from fresh ingredients.

On 10 December 2014 we did not observe a lunch time meal as all of the people that used the service went out for a Christmas party lunch at a local restaurant. Therefore while we were unable to observe people being supported at meal times we read about their preferences in care plans. We read information that told us one person preferred finger food and was a vegetarian. Another had health issues that required a special diet.

We saw that care plans contained no nutritional risk assessment screening tool, although there was a risk assessment document stating information about food likes and dislikes and that, for example, one person required their food intake monitoring. However, there were no details about providing protein to the person with vegetarian preferences and there were no food or fluid intake charts in use to show food intake was monitored. One of the examples we saw in the care plans said, "(The person) has a poor diet, won't eat savouries, so encourage them to eat these. (The person) says they eat a vegetarian diet so offer mashed potatoes and vegetables." The information we saw did not help to ensure that people's nutritional needs were fully understood and met.

One person that used the service told us they had lost weight since coming to live at Bay View and this was

confirmed by their visitor. The weight chart in their care file showed their weight on admission in March 2014. It also showed they had lost 8lb in the first six months and had put on 4lb over the next four months. Overall they had lost 4lb since admission. It was recorded in their file that they required their food intake monitoring.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We saw that people had information in their care files about their health needs and any medical conditions they had been diagnosed with. People told us they were able to see their G.P. and other health care professionals when they needed to. A Community Nurse visited people during our inspection, but we did not have an opportunity to speak with them. Care file records showed that people's health needs had been reviewed. They showed that health care professionals supported people with their health needs when necessary.

05 February 2015.

On 5 February 2015 we found that there was no central staff training record to identify when staff required refresher training, but we saw some staff training certificates in staff files. These included training that had been completed in previous employment elsewhere. We were told by the registered manager that no staff, except them and one other, had completed safeguarding adult's training, but the registered manager had some safeguarding workbooks for staff to work through in their possession. The registered manager told us that she and five other staff had completed moving and handling training (we saw certificates for the three staff whose files we looked at). She told us that all staff had been trained by her to administer medication (we saw a certificate for one of the three staff whose files we looked at).

The registered manager showed us a pharmacy publication titled 'Care Homes Medication Handling Training' which they said had been issued to all staff, along with details of an e-learning package, and that she checked the workbooks when completed using her answer book. They explained that when workbooks were checked and staff had passed the requirements, training certificates were requested from the pharmacy.

They told us that workbooks had been checked already and they were waiting for certificates to be sent to them. We asked the registered manager what qualification they had gained to enable them to train staff in management of medication and they told us they had completed medication training but provided us with no evidence of this. There was no evidence given to us to show that staff had completed workbooks or e-learning, except in the case of one staff. The registered manager told us they had observed staff administering medication to assess their competence, but had not recorded any competency assessments to evidence this. The provider was still in breach of regulation 23.

We were told by the registered manager that staff had been booked to attend Mental Capacity Act training on 11 February 2015.

We were informed by the registered manager that the person who had not been involved with decisions regarding their care and independence had been referred to ERYC and a review meeting had been held with them and the person on 3 February 2015. This was later confirmed by the reviewing officer at ERYC and so the registered manager had made some improvement regarding 'respecting and involving people that use services' under regulation 17 since our visit in December 2014.

However, further discussion with the reviewing officer revealed that the original referral made by the registered manager to the OT had been for an assessment of mobility needs with regard to staff assisting the person to rise from their chair and bed, and not about using their mobility equipment. Referral to the OT about mobility equipment had been made in January 2015 and discussion with the reviewing officer revealed that it was still the case that the person had not been informed their equipment was on the premises. This meant the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed people having their mid-day meal which was meat pie from the frozen food options with mashed potato, broccoli, carrots and gravy. One person who ate a vegetarian diet told us they had Yorkshire pudding and flaky pastry with their vegetables. When we asked them if they had any filling in the pie, as we could not see any, they said, "I don't know. It doesn't look like it, but this pastry is

Inadequate

Is the service effective?

not flaky." They said, "I don't know what they give me half the time." Another person told us they had thoroughly enjoyed their meal, which had been supplemented with a glass of beer.

We were told by a senior staff member that another person had not been eating well. We saw in their care file they had an admission assessment in place that included a nutritional assessment. This recorded that they were at high risk from poor nutrition. Dietary records were in place, had been reviewed and food and fluid intake charts had been introduced. Charts showed the person had consumed inadequate amounts of food and fluid to meet their needs. They showed that in the previous four and a half days the person had consumed the equivalent of no more than one day's food intake (one and a half Weetabix, one cheese and ham sandwich, one quarter slice of cheese on toast, a Marks & Spencer fruit and jelly, half a bowl of Ready Break and one bowl of raspberry jelly). The previous four days also showed very low consumption of food and fluid, with nothing being recorded for 29 January 2015. They showed that the person's food and fluid intake was poor throughout the whole of the time they had used the service.

This meant that people were still not receiving the foods that reflected their choices and preferences or that met their nutritional needs with regard to adequate amounts of food. The provider was still in breach of regulation 14.

Requires Improvement

Is the service caring?

Our findings

The service was caring but had areas for improvement. People were spoken with respectfully by staff and staff made efforts to offer people choice on a daily basis, but people were not always enabled to be fully independent in their actions or decisions. People were not consistently treated the way they wanted to be treated.

10 December 2014.

People told us they had mixed views about being adequately cared for at Bay View and so they did not feel they were consistently respected and listened to. They said, “That’s something they do here, they know me and what’s wrong with me and they look after me very well," “The care is good. I can’t fault it” and “Some (staff) are caring others aren’t. I hate having to wait and wait all day which is what happens. I could do with a one to one carer like others have got.” We noted on checking with staff that no one in the service received one-to-one care.

Another person said, “The carers are alright but I can't come and go as I want.” This person explained about their mobility problems and not having their personal mobility equipment with them to use. This was passed to the registered manager who explained that although the person was not aware of it their equipment was available, but there needed to be a re-assessment of their ability and safety before they used it again. This was not a stance which fully involved the person in the process and did not help to ensure they knew what was happening in their life.

These comments from people told us not everyone was entirely satisfied with all aspects of their care and support and that not everyone was kept fully informed with decisions about their daily lives.

People said their privacy and dignity was maintained. We saw nothing to contradict this. Observing staff interaction with people showed that they knew them well and people were shown respect and kindness as standard practice. People’s responses indicated that this behaviour was quite usual, as they told us they were treated kindly. We saw that staff explained what they were doing when they supported people and because people understood and communicated well the explanations given were short and simple. This helped people to know what was happening to them when they received support from staff.

People said they were able to express their views and were heard doing so. They were all clearly comfortable saying whatever they wanted to the staff and to the inspection team. People told us they would let us or the staff know if they thought an aspect of their care was inadequate.

An extra staff on duty to help take people out to lunch told us they thought “Staff were very kind to the people here.” Another said, “The staff are very good, they go above and beyond, so I know they care. If you wanted to know if I was really caring you would have to watch me. It is no good taking my word for it as I could tell you anything.” A third said, “The care here is very good, not at all regimented. We are quite soft with people. We chat and spend time with them when we can.” This helped ensure people were treated individually.

We observed staff providing support to people on request. Staff were patient but assertive and did what had to be done without question. We saw that staff only had the time to attend to people’s basic needs however, because of the minimum staffing levels on duty. For example people were assisted to get ready for their planned trip out and were given drinks. They were assisted with personal comfort and to wrap up warm. It was just before lunch time that extra staff came on duty to assist everyone in wheelchairs to go across the street to a local restaurant for a Christmas party lunch. However, no one received any individual attention from staff sitting with them and talking about the event before or after it. And no one spent time with staff doing an activity, although staff told us they did spend time with people when they could.

We saw that people were adequately ‘groomed’ and wore the clothes they had chosen. With the exception of one person, people sat where they chose to within the service. The person’s visitor told us that they and the person did not agree with the separation. An explanation was given to us by staff when we asked about this. Staff told us the person was much more settled when sitting on their own and so they encouraged this.

A visiting relative we spoke with told us that this person was not entirely satisfied with the arrangement of living in care and so nothing that was done for them helped them to have a sense of wellbeing. We saw that their demeanour and the way they expressed themselves reflected this. The situation could have been the same for the person in any care setting. Other people engaged more with each other and were more positive about their situation.

Requires Improvement

Is the service caring?

We were told by staff there were no arrangements for advocacy services to be involved in anyone's care, as people all spoke up for themselves and had family who could support or represent them as well.

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive. We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information to help meet people's needs. The complaint procedure was not readily available to people and cooperation with other organisations was inadequate so that people did not always receive the care and treatment they required in a timely manner.

10 December 2014.

People told us they thought they were adequately cared for. They said, "The girls are good" and "We're alright here." One person said, "I don't like being in care and want to go home, but the staff do alright."

People had individual care files that contained a personal details form, consent to share information form, a care plan, a patient passport to give to healthcare professionals on entering a hospital so the person's needs would be known, an admission assessment, a life history, daily routine details, risk assessments, professional visitors record, likes and preferences, a weight chart, details of health conditions and a list of medication taken.

We saw in care files that some information was missing from the documentation in use. For example one person's file had blank areas on their personal details form, a blank life history, no date and no details of their wishes upon death on their pre-admission assessment form. Another person had only dates of when a health care professional had visited with no reasons why and no outcome of the visits. A third person's file had all documents completed and there was evidence that the person's wishes regarding their personal hygiene were respected, as they had been assisted with a shower six times and a 'strip wash' 41 times in 42 days. Overall there was poor consistency in completion of care file documentation.

We saw from care plans that they were not as clear as they should be. For example information was given about people in the form of a statement telling the reader a fact like "Unable to move independently from lying down to a sitting position". However, there were no details on how to help the person to achieve this. Another example was "Has wheelchair in their room" (for use to aid mobility) but the information did not say when and why staff should use the wheelchair, whether the person only wanted to use it when outside the service or all of the time.

Another person's file recorded they 'Required full support in the morning to wash and dress' and 'They go out every Tuesday and Wednesday,' but neither of these comments gave staff any details of how to assist with washing and dressing, what time the person went out, who with or where to. Other information on a medication plan said what was important to the person was 'Medication' and 'How best to support me with this'. However, the information to qualify this was recorded as, 'The person needs their medication given to them.' There were no details of when, how often, by what method and so on.

As well as care plans not being clear, we saw that they were not person-centred. They were written in the third person, did not show evidence that people had been involved in compiling them and did not contain information that was centred on the person's individual needs for support.

These documents and care plans with information missing, with no clear instructions for staff on how to care for people and no person-centred information did not fully enable staff to meet people's needs. We understood that staff worked on providing care based on what they knew about people from spending time with them rather than reading care plans. When asked about assisting people with their care, staff said, "We know that they all want to go (to the bathroom) because one of them has asked" and "People don't particularly want much. They are happy with the routines." They also said about receiving new information regarding people's changes in need, "I just come to meetings. I've attended them all" and "I know about people's medical conditions and special diets and what they like. I know that no one has any special religious or cultural needs." Staff did not refer to using care plans to ensure they had the right information about meeting people's needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

When we asked people about the activities they took part in everyone mentioned that they played bingo and they had all enjoyed a recent trip to Burton Agnes Hall. People

Is the service responsive?

didn't say whether there were any other activities taking place on a regular basis. We saw no activities for people during our visit except for watching television. We acknowledged that people were getting ready to go out for lunch and had little time for anything else that day. Everyone said their family and friends were able to visit them any time.

There were only five people using the service at our first visit and we were told by staff that all of them came to the lounges each day for company, but one sat alone and so they were the only person to experience any social isolation. However, they received a visitor most days of the week and staff took time to speak with them at intervals. Involvement with people in activities was something the provider was not doing well.

We saw that people made choices with regard to how they dressed, what they ate, where they sat, what they watched on the television and where they received their visitors. However, they were 'bound' by some routine in the service regarding when these things took place. For example people were all assisted to rise, wash and dress before the staff could provide breakfast, because of there being only two staff on duty in the building.

We did not see if there was a complaint procedure in place as the policy and procedures file presented to us by the registered manager did not contain one and no other complaint information was offered to us. We saw no complaint policy posted in the service.

We saw there was a 'Statement of Purpose' (SoP) in the policy file. The registered manager had told us earlier that there was no SoP. It said people would be provided with a key to their bedroom, they had a safe place to store their valuables and meals were provided by fully trained catering staff. It said full English or continental breakfast and a choice of two main meals could be provided. People had not told us these were available and there were no menus to confirm any of this. There were no catering staff employed.

There could have been a complaint procedure within the SoP but because on reading it we found that much of it bore no resemblance to the actual service provided, we did not continue to look. For example at point 3.0 there was information making a declaration of the services available but this stated the name of another registered care service, which was in another coastal town. At point 5.7 the SoP said there were two office telephone lines and one service user payphone on the ground floor available for staff and people to use. We asked the registered manager and a care staff if there was a payphone for people that used the service or two telephone lines into the office and they both said, "No."

When we asked people that used the service if they knew how to make a complaint we found that no one was aware of any formal process for making complaints, but everyone said that if they had an issue to raise then they would do so. One person said, "I tell them. I won't stand for it if I don't like it but there's nothing like that here." Another person said, "There's nothing formal and we're not really asked for our views. I would complain if it was necessary." A third person said, "I complain to the managers. Sometimes something happens (to put it right) but mostly it doesn't." This person was unable to give examples of any outcomes of complaints they had made.

05 February 2015.

On 5 February 2015 we were told by the registered manager that all but one person's care plan had been reviewed and rewritten to include a person-centred approach, more detail on how to care for people and improved risk assessments. There were eight people using the service at the time of our second visit, one of whom was in hospital.

We looked at two care plans and found one of these had been written according to a person centred approach. It contained assessment and action plan documentation that is recommended to service providers by ERYC and therefore contained the information necessary to show what the person's needs and strengths were and what care and support they required. It contained recording sheets for diary notes, GP visits and activities, and systems in place to review the overall care plan.

The other care plan we looked at had not yet been reviewed but some new documentation had been added. A new moving and handling risk assessment had been included, but it did not have the person's name or a date on it. A second document had been completed on 16 December 2014 which also had no name on it. This was in response to staff having been observed performing an unsafe lifting technique in December 2014.

It gave details of the event, saying this was likely never to happen again, that all staff had been spoken to, that an OT had been supporting Bay View in assessing the person's

Requires Improvement

Is the service responsive?

needs and that all staff were responsible to ensure the person's dignity was respected at all times. It did not contain information to staff on how best to reduce any risk of harm to the person when they were being transferred: hoist equipment to use, alternatives if the person refused to be hoisted, when to use the hoist or when and how to use an alternative. There was a note in the file to say the person had been visited by an OT the day before our visit, which recorded that a new hoist sling was to be obtained and was on order. This was still a breach of regulation 9.

We found there was a new concern in relation to a person that had been admitted since our visit in December 2014.

The care plan for this person contained an admission assessment that included a nutritional assessment. This recorded that the person was at high risk from poor nutrition. A dietary record had been put in place on admission. This was reviewed on 24 January 2015 when food and fluid intake charts had been introduced. We asked the registered manager to show us the food and fluid intake charts, as the care plan file noted these were held in the person's bedroom.

The chart shown to us included details of food and fluid intake between 28 January 2015 and 5 February 2015. We asked the registered manager if this person had seen a GP regarding their poor nutrition or had been referred to a dietician and were told they had been referred to a dietician on 2 February 2015, but there was no information available to evidence this. Information showed that the person had used the service for 36 days while being at high risk of harm from poor nutrition before being referred to the dietician.

We were told of a second new concern about a person's experience in relation to cooperating with other providers. On 11 February 2015 we received information from ERYC about another person that used the service. We were advised that a safeguarding alert had been sent to the ERYC Safeguarding Adult's Team that same day.

The information received was that the person was visited by a relative on 8 February 2015 and found to be unwell. The relative asked the staff on duty if a GP had been contacted. They were told that the GP had not been contacted and so they telephoned the GP themselves. The person saw a GP on 8 February 2015 and was admitted to hospital with a serious illness and later diagnosed with further complications. The staff on duty had failed to seek appropriate medical advice and assistance to ensure the health and welfare of people that used the service.

This was a breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The registered manager had not used quality monitoring systems to ensure service delivery was safe or effective. There was no vision and no clear values for staff to aspire to. The registered manager indicated to us that they did not fully understand the responsibilities of their registration or role. They did not fully demonstrate good integrity and honesty. There was poor and inaccurate information available to people.

10 December 2014.

When we asked the staff about the culture of the service they said, "The staff are good. They go above and beyond for the people that live here" and "The place is relaxed and not at all regimental. We chat to people and spend time with them when we can." We found that the culture of the service was informal, but built around routine. We likened it to a situation where people were living in their own homes being cared for by relatives. People were assisted with their basic needs for comfort, sustenance and shelter.

The service, registered by The Commission in August 2013 under the company name of Quality Care UK Limited, had a registered manager in post who had also been registered to manage the location at the same time.

When we asked the registered manager if the service had any visions and values they told us, "No."

There has been no changes to the registration of the service other than the service had changed its name in October 2014 from St Kitt's to Bay View.

From speaking with people that used the service we judged that the registered manager was not always as open with people or with other organisation professionals as they could have been. For example, the registered manager had not been open with the person that thought their mobility scooter was still at their previous placement. This has already been explained earlier in the report in the section on 'effective'. Also the registered manager had not been open with the Commission Inspectors about safeguarding alerts and one person's mobility needs. These are explained below.

At our inspection on 16 April 2014 the registered manager had told us they were aware of their responsibility to inform The Commission about any safeguarding alert they made to the local authority, as they had been managing care homes for several years. This was recorded in our report of that visit. We saw during our visit on 10 December 2014 in the service's safeguarding records held, that the registered manager had made an alert to the local authority's safeguarding adults' team in July 2014. However, they had not informed the Commission of this alert. When we asked why they had not informed us the registered manager told us twice that they were not aware of their responsibility to inform us of safeguarding referrals. This was contradictory information to what we were told in April 2014 by the same registered manager.

We had received information of concern from a member of the public, a potential employee, the day after they called at the service on 24 September 2014 to collect a job application form. They told us that the registered manager had allegedly behaved unprofessionally with regard to confidentiality of information and had unsafely handled medication. The registered manager had allegedly shown disregard for a person's privacy and dignity when assisting them to the bathroom. However, people that used the service had not experienced any actual harm as a result of this.

The person that told us these concerns had information about certain situations that had arisen in the service around that time, which they said they had obtained from the service on the day they had visited. We had visited the service on 23 September 2014 to undertake a 'follow up' inspection for the purpose of assessing improvements against the compliance actions made at an earlier inspection in April 2014. At the 'follow up' we had heard a telephone conversation between the registered manager and a person asking if the service had any job vacancies. We heard the registered manager tell the caller to visit any time to collect a job application form, as although there were no job vacancies, there could well be in the near future. We concluded the person making that telephone call was the same person that visited on 24 September, who observed concerning practice and relayed their concerns to us on 25 September 2014.

During our visit in December 2014 we asked the registered manager about these concerns and they said they could not recall the situation at all and could not recall anyone visiting the service in September 2014 to collect a job application form. They denied they would ever have behaved in such a way and provided no further information to us about the situation.

Inadequate

Is the service well-led?

We have reported in the 'responsive' section above that the registered manager informed us the service had no 'Statement of Purpose' (SoP). We saw that the registered manager was unaware of this document when we told them it was in the policy file. Being unaware of it meant the registered manager had not ensured it was accurate or up-to-date and that it informed people about the actual service people could expect to receive. This is a responsibility that the Commission would expect a registered manager to carry out.

We asked the registered manager to provide us with evidence that the premises had been maintained in a safe condition by showing us the certificates of safety for the gas, electricity, fire system and lifting hoists. These were either out of date or unavailable and had not been checked for this by the registered manager, nor had the registered manager proactively sought to obtain new updated safety certificates.

In light of these examples the 'fitness' of the registered manager is being considered in respect of their 'skills' under regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is an area the Commission is exploring. Because the registered manager was unable to provide us with safety certificates and other information of explanation we undertook to contact the provider. Therefore, on 19 December 2014 we sent the provider a letter of request under Section 64 of the Health and Social Care Act 2008 to supply us with specific information, by a specified date. Section 64 of the Act relates to the authority of the Commission to require the provision of documents and information.

We asked the provider for some explanations regarding the registered manager's conduct on the day of our inspection with regard to the hoisting situation mentioned earlier in our section on 'safe'. This was sent to us on 8 January 2015 in an email, but it was sent after the Section 64 letter specified target date of 7 January 2015. The explanation we received from the provider was that the registered manager believed the person was being more compliant with staff and transfers using the hoist. As the registered manager was the second staff on duty three days a week it is difficult to accept they were unaware the person was still refusing to be transferred using the hoist.

We asked the provider for other information in the letter, which we have not yet received. The provider has therefore not complied with our request under Section 64 of the Health and Social Care Act 2008. This is an area the Commission is considering with regard to other enforcement action we could take.

At our scheduled inspection on 16 April 2014 we found there were poor systems in place regarding quality assurance. While this had improved at a follow up inspection on 23 September 2014, the provider had still not established a thorough system of monitoring, analysing and planning improvements for the service. We had judged that more time was required by the provider and registered manager to develop and embed the quality assurance systems. During this inspection in December 2014 and February 2015 we found there was still no collation or analysis of information and an action plan had not yet been formalised for implementation. This meant that while shortfalls in service delivery might have been identified there was no means of planning to make improvements to them. People might therefore not see any improvements in the safety or the quality of the service.

The provider or registered manager had extended the quality assurance system to include the auditing (checking) of some other areas back in September 2014, which we were aware of at that time, but no new ones had been audited since our visit in September 2014. One of the audits that had been carried out by the registered manager (weekly checks on the fire system, emergency lights and fire doors), was not supported by consistent records. There was no specific form to record fire system checks; the one used was titled 'miscellaneous record'. While this is not a breach of regulation it is an indication that management of the service was poorly organised and added to our concerns about the manager's 'fitness'.

We saw that health and safety audits had been completed by the registered manager on 5 May and 9 September 2014, where it was identified that the dining room, three bedroom carpets, as well as one bathroom floor covering needed replacing. The registered manager confirmed no action had been taken yet to replace these following either of the audits. However, further information we received from the provider was that the registered manager should have told us the three bedroom carpets had been replaced in October 2014.

We identified that other areas of the premises were unsuitable and these have been listed in the section above on 'safe'. Areas we identified for repair or replacement of

Is the service well-led?

furnishings had not been identified in any health and safety audits completed by the registered manager. We identified for ourselves that there were three en-suite toilets that had old and worn floor coverings.

We saw that a medication audit had been completed 27 October 2014, which stated everything was 'compliant'. An infection control audit had been completed 22 August 2014, which again stated everything was 'compliant'. This included checks on food being within 'best before' dates, and fridge temperatures reading at a safe range. We have reported above in the section on 'safe' that an Environmental Health Safety check on 16 September 2014, less than four weeks later than the registered manager's audit, had revealed concerns with these areas of food hygiene. We question the effectiveness of the registered manager's audit.

We were told by the registered manager that people that used the service had completed satisfaction surveys in May and June 2014. We had already viewed these at our inspection in September 2014, where they had been used to show improvements made to the quality assurance system. People we spoke with were unable to recall these. We were given no further information about people's levels of satisfaction having been sought since June 2014.

We saw that the 'miscellaneous' fire safety records for checks carried out on the fire system recorded that 'all' equipment items were tested and there was an occasional entry that said 'emergency lights' or 'fire alarm looked at'. We saw that the last fire drill carried out was dated 5 June 2014 and the drill had included three of the nine staff employed. A record showed that all staff had completed fire safety training on 7 April 2014. We have reported on the lack of a premises fire risk assessment and 'personal emergency evacuation plans' for people that used the service in the section above on 'safe' and we are reporting here that there was no audit in place to identify these were missing.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end of the full version of the report.

We found no evidence of the service exercising any questioning practices with regard to best practice and care.

People that used the service received a consistently family orientated style of care, but this was not a style that reflected any theory based methodology or tested and proven strategies of care.

We found that the service maintained certain records about people which in the main provided personal details and a care plan based on an assessment of need. However, care plans and risk assessment documents were lacking in actual action plans to tell staff how best to meet people's needs and lacking in actual action plans to tell staff how to reduce risks to people. Improvements in the area of record keeping were required.

5 February 2015.

The registered manager showed us a publication that had been purchased by the provider, which contained a complete auditing system and tools to enable any care home to carry out comprehensive audits and satisfaction surveys. This had been shown to us in September 2014 when we visited the service to follow up on progress made to become compliant with the regulation on assessing and monitoring the quality of service provision. While none of the tools had been used in September 2014 the registered manager had implemented some basic auditing systems and we informed them we would enable them to spend more time embedding these and implementing others. This was so they could establish a more effective quality monitoring system.

However, we found in December 2014 and on 5 February 2015 that no new audits had been set up or carried out and none of the publication audit tools had been used yet. Therefore the effectiveness of systems had not been improved.

There were no new audits carried out since our previous visit, on any of the areas discussed earlier in this report: medication, health and safety, fire systems and infection control. The medication audits we were presented with were the ones we had already seen in December 2014. The health and safety audits we were presented with had also been seen in December 2014. The registered manager told us they had been concentrating on auditing care files and then reviewing and updating them.

With regard to the gas safety certificate the registered manager told us that this work had still not taken place and a gas engineer was due that day. The inspectors saw that two gas engineers did visit the service on 5 February 2015

Inadequate

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to carry out this safety check. However, this meant that there was no gas safety certificate in place from 9 July 2014 until 5 February 2015 and this had been brought to the attention of the registered manager in December 2014. Their lack of recent fire safety auditing and lack of action over the past eight weeks showed they were disregarding the importance of checking the safety of the premises. This meant people that used the service were still at risk of harm because there were insufficient checks on some aspects of service delivery.

There had been a meeting held for people that used the service and there was evidence in minutes of the meeting that their suggestions of a cheese and wine afternoon had been carried out and key workers from within the staff team be chosen by people themselves. There had been a staff meeting held on 23 January 2015 and staff views had been recorded in the minutes.

The lack of evidence that new audits had been completed or that fire safety systems and electricity systems had been checked, meant that quality monitoring systems were still ineffective in ensuring people who lived at, worked at or visited the service were protected from and were not at risk or at potential risk of harm. Therefore this was still a breach of regulation 10.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that Quality Care UK Ltd had not protected people against the risk associated with unsafe care and treatment because of unsafe lifting techniques. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that Quality Care UK Ltd had not protected people against the risk of having their health, welfare and safety safeguarded because they were not supported at all times by sufficient numbers of suitably qualified, skilled and experienced staff. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that Quality Care UK Ltd had not protected people against the risk associated with unsafe or unsuitable premises because of inadequate maintenance. This was a breach of regulation 15 of the

This section is primarily information for the provider

Enforcement actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that Quality Care UK Ltd had not protected people against the risk of exposure to health care associated infections because the provider did not operate a system to assess the risk and prevent, detect and control the spread of infection. The provider did not maintain appropriate standards of cleanliness and hygiene in relation to the premise and the materials used in the care of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that Quality Care UK Ltd had not protected people against the risk of receiving care and treatment from staff that were unsuitable to work in the service. This was because the provider had not ensured staff were of good character and had not ensured information about them as specified in Schedule 3 was available. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that Quality Care UK Ltd had not protected people against the risk associated with the unsafe use and management of medicines by means of making of appropriate arrangements for the safe administration of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that Quality Care UK Ltd had not protected people against the risk of being cared for and supported by staff that were inappropriately supported by the provider to enable them to deliver care and treatment safely to people. This was because staff had not received appropriate training, professional development and supervision. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Enforcement actions

We found that Quality Care UK Ltd had not protected people against the risk of receiving care that was undignified and disregarded their independence. This was because the provider had not made suitable arrangements to treat people with consideration and respect. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that Quality Care UK Ltd had not protected people against the risk of inadequate nutrition and dehydration by means of the provision of support for the purposes of enabling them to eat and drink sufficient amounts to meet their needs. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 (and also 9) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that Quality Care UK Ltd had not protected people against the risk of receiving care or treatment that was inappropriate or unsafe because the provider had not always adequately planned for the delivery of their care. This was a breach of regulation 9 of the

This section is primarily information for the provider

Enforcement actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that Quality Care UK Ltd had not protected people against the risk of poor health, welfare and safety where responsibility for the care and treatment of service users was shared with others. This was because they had not been referred to healthcare professionals to obtain appropriate health and social care support. This was a breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We are taking enforcement action against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that Quality Care UK Ltd had not protected people against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided. This was because the provider had not ensured sufficient audits had been carried out and used. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are taking enforcement action against this provider.