Runwood Homes Limited

The Mill House

Inspection report

Mill Road
Horstead
Norwich
Norfolk
NR12 7AT

Tel: 01603737107

Date of inspection visit:
11 December 2018
18 December 2018

Date of publication:
13 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Mill House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Mill House is registered to provide personal and nursing care to a maximum of 45 older people. At the time of inspection there were 33 people using the service.

At the last inspection on 20 June 2016, we rated the service 'Good' in all key questions and the service was found to be compliant with all regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we identified that the service was failing to adequately protect people from the potential risk of harm and was in breach of regulations 9, 10, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new manager had started working for the service five weeks prior to our inspection and was in the process of registering with the Commission. 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 meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Risks to people were not appropriately planned for and managed. Some staff practice we observed placed people at risk of harm and staff did not demonstrate a good knowledge of reducing risks to people.

There were not enough suitably skilled, supported and knowledgeable staff to meet people's needs in a timely way, including their social and emotional needs. People told us they were often left alone without staff present and had to wait too long for staff assistance.

People did not receive personalised care that met their individual needs and preferences. There was a task focused culture among the staff team who did not always demonstrate a knowledge of people as individuals and their individual needs. Care plans were not personalised and staff did not have time to read people's life histories to learn about their past.

People were not adequately supported to be engaged in meaningful activities. The provision of activities for people in the service was poor and people with more specialist needs or who spent time in their bedrooms were not engaged.

Staff did not always treat people with dignity and respect. Observations concluded that staff spoke about people's needs and shared intimate details of their personal care with other staff in communal areas. On

occasions staff spoke about people in a patronising way.

Whilst most interactions between staff and people using the service were caring, some staff members failed to recognise their own poor practice and the poor practice of others and how this impacted upon people using the service. The provider and management team had failed to address these issues promptly enough which meant this culture had been allowed to develop and continue.

The quality assurance system in place had identified shortfalls in the service in September 2018. Despite this, the provider failed to bring about improvement quickly enough. This means that people have continued to receive poor care which could place them at the potential risk of significant harm.

People received appropriate support to maintain healthy nutrition and hydration. However, care planning around the support people required was insufficient to guide staff on how to meet their needs effectively.

People and their relatives were encouraged to feed back on the service in a number of different ways and participate in meetings. However, it was not clear how this information was used to bring about meaningful improvement to the service. People and their relatives told us they knew how to complain and complaints had been investigated and responded to appropriately.

The new manager was visible in the service and led by example. Staff told us they felt more supported by the new manager and able to raise any concerns with them.

Medicines were stored, managed and administered safely.

Checks were carried out to ensure that the environment and equipment remained safe. The service was clean and measures were in place to limit the risk of and spread of infection.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks to people had not always been identified, planned for and appropriately managed. Staff were not always aware of risks to people.

Poor staff practice put people at risk of harm.

There were not sufficient numbers of staff deployed to meet people's complete needs.

Medicines were managed and administered safely.

The premises were safe and clean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was not complying with the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards and staff did not always uphold people's right to choice.

Staff did not have appropriate knowledge to deliver safe and effective care to people, and this had not been identified by the service.

People were supported to eat and drink sufficient amounts. However, the support they required was not always clearly set out in care records.

People were supported to have contact with external health professionals such as doctors.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst staff were kind and caring towards people, they did not recognise that their poor practice placed people at risk of harm or of having their right to choice compromised.

People were not consistently supported to be involved in the process of their care planning.

People were not consistently enabled and encouraged to be independent by staff.

Staff did not consistently uphold people's right to privacy, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not supported to engage in meaningful activity and told us they were bored.

People did not consistently receive personalised care.

People and their relatives were made aware of how they could complain.

Is the service well-led?

Inadequate

The service was not well-led.

Whilst the service had identified some shortfalls, this had not led to prompt and robust action which minimised the serious risks we identified at this inspection.

People and their relatives were provided with opportunities to feedback on the service. However, it was not clear how this was used to bring about meaningful changes in the service.

The new manager was visible and led by example. Staff told us they felt more supported by the new manager.

The Mill House

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.

This comprehensive inspection was carried out by two inspectors on 11 and 18 December 2018 and was unannounced. An Expert by Experience formed part of the inspection team on 11 December 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Services have to notify us of certain incidents that occur in the service, these are called notifications and we reviewed these prior to the inspection.

Some people using the service were unable to communicate their views about the care they received. We carried out observations to assess their experiences throughout our inspection. We spoke with six people using the service, four relatives, four care staff, a nurse working for the service and the manager.

We reviewed ten care records, three staff personnel files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 20 June 2016 we rated the service 'Good' in this key question. At this inspection, we identified that the service was failing to adequately protect people from the potential risk of harm. The service is now rated 'inadequate' in this key question.

The care plans for the majority of people whose records we reviewed had been created some years prior to this inspection and had not been updated appropriately as people's needs changed to ensure there was clear guidance for staff. In some cases, changes in people's needs had not been recorded at all, and in others they had been recorded on a review sheet but not in the body of the care plan which made the information more difficult to find. One person whose records we reviewed received their nutrition via a tube (PEG) placed directly into their stomach. We found that there were four different sets of instructions about the amounts of food and fluid which the person should receive through their PEG tube and over what period of time. This could have caused confusion for staff about which one should be used. For another person, they had been prescribed more thickener to have in their drinks to reduce the risk of choking or aspiration, but this had not been reflected in their care plan.

The service was not adequately protecting people from the risks of choking. There were no choking care plans in place for people identified as at risk to guide staff on how they should reduce the risk. At the start of our second visit, the manager provided us with a summary of people's care needs which they stated would be provided to new and agency staff and would also be displayed on the wall in staff areas. We reviewed this summary and compared it to people's care records and our observations of people's care needs. We identified multiple errors in this summary which meant that incorrect information could have been provided to staff about the risks to people. For example, for two people who were at risk of choking and were on a soft diet, the summary stated they were not at risk of choking and had a normal diet.

A letter from the hospital dated 7 June 2018 for one person stated they had been admitted to hospital due to aspiration pneumonia, which occurs when you inhale food or drink into your lungs. This letter set out detailed instructions for how staff could reduce the risk of this happening again. Despite this, the information was not transferred into care planning, nor were staff made aware of it. This means it was unclear how the staff could consistently support this person to reduce the risk of them developing this condition again.

Observations of staff practice demonstrated that not all staff were aware of the risks to people and how these risks could be reduced. We observed two staff members provide one person with two biscuits as a snack. The person was tipped far back in a specialist chair and the staff did not position the person upright to eat. We queried this with staff at the time who told us this was to stop the person 'getting out' of the chair. We observed that the person proceeded to place an entire biscuit in their mouth and got into some difficulty. The staff member noticed and asked if the person was okay, to which they indicated they were not. The staff member sat them up and they spat out the biscuit. Following this, we asked the two staff present if the person was at risk of choking and they told us they were not. When we reviewed this person's care records we identified that they were at risk of choking and on a soft diet so they should not have been

provided with biscuits. We asked a nurse how they should be seated for snacks and meals, and they stated the person should be sat upright for all drinks and food because of their risk of choking.

In the care records for another person on a soft diet, we found an entry dated 15 November 2018 written by a nurse who stated that they had found the person eating oranges, which they should not have on their soft diet. We asked the nurse about this and they stated the orange could only have been provided by staff. It was unclear who had provided the person with the oranges because after the inspection the provider told us they were provided by a relative. However, no records to reflect this could be provided. We asked for evidence to demonstrate the incident had been reported to the management team and appropriately investigated but this could not be provided. The new manager was unaware of this incident which had occurred prior to them starting in the role and could not locate documentation to evidence it had been investigated. This meant that it was unlikely this had been addressed with staff to reduce the risk of it occurring again.

Staff told us they did not read people's care plans, and that these were for the nursing staff. Staff we spoke with did not have a good knowledge of some risks to people in their care, such as the risk of choking, and how they should be reduced. This was confirmed by our observations and records we viewed.

During our first visit we observed two staff assisting one person to stand from their chair in an unsafe manner. The person was presenting with some confusion at the time and was not fully consenting when the manoeuvre was carried out. The way they were supported by the staff to stand placed them at risk of injury but the staff did not appear to have an awareness of this. We reviewed their mobility care plan and found that it did not contain sufficient information or guidance for staff on how to support the person to move safely.

We were so concerned about the risks to people that we provided the management team with feedback at the conclusion of our first visit and asked them to take action. This included implementing appropriate care plans for two people with complex needs who had been placed at risk of receiving inappropriate or unsafe care. We reviewed these care plans during our next visit and found they were satisfactory. However, despite there being a week between our inspection visits the management team and provider had not used this opportunity to ensure they had oversight of all the risks to people and implement appropriate care planning for those with more complex needs or who were at more significant risk. This meant that when we returned for our second visit we identified further significant concerns which placed people at risk of harm which the management team and provider were not aware of.

Following our second visit we wrote to the provider requesting information to assure us that they had oversight of all the risks to people, particularly around the risk of choking, and information to demonstrate they had ensured staff were aware of people's needs and how to reduce risks to them.

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

The service did not deploy sufficient numbers of staff to meet people's complete needs, including their social and emotional needs. We observed that many people were disengaged with their surroundings throughout our visits and that people who preferred to or needed to stay in their bedrooms did not receive much interaction from staff. One person told us, "What I don't like is that after tea I have to sit in this chair in the lounge until they come for me to take me for bed. They give me a drink and disappear at say a quarter to eight. I can't get out of my chair and there's no buzzer near me to press. There's no staff, nothing. I can't shout for help so just have to wait. I can tell you I've had to wait well over an hour sat here." Another person

commented, "They only have time for a basic chat." A relative said, "We've noticed in the day room there are periods when no member of staff calls in to check, I'm not happy that they're left alone." Another relative told us, "They are just so busy to find any time to chat." This confirmed our observations that people, many with complex and high level needs, were left in communal areas for extended periods of time without staff presence and with no way to call for staff assistance. During one of our visits we observed one person to be coughing a lot and in some distress. We could not locate a staff member to assist them for several minutes and had to go onto a different floor of the service to find one. At other times we observed it was difficult to find a staff member to speak with as we could not find any.

Staff told us they sometimes struggled to meet people's needs but felt they could meet people's basic needs with the numbers they had. However, when we spoke with them about meeting people's social and emotional needs they stated they didn't have time for that. This was confirmed by our observations when one person was trying to have a conversation with a staff member. It was clear the staff member was trying on many occasions to politely excuse themselves. This was so they could complete other tasks but this meant that the person did not receive the attention and social interaction they required to reduce the risk of them being socially isolated.

On 20 September 2018 the provider had an external consultancy carry out a mock inspection of the service. The report from this mock inspection states that their observations and what people told them indicated there may not be enough staff. Despite concerns about the staffing level being raised on 20 September 2018, at this inspection we found that the staffing level was still not sufficient to meet people's needs in a timely way.

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

The service did not have appropriate processes and procedures in place to identify and investigate potential abuse, for example unexplained bruising. We asked staff what they would do if they noticed bruising on a person's skin and they told us they would complete a body map record, however, we found none of these for bruising in the care records we reviewed. We asked the nurse what action they would take and what the process was. They stated they would complete a body map but would not complete an incident record. Neither the care staff nor the nurse understood the scope of unexplained bruising in terms of safeguarding people from abuse. This meant we were not assured that systems to identify and investigate potential abuse were robust enough.

Despite the concerns we identified, the majority of people we spoke with told us they felt safe. One person said, "I am secure and safe." Another person told us, "It's safe overall living here and the day and night staff care about us." However, one person told us they did not always feel completely safe and we fed this back to the management team so they could address it with staff. The person told us, "It depends on who puts me to bed as whether I feel safe. I need two [staff] and some can be a bit rough but I can't remember their names. It can really hurt me."

Recruitment procedures for new staff were safe and appropriate checks were carried out to ensure prospective staff had the appropriate skills, experience and character for the role.

Medicines were stored, managed and administered safely. We audited the number of remaining medicines against the number of medicines signed off as administered in Medicines Administration Records (MARs). We found that these indicated people's medicines had been administered in line with the instructions of the prescriber. There was an appropriate system in place to identify any shortfalls in medicines administration

and robust action had been taken to learn from errors and previous shortfalls. The service's quality assurance process had identified that staff were not always recording the reasons for medicines not being administered, and action was being taken to make this clearer.

The environment and furniture within it appeared hygienically clean and free from unpleasant odours. There were cleaning rota's in place which delegated duties between domestic staff and regular audits were carried out on the cleanliness of the service. People and their relatives told us the service was clean. One person said, "My room is kept clean and lovely in every way." Another person told us, "My room is nice and clean."

There was an appropriate system in place to monitor the safety of the premises and manage environmental risks. Records demonstrated that the service had an external company service the fire detection and prevention systems regularly. The service also carried out tests of the fire alarms to ensure they remained in working order. The service had employed an external company to risk assess and carry out checks on the water systems to look for the presence of legionella bacteria. Additionally, the maintenance staff carried out regular flushes of the water system and checked water temperatures to ensure the risk of the presence of legionella bacteria was reduced. Appropriate testing was carried out of electrical appliances to ensure they remained safe for use. Regular audits and checks on the safety of the premises were carried out by maintenance staff. Any issues identified were recorded and signed off when they were resolved.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 20 June 2016 we rated the service 'Good' in this key question. At this inspection, we identified that the service people received had deteriorated and improvements were required. The service is now rated 'Requires Improvement' in this key question.

Observations of staff practice and discussions we had with staff demonstrated that some staff could benefit from further training and development. Staff members we spoke with did not demonstrate a good knowledge of safeguarding and the Mental Capacity Act 2005 (MCA). The training matrix provided to us showed that the majority of staff were up to date with training in MCA. However, observations of staff practice did not always demonstrate that they fully understood and acted in accordance with the MCA. Staff had not received training in subjects specific to the needs of people they cared for. For example, several people had diabetes and Parkinson's disease but staff had not received training in these areas. In addition, staff had not received training in supporting people with behaviour that challenged them. We observed that staff ignored one person who was displaying behaviour that they found challenging and did not appear to have a knowledge of techniques that could be used to de-escalate these types of situations and reduce the persons distress. Staff had also not received training in providing care to people coming to the end of their life despite the service providing end of life care. Our review of care records and people's daily notes concluded that the quality of recording by care staff was poor. The service had identified this but staff had not received any training in record keeping. One staff member we spoke with told us they felt training in this subject would be helpful as they were unsure what they should be writing sometimes.

Whilst staff told us they felt supported, they had not received regular appropriate supervision and appraisal. All four of the staff we spoke with told us they had not had a supervision session with their manager in the past year and had not had an annual appraisal. This means they had not had individually arranged opportunities to discuss any concerns, training or development needs. Staff meetings were infrequent and staff had not had their competency assessed in their role. Therefore, it was unclear how the service was monitoring the practice of its staff, driving improvement and development and identifying possible training needs.

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

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA,

whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Two people told us that staff asked their permission before assisting them. One said, "They always ask permission before they do anything." Another told us, "They ask permission before supporting me and call me by my name." However, our observations demonstrated that staff did not always support people to make choices. For example, we observed staff ask one person who was living with dementia if they wanted to go to the dining table for their lunch. The person said no, and the staff member said, "So you don't want any lunch then?" The person said they did want their lunch so the staff member then started trying to get them up from their chair but it was unclear why the staff member did not offer the person the opportunity to eat in their chair where they were comfortable. We also observed that staff sometimes told people how they were going to spend their time. For example, a staff member went to one person and said they would be going downstairs for an activity. They weren't given a choice about this. We observed that staff took everyone downstairs, apart from one person who was more independent and chose not to partake in activities. Staff we spoke with did not demonstrate a good knowledge of the MCA and Deprivation of Liberty Safeguards (DoLS) and the appropriate process they should take in supporting people to make decisions.

This was a breach of Regulation 11 'Need for Consent' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required to care planning around managing people's nutrition and hydration. Care planning did not set out in sufficient detail the support each person required to reduce the risk of malnutrition and dehydration. Changes to people's needs had not led to updates in their care planning and guidance provided by professionals such as dieticians had not been transferred into care planning. We observed two occasions where people did not always receive the support they required to eat and drink. One person was unable to access food and fluid independently. A staff member was assisting them to drink but was called away by another staff member and did not return. We observed at lunch that one person did not receive as much support, encouragement and oversight from staff as they may have benefitted from. This support could have assisted them in eating more of their meal. Despite this, in the majority of cases people did receive the support required to eat and drink. Food and fluid charts evidenced that people received sufficient amounts of suitable food and drink to reduce the risk of malnutrition and dehydration. These also evidenced that people with a low weight or who were at risk of malnutrition were offered frequent snacks to boost their intake. The service monitored people's weight and records demonstrated that the service had made referrals to dieticians to obtain specialist advice on supporting people to reduce the risk of them losing further weight. We spoke with the kitchen staff who were aware of which people were at risk of malnutrition and therefore required their meals to be fortified with extra calories.

We observed that the meal time experience was pleasant and positive. The service had identified shortfalls in this area prior to our inspection and had made improvements to the overall organisation and atmosphere of the meal time. Staff supported people to eat in a dignified manner and offered people ad hoc support to eat their meals. For example, staff offered to cut people's food up if they saw they were struggling. People were given a choice of meals and those living with dementia were shown the different options so they could make a visual choice. Meals were served quickly from a hot trolley to maintain their temperature and were presented in an appetising way. People made positive comments about the food they were provided with. One person said, "The food is lovely, wholesome. I like the choice on offer." Another person told us, "The food is lovely." A relative commented, "[Relative] is a 'foodie' and loves the meals they serve up."

People were enabled to access support from external health professionals such as doctors, dentists, opticians and mental health professionals. However, improvements were required to ensure that the

outcome of visits from health professionals was clearly recorded and any advice provided transferred into care planning.

The service had been decorated in a way which would assist people living with dementia to orientate themselves. There was appropriate signage to make it easier for people to find their way to key areas such as the toilet or dining room. Corridors and rooms were decorated differently to make it easier for people to find their way around the service.

Requires Improvement

Is the service caring?

Our findings

At the last inspection on 20 June 2016 we rated the service 'Good' in this key question. At this inspection, we identified that the service people received had deteriorated and improvements were required. The service is now rated 'Requires Improvement' in this key question.

Whilst we observed that staff were usually kind to people, they were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

The providers quality assurance system had identified in September 2018 that the staffing level may not be sufficient to meet people's needs. Despite this, the service failed to take appropriate action to protect people from the risks of social isolation and disengagement. The numbers of staff deployed meant that people received care that was task focused, impersonalised and therefore not consistently caring.

People's dignity and respect was not always maintained by staff who spoke about people's intimate care needs in communal areas. We observed one staff member call to another staff member in the dining room to state they had 'just changed [person's] pad' and that it was full. Another staff member stated one person was very tired today and another staff member responded, "I'm not surprised, [person] spent all of yesterday screaming." On another occasion, we observed staff asking someone very loudly if they wanted to go to the toilet. When the person said they did, the staff member then called to another staff member across the room and said they needed the toilet. We observed that staff members ignored one person who was vocalising loudly in their bedroom. Several staff members walked past their bedroom and no one stopped to check on the person. We observed staff sometimes spoke to people in a patronising way. One staff member commented to another what a 'good girl' one person had been for eating all of their lunch. The above examples did not uphold people's dignity and respect.

People's care records did not set out the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

This was a breach of Regulation 10 'Dignity and Respect' of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Improvements were required to ensure people and their representatives were involved in the planning of their care and that their views were documented. The records for many people had not been updated for some time and therefore people had not been given the opportunity to take part in reviews.

Despite our observations, people told us the staff were caring and kind towards them and we did observe some positive interactions between people and staff. One person said, "They are very kind and concerned for us all." Another person commented, "Generally they are caring." Another person told us, "They treat me

very nicely and yes they are very respectful and really treat me as a person who matters to them."

Relatives told us they were free to visit their relatives at any time without restriction. They told us the service was accommodating and enabled them to have quiet time with their relative. Relatives were invited to events organised at the service and had the option of dining with their relative if they wished. This meant people were supported to maintain meaningful relationships with those close to them.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 20 June 2016 we rated the service 'Good' in this key question. At this inspection, we identified that the service people received had deteriorated and improvements were required. The service is now rated 'Requires Improvement' in this key question.

Whilst the majority of staff appeared to know people's basic requirements such as the types of food and drinks they liked, staff could not always tell us about people's past or hobbies and interests. This meant the staff could not engage people in conversation around subjects about their histories which they would have enjoyed. The service had created detailed life histories for people using the service which were available in their care records. However, it was clear staff were not using these to gain insight into people's past lives. Staff told us they had no dedicated time to read people's care plans or life histories when they started working for the service. This was confirmed by the manager who said there was not time set aside for this as part of the induction period. Therefore, it was unclear how the service could ensure people consistently received personalised care. This was particularly important for people who were unable to speak about their past and their experiences due to their complex health needs or more advanced dementia. Staff having knowledge of people's life experiences can help them to better understand people living with dementia, particularly those who may display behaviours the staff find challenging.

Care plans we reviewed were generic and did not include specific information about people's preferences, likes and dislikes and how they would like their care to be delivered by staff. Where people were unable to verbally communicate there was limited information about the other ways they may express their thoughts and feelings. For example, one of the care records we reviewed stated the person communicated with facial expressions and body language. However, it did not state what facial expressions and what these may mean. This could result in people not receiving support they required to relieve their distress. Where people were unable to verbally consent to care and treatment, the service had not explored the other ways they could imply consent and ensured this was documented.

There were no adequate end of life care plans in place for people using the service. We reviewed the records of two people who we were told was coming to the end of their life and who had anticipatory medicines in place. Anticipatory medicines are prescribed so that they can be administered promptly to make people as comfortable as possible when they reach the final days of their life. There were no end of life care plans in place making clear how staff should meet their complex needs and ensure their comfort and dignity. It was not clear from their care records what their wishes would be during this time.

The service was not providing people with opportunities to be engaged in meaningful activities. The service had a member of activities staff, however, they told us they only provided activities three days one week and four days the next and worked as a carer at other times. They told us the extra day per fortnight had been agreed after they wrote to the Chief Executive of the provider organisation raising concerns about the limited resources available for activities. The manager told us that the resources available for the provision of activities was linked to the number of people using the service rather than their needs. Care staff told us they did not have time to engage people in activity and rarely had time to spend one to one time with

people. This was confirmed by our observations.

Activities that were provided were not personalised to the preferences of people using the service. We were told an activity was taking place on the morning of our inspection. However, we observed that this consisted of people being supported to go to a coffee shop area that had been created for a hot drink and a group chat. Our observations concluded this was not personalised, meaningful or engaging for people. At other times we noted that people were disengaged with their surroundings, often left alone by staff in communal areas with the television on. We observed the same channel was on all day and people were not engaged with this. There was very limited opportunity for people to leave the service and go on trips. One person told us that during the summer the activities coordinator would take a group of people for a walk to the nearby river but could not think of any other opportunities they had been given to go on trips.

People told us there were not many activities for them to take part in. One person said, "Activities might be on a schedule but they don't involve enough of us, unless it's the singing events or things for Christmas and I get involved in those." Another person told us, "No one has asked me or encouraged me to take part in any activities." One other person told us they got bored. When we asked what they did during the day they said, "I just stare out of that window all day." We observed that the view from the window was of the car park. Two people we spoke with who had poor sight told us the service did not provide them with any sources of activity and that they had not had contact with the activities coordinator. One person said, "There's nothing for me to do. I can't see and I can't walk. What could there be for someone like me who can't see. The activity coordinator doesn't speak to me or visit me in my room. I don't like singing. I've tried the exercise class but I can't really take part because of my mobility. In my bed I have to lie flat on my back so I can't reach the switches for my radio. I get bored of course I do." A relative said, "In the afternoon nothing much seems to be happening. There's a quiz on a Friday but nothing really for someone blind like [my relative]. They have nothing they can adapt for [my relative]." One other person who was unable to get out of bed told us, "I've not met the activity co-ordinator." This confirmed our observations that people in their bedrooms were not involved or engaged in activities and were at risk of social isolation.

People did not always receive personalised care because staff were task focused and provided people with care on a 'schedule' rather being responsive to people's individual needs. For example, we observed one person ask for a cup of tea and a staff member informed them that the tea trolley would be coming in half an hour. One person told us that staff regularly encouraged them to go to bed at a certain time but that they preferred to stay up later.

This was a breach of Regulation 9 'Person Centred Care' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were made aware of how to complain about the service. The complaints procedure was available in a communal area near the signing in book. We reviewed the contents of complaints recently received and these were investigated and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 20 June 2016 we rated the service 'Good' in this key question. At this inspection, we identified multiple breaches of regulations and the service is now rated 'Inadequate' in this key question.

A new manager had started working for the service on 5 November 2018 and was in the process of registering with us. A representative of the provider told us they had moved the manager from another of the providers services because they had identified shortfalls that needed addressing at this service.

At this inspection we found that the service provided to people had deteriorated significantly. People did not always receive care that met their needs in a timely way and protected them from harm. The service was found to be in breach of multiple regulations and although a representative of the provider organisation told us they were aware of the shortfalls at the service, prompt action had not been taken to address these.

On 20 September 2018 an external consultant carried out a thorough mock inspection of the service and identified numerous areas for improvement. Despite this, many of these issues remained at our inspection visits on 11 and 18 December 2018. The process of making improvements following the identification of these shortfalls was not prompt enough and this meant people continued to be placed at risk of not receiving care which met their needs.

On 20 September 2018 it was identified that staff did not demonstrate a knowledge of safeguarding or Deprivation of Liberty Safeguards. It was also identified that staff had not had planned supervision and appraisal for over a year. Despite this, staff still demonstrated poor knowledge of these subjects during our visits and still had not received supervision or appraisal.

Concerns were raised by the consultant about the staffing levels, and they noted in their report that people were left in communal area's for in excess of 30 minutes with no staff present. They stated that care provided was task focused and that there was an absence of activities which indicated the staffing level may not be sufficient. They also stated that as with the previous review they carried out, people expressed that they had to wait a long time for support and felt there were not enough staff. They also noted that staff stated they felt the staffing level was not sufficient. Despite this, at our visit we found there were still not sufficient staff to meet people's needs in a timely way and this had not been identified by the service. This placed people at risk of social isolation, loneliness and not having their care needs met in a timely way.

The consultant also identified concerns about the quality of care planning and risk management. Despite this, these issues remained at our inspection and the service had taken no prompt action to ensure they had oversight of all the risks to people and how these were managed. This meant that staff still did not have sufficient information to guide them on how to provide safe care to people and that risks such as choking continued to be inadequately planned for and managed.

In addition, the consultant identified that people's dignity was not always upheld by staff who spoke about people's intimate care needs in communal areas. Our observations concluded this practice continued

during our visits.

Whilst the service did create a detailed action plan following receipt of the consultant's report, it is clear that action had not been taken promptly or robustly enough to protect people from harm. Additionally, it is not clear why the significant failings in the service had not been identified by the providers internal quality assurance process and addressed prior to 20 September 2018.

Whilst the manager had arranged a visit from the Clinical Commissioning Group (CCG) to consider the safety of medicines, they had not effectively utilised best practice guidance and support that is available from other external organisations to improve upon and develop the service. Whilst the provider had several other services nearby, it was not clear how the managers had worked together in order to share best practice and ideas. A representative of the provider told us one of the nearby services had good activities provision so it was unclear why ideas and practice had not been shared across the two services to improve the lives of people.

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

Despite the concerns we identified, people and their relatives made positive comments about the management of the service. One person said, [The manager] seems open to ideas put forward. I can say she's responded directly to a couple of my suggestions. She's removed the TV from the entrance area. It was intruding and no one watched it. At one point in the afternoon there was one tea trolley and if you missed it, it had gone upstairs. Now there are two." Another person told us, "We all get on with [the manager] okay. [Manager] was here before and we've always found her accommodating." However, three people said they did not know who the manager was or who ran the service.

People and their relatives were given the opportunity to feedback their views through surveys and residents/relative's meetings. We reviewed the results of the most recent surveys and saw that the majority of these were positive. We reviewed the minutes of relatives and resident's meetings but these were too brief to ascertain what views people expressed and therefore whether they were acted on by the service.

The new manager was visible in the service and staff told us they felt better supported in their role. They told us they felt able to raise concerns with the new manager and felt these would be acted on.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences. 2.But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. 3.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; b.designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; c.enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment; d.enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible; e.providing opportunities for relevant persons to manage the service user's care or treatment; f.involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 1.Service users must be treated with dignity and respect. 2.Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— a. ensuring the privacy of the service user; b. supporting the autonomy, independence and involvement in the community of the service user;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent 1.Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor

and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2.Persons employed by the service provider in the provision of a regulated activity must— a.receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, b.be enabled where appropriate to obtain further qualifications appropriate to the work they perform.