CareQuality Commission

Essex County Care Limited

Trippier

Inspection report

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Date of inspection visit:
19 June 2017
21 June 2017

Date of publication:
13 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 19 and 21 June 2017. The inspection was prompted in part following information of serious concern received from the local authority and to check that the required improvements from our previous inspection on 11 and 16 November 2016 had been made. We found there had been a lack of oversight by the provider to ensure that the service delivered was of a good quality, safe and continued to improve. People's safety and welfare were compromised because the provider did not have robust and effective quality monitoring processes to identify issues that presented a potential risk to people. Thorough risk assessments had not been carried out to identify risks in relation to people's healthcare needs. People were not protected from the risks associated with environmental factors such as heat or ineffective cleaning systems.

Trippier is a care home that provides accommodation and personal care for up to 36 older people who are vulnerable due to their age and frailty, and in some cases have specific and complex needs, including varying levels of dementia related needs and end of life. On the day of our inspection there were 29 people using the service. This was an unannounced inspection.

There was a registered manager in post. 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 culture within the home did not promote a holistic approach to people's care to ensure that their physical, mental and emotional needs were being met. Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to identify the issues we found during our inspection.

There was not an effective system in place to ensure there were sufficient numbers of staff on duty to support people and meet their needs. There were not enough staff to provide adequate supervision, nutritional support, stimulation and meaningful activity. This had a direct impact on people's safety and welfare.

People's care had not been co-ordinated or managed to ensure their specific needs were being met. Risks to people injuring themselves or others were not appropriately managed. People's medicines were not being managed effectively to protect them from the risks of not receiving prescribed medicines.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to all of people's needs.

Care plans were incomplete, inconsistent and task led. They had not been updated to reflect people's current care needs. Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference.

Training for staff was not managed effectively. There were shortfalls in mandatory training and not all staff had received training in subject areas relevant to their role. Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) However, this wasn't always seen in practice. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Staff were aware of their responsibilities with regard to safeguarding people from abuse. However some staff did not know the procedures for reporting concerns outside of the organisation to the professionals responsible for investigating abuse. Staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

Following this inspection we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us how they would address the concerns and an action plan was returned to us the following day. We also shared our concerns with the local authority and their safeguarding team. We took immediate enforcement action to restrict admissions and force improvement.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Commission is considering its enforcement powers.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

There were insufficient numbers of staff on duty to meet people's care and support needs.

People were not protected from the risks associated with environmental factors such as heat or ineffective cleaning systems.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

People were not protected from the unsafe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

Training and development was not sufficient in some areas to assist staff in the delivery of safe and effective care.

People were not always supported effectively with their nutritional needs.

People were not always supported in line with the Mental Capacity Act.

Is the service caring?

Inadequate

The service was not caring.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were incomplete, inconsistent and task led. They had not been effectively updated to reflect people's current care needs.

There was a lack of general activity throughout the day to ensure people's well-being.

It was unclear how the results of people's feedback was used to drive forward improvements.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

There was not a positive culture which fully reflected the best interests of the people it served.

Care Quality Commission

Trippier

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 19 and 21 June 2017. The inspection on 21 June commenced at 04.00am to give us an understanding of staffing and how people's needs were being met during the night.

The inspection team was made up of three inspectors who were accompanied on the 19 June 2017 by a specialist professional advisor with a background in nursing.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the registered manager and three managerial staff from another service operated by the same provider. We also spoke with twelve care, housekeeping and kitchen staff and an agency worker.

We spoke with 15 people who used the service, one relative, two visitors and three health care professionals who visit the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed 24 people's care records and other information, for example their risk assessments and medicines records.

We looked at four staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we found that people were not being protected against the risk of unsafe care, particularly in relation to insufficient staffing levels and medicines management. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection we found improvements had not been made.

There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. One person told us, "There are not enough staff to go round. Sometimes you have to wait for up to two hours before somebody may respond to a buzzer. I am paralysed, I can't move and depend on staff. For dinner I have to wait for everybody to be fed downstairs before I have mine. Sometimes I feel I am the last one to be fed. By the time the food gets to me it is very often cold and I have lost my appetite. Sometimes I eat the food because of hunger and not because I enjoy it." Our observations confirmed what this person had told us. On one occasion during our inspection a call for assistance took 17 minutes for a response. We also observed that it took one and a half hours for the person to receive their lunch and by the time it reached them it was cold and dry. The person refused their food because of this and no alternative was offered.

The systems in place for determining staffing levels and shift planning were not effective to ensure sufficient numbers of staff to meet people's needs. A dependency level assessment tool was used to help calculate the numbers of staff required. We found this did not accurately reflect people's dependency levels. For example, people living with complex and high levels of dementia needs had been assessed as being low dependency. A new dependency tool to determine the amount of support each person needed was about to be introduced. However, this was not yet in operation and it was unclear how many extra staff would be allocated to ensure all of people's needs were met and how long it would be before additional staff were recruited. Additional factors such as the layout of the building which may affect how many staff were needed had not been considered.

The call bell system only alerted staff to which area of the service a person was calling from, not the specific room. This meant that staff had to find which room people were calling from before attending. This further delayed response times and added to the workload of staff.

At our last inspection in November 2016 we identified that people were left at risk because there were insufficient numbers of staff available during meal times. We found that people's mealtime experience had not improved and people continued to be at risk. A person who was at risk of choking and requiring supervision when eating and drinking, choked in the dining room when having a drink. There were no staff in the dining room. We alerted three members of staff who were in a lounge writing up records. We observed this person again at tea time and saw that even though they had choked earlier they were still eating a meal without supervision. Other staff were busy serving meals and there were not enough to provide people with the level of support they required with their meals.

Lunch time on the first day of inspection was chaotic and staff were unsure who had been provided with

food and who had not. In one incident inspectors had to tell a member of staff that a person had not had their meal. A member of staff commented about the lunch time service, "There are not enough staff and if they don't listen or they get interrupted by a resident, they lose track. It's a lack of communication."

Three managerial staff from another service arrived on the morning of the second day of our inspection, it is not clear if this was pre-arranged or a response to the inspection. They served peoples breakfast because there was no other staff available in the dining room. Three people had been sitting in the dining room waiting for breakfast for two hours. There had been no food or fluids accessible or offered to people during their wait. Three people in their bedrooms were observed to be awake at 7.00am but had not been offered any drinks for two hours because staff were supporting other people with their morning routines.

Staff told us that there were not enough of them to meet people's needs. One said, "No way [enough staff] we need more," Another explained about the night shift, "It's been very busy. There is never a quiet night. I'd like to be everywhere at once but it's not possible. We need four really. You could have two [members of staff] with one person, that just leaves one [member of staff]. Sometimes the buzzers are continuous." A visiting healthcare professional also confirmed, "They are always short. It's always difficult to find someone. There should always be someone with us. Because they are so short staffed it's difficult for them."

Staff were working excessive hours, up to 55 hours a week with many working three14 hour shifts in a row. Sickness rates were high which meant that agency staff were used. A member of staff explained why this was not effective, "If we had enough [staff] we wouldn't need agency. Agency don't know our routine, they don't know our residents. It slows us down even more." On both days of our inspection staff had to work beyond the end of their shift in order to complete their tasks and provide assistance. Staff were rushed and flustered and told us they did not always have time to take a break. We heard a member of staff say in response to a call bell, "Oh I'm sorry, I need the toilet I can't answer that." This meant the person had to wait longer for another member of staff to become available. A visitor told us "They need more staff. They are snowed under. They work really hard but there's not enough. The staff are very nice but there's a big staff turnover."

On the second day of inspection we arrived at 4am. Night staff stayed for another hour after their shift had finished because two of six staff had not arrived for the morning shift. They told us they had no break during the night as they had been too busy. This had resulted in them working 11 hours without a break. They were also responsible for completing some domestic chores but had been unable to complete these effectively in addition to their caring duties. One person told us, "You only have to have one staff member call in sick and then it is really difficult for them. Especially at night because there are only three on, if one doesn't come in we have just the two." This demonstrated that people could not be assured that there would be enough staff available to meet their needs during the night.

There were insufficient staffing levels to promote people's wellbeing and meet their social needs. One person told us, "I don't see anybody and feel isolated because there are not enough staff to take me downstairs and in the garden. I have my TV on for company." Another person said, "My eyes are not very good, I can't read anymore, I just watch TV every day. I go down for my meals. It's better for me to stay in my room but I don't see staff much, they pop their head round sometimes but they don't stay." We did not observe staff interacting in a meaningful way with people other than when they were delivering personal care.

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

On 16 June 2017, Public Health England issued an amber heat alert in relation to excessively hot weather and that the period of hot weather would continue until Thursday 23 June 2017. On the first day of our inspection the temperature was 30C. The additional risk to people's health, safety and wellbeing from extreme heat had not been identified, recorded and planned for and additional measures had not been taken to ensure staff were supporting people and meeting their needs. One person told us, "I felt awful yesterday, it was so very hot and the central heating was still on. The maintenance person was on holiday and nobody could turn it off. He is back today and it has been turned off." Another person we spoke with was distressed by the heat; they did not have access to fluids because their drinks were placed out of reach. We brought this to the attention of the manager and staff. On the second day of inspection, we found that drinks were still being placed out of the person's reach. They required a second bedside table to accommodate the drinks but this had not been provided. Despite raising the risks associated with hot weather at the first day of our inspection people continued to be at risk.

There were not enough fans available to help make people more comfortable. Where fans were provided these were at times ineffective because they had been placed in inappropriate positions or had not been switched on. We heard a family member tell staff they had turned on their relatives fan at 1.00pm. Staff had not previously checked whether the person was comfortable and wished for the fan to be turned on. By the second day of our inspection some additional fans had been provided but these were still not available for all people.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely. Individual risk assessments were not effective and care planning strategies were not in place in relation to people's dementia related needs, moving and handling, nutritional needs, skin integrity and prevention of pressure ulcers, catheter care and appropriate use of bed rails. Staff did not have guidance on the support people required to meet these needs and keep them consistently safe.

Some people had bedrails in place to prevent them falling from their bed. Although risk assessments were in place they were not effective as they had failed to identify all of the risks to people. We found that four people had bedrails without any protective covers to prevent the risk of entrapment of limbs. We brought this to the attention of the manager who told us that these were usually in place and arranged for them to be fitted. However, when we checked later in the day we found they were not covers designed specifically for this purpose and had been fitted in a way which meant entrapment was still a possibility. One person told us that these were not usually in place and commented, "I don't like them and I don't understand why I have them." The addition of the covers meant that the person was not feeling the benefits of the fan beside them. They had been given no explanation about the reason for their use and their fan had not been repositioned to make them more comfortable.

Risk assessments for people with indwelling catheters were not effective. One person had recently attended hospital due to a catheter blockage. There was no record of monitoring of fluid output or effective catheter maintenance prior or following their hospital admission. Care plans specified that urine bags should be checked hourly and emptied. However, staff were not recording the amount of urine output. This meant issues with the catheter may not be quickly identified, putting people at risk of infection/further blockages. Fluid charts did not show a target amount to be consumed and where intake was seen to be low there was no evidence of any action being taken. This further increased people's risk of dehydration and potential infection.

One person had been from admitted from hospital to Trippier for respite care three days prior to our inspection. On the first day of our inspection a care plan was not in place and staff had limited information on their needs, risk or how to deliver their care. A pre-admission assessment stated that they had epilepsy

and were susceptible to regular major seizures. Prior to admission to hospital the person had been prescribed emergency medication to be administered in the event of a prolonged seizure. The emergency medication had not been provided by the hospital on discharge. We found that this had not been followed up on admission by the manager or staff at Trippier which meant that this medicine was not available should it be needed. When we brought this to their attention the manager requested that this be prescribed by the persons GP.

On the second day of our inspection a risk assessment and a care plan had been put in place in relation to epilepsy. However, this was not specific to the person's individual needs and did not alert staff to signs which may indicate the person was going to have a seizure. Senior members of staff were not aware that emergency medication had been prescribed and did not know if it had been delivered. Staff were not aware of the type of seizures the person experienced or how they were to meet their needs and reduce risk of harm. The person told us that they usually had a major seizure once a month and small seizures often, sometimes up to ten a day. They also told us they normally took their anti-epileptic medication at 7.00am and this was to be taken four times a day which required six hours in between doses. It was not administered to them until 10.00am. It was therefore not going to be possible to administer the remaining doses for the day at the correct intervals placing them at increased risk of seizures.

The introduction of a new medicines system had reduced some of the risk of medicines errors occurring. However we continued to identify serious shortfalls. There was no stock available of pain relieving patches prescribed for two people. These patches were to be applied weekly and next due two days after the first day of our inspection. Staff were unable to demonstrate that the lack of stock had been followed up. We were therefore concerned that these people could experience a delay in receiving the patches and be exposed to unnecessary pain.

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered. This meant that staff may not be aware when a person needed medicine such as pain relief because there was no guidance to show how people communicated that they were in pain where they were unable to verbalise how they were feeling.

People were not protected from the risks associated with the unsafe management of food and ineffective cleaning systems. On the first day of inspection we noted that the kitchen and servery area had not been adequately cleaned. A member of kitchen staff told us, "We did have a kitchen assistant but not anymore. We don't have time to scrub tiles or deep clean." We bought this to the attention of the registered manager and found on the second day of our inspection that a deep clean had taken place in the kitchen. However, the servery area remained very dirty and we saw that fishcakes and beans which had been served on the evening of 19 June 2017 were still in the holding cabinet on the morning of 21 June 2017.

We found further shortfalls with equipment and practice within the service which did not protect people from the risks of poor hygiene and infection control systems. A bedroom floor soiled with urine had not been cleaned up nor had a soiled chair in the dining room. Weekly cleaning schedules showed that cleaning was not taking place in line with the services own procedures. For example, bins had not been washed since 13 May 2017.

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

Staff were aware of their responsibilities with regard to safeguarding people from abuse and told us they felt comfortable reporting concerns to the management team. However, some staff did not know the

procedures for reporting concerns outside of the organisation to the professionals responsible for investigating abuse. Staff did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2016 we identified that at times there were no care staff present in the dining room when people were eating their meals. At this inspection we found that this had not improved. People identified as being at risk of choking were left unattended and others were left for long periods of time without being offered anything to eat or drink.

We observed that lunchtime was chaotic and the system was not effective in ensuring that everyone received food at an appropriate time or the support they needed to eat or drink. There was a lack of organisation and confusion about who should have what meal and dessert. Staff could be heard discussing this loudly. Some choices were offered such as what drink people would like but there was a task focused atmosphere and the mealtime experience was not a relaxed or social occasion. There was a radio on playing a modern radio station but no evidence that staff had checked with people that this would be their preferred choice of music .

Feedback about the food was mixed. One person told us, "I always enjoy my food. The food is very nice." However another person said, "We are never told what we are having, the dinner was disgusting, worse than school meals."

Care plans had not been updated to reflect people's current nutritional needs. One person had been seen by the SaLT team who had advised that changes be made to the way in which their meals were prepared. Their care plan had not been revised to reflect current guidance and therefore we could not be assured that the person was receiving care appropriate to their current needs. The care records for one person contained three different nutritional risk assessments which gave varied results of level of risk from low to high. Another person scored as being not at risk on one assessment but at very high risk on another. The daily food chart of a third person indicated that they had not eaten any of their lunch but their daily record gave conflicting information and said they had been assisted with their meal. Without up to date and accurate information about peoples nutritional needs staff were unable to recognise when they may be at risk and provide the appropriate level of support.

Where people were assessed as at risk of dehydration or poor skin integrity their fluid intake was not monitored effectively. Fluid intake was not always being recorded by the care staff and there was no oversight to ensure people were having sufficient to drink to meet their needs or take necessary action when they were not. In some cases staff encouraged individuals to drink but drinks were placed out of some people's peoples reach or people were not provided with their fluids in a way in which they could easily drink them. One person told us, "I have to depend on staff for a drink, they are always out of reach."

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider could not demonstrate people were receiving effective care and support from staff who had the knowledge, skills and competency to carry out their roles and responsibilities.

Training for staff was not managed effectively. Not all staff had received training and/or update training in subject areas relevant to their role. Twelve staff were overdue moving and handling training and we and other professional visitors witnessed poor practice in this area.

Staff cared for people with epilepsy and diabetes but they had not received training about these subjects to enable them to recognise and meet those people's needs more effectively. Our observations and entries in the communication log book showed us that there were frequent incidents when people's behaviour could become challenging. However staff had not received adequate training to ensure they were equipped with the knowledge they needed to support people when their anxiety escalated, in a safe and consistent way to protect them and others from the risk of harm. Without sufficient training, staff could not be sure that they were assisting people correctly, putting people at risk of serious injury and harm.

Roles and responsibilities of staff were unclear. Some staff described as 'Trainee Seniors' were identified as being in charge if shifts with no clear demonstration of their competence or supervision to lead the shifts. Where disciplinary action had been taken due to poor performance it was unclear how this was being followed up and steps taken to ensure the member of staff was competent in their role.

The qualification and competency of agency staff was not always known before they commenced work. On the first day of inspection the management team had not been sent profiles of two agency workers on shift and had to call to ask for these to be sent once the staff had already started work. On the second day of inspection the manager asked an agency member of staff if their training was up to date but had not received evidence of this from the agency. This agency worker had not worked at the service before and told us that they did not know the support needs of people. Although they received a handover from a senior carer before commencing the shift ,this was given verbally and they had nothing given to them to refer to in order to help them have a clearer understanding of people's needs. They told us that they usually liked to read people's care plans before starting work in a service that was new to them, however they had not been given the time to do this.

We later observed the same staff member wandering around the corridors and not supported by a permanent staff member. We also observed that one person was unsettled at being supported by a person they did not know. They said, "[Agency member of staff] shouldn't be here." And became distressed. They had not been given time to get to know the agency worker before they provided care.

This is a breach of Regulation 19 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decision for living in residential care.

Mental capacity assessments had been completed, however the exact decision to be made was not specified and the action to be taken was not specific to the individual's needs. There was no evidence of any involvement of relatives or relevant healthcare professionals to demonstrate why the decision was in the person's best interests.

People had access to health care services and received ongoing health care support where required. However they could not be assured that the guidance given by health care professionals would be followed to ensure they received safe and effective care and support in line with their current healthcare needs.

Inadequate

Is the service caring?

Our findings

Although people said staff were caring and kind, staff had not been equipped with the appropriate knowledge to help them to understand the needs of people. Care staff were not supporting people in a consistent and planned way. This, therefore, placed people at risk of receiving inappropriate and poor care.

The provider had not ensured the service promoted a caring and respectful culture. A person told us, "I have no grumbles about staff." Then added, "I do have to wait sometimes for staff to come but I know they have other things to do. I would like a TV, I have asked for one. It is very lonely and quiet I do not even have a radio. I don't get any visitors. I don't know who the manager is."
Time spent with people was largely limited to when they were being assisted in some way and was task focussed. We observed staff answering people's calls for assistance then quickly leaving without spending time to reassure and listen to the person. Although staff were intuitively caring, their daily routines did not promote a culture which supported people with all of their physical, psychological and emotional needs.

People's support was not led by the needs and preferences of the individual. At the request of health professionals one person was to be weighed in the mornings when they got up. We observed this person being assisted out of bed at 4.30am to be weighed after they called for assistance. It was not recorded in their care plan that it was their preference to be weighed at such an early hour. Another person was got up and dressed at 6.30am. They remained sat in their wheelchair asleep. One person we spoke with at 8.40am told us they had been waiting a long time to go to the toilet that morning. Staff had supported the person to wash and dress but they had been seated in their chair since with no food or drink offered. T

Staff did not understand the reasons people became anxious or upset. There were no details in peoples care plans to tell staff about , triggers that might make this worse, or ideas about how to distract or engage positively with them. Without this understanding staff were unable to provide person centred care to ensure people's well-being.

People did not always feel that they were listened to, respected and their views acted on. One person told us, "They ask me what I would like, but they don't act on it. If you don't believe me have a look at the form and what the staff have done about it. I have asked for different food instead I get what they want me to have and when. I still have my food late and last. I remain in my room when I prefer to go out in the garden, the lounge and go shopping." We observed that another person for whom communication was difficult had been given blackcurrant squash to drink. Their care plan indicated they preferred orange and they pointed to a jug of orange drink sitting on the serving counter to tell us they would like that instead. A member of staff spoke with us about this person and demonstrated a lack of respect and empathy when they commented, "That's the one who's hardest to communicate with. There is a book but you can't always get it when [person] is impatient." This demonstrated that staff did not always take the time to understand people's choices, wishes and preferences and act on them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found that the service was not always responsive to people's needs. There had been no improvements in this. People did not receive care that was personalised and there was no consistent and planned approach to support people.

The providers' website stated, 'We believe in providing a level of personal care and support that meets the needs of each individual and aim to promote and maintain freedom of choice and independence. Together with our residents, their families and friends, we create a personalised Care Plan which we review and update regularly to reflect changing needs to ensure the utmost care and support at all times'. This did not concur with our findings.

There was a lack of clear guidance and key information for staff to enable them to support people with their specific health conditions such as diabetes, epilepsy or catheter care and maintenance. Therefore staff did not know the signs and symptoms to be aware of, or their relevance to indicate a risk to the person's health, safety and wellbeing and may not recognise the need to take action in order to prevent them from becoming seriously unwell.

Care plans were incomplete, inconsistent and task led. They had not been effectively updated to reflect people's current care needs and they were not regularly accessed by staff to ensure they were kept up to date. On the first day of our inspection staff were unable to find a care plan for a person who had moved into the service three days previously. The senior member of staff in charge of the shift said when asked, "Care plan for [person]? I think [Registered Managers] got it. I haven't seen it. I wasn't here when [person] moved in." The member of staff had not looked at the person's care plan despite being responsible for the shift and was therefore unable to tell us what their health care concerns were and how they should be supported with these.

Other care plans were seen to give inconsistent information and although records stated they had been reviewed the majority of reviews read as, 'no change' or 'remains the same' despite feedback from people and communication from healthcare professionals indicating that there had been changes.

One person's care plan stated that 'fluid must be at hand,' which assumes that the person was able to reach the drink, hold the cup and drink independently. This person told us that they needed assistance to drink as they were unable to hold the cup themselves. Staff we asked about this person were uncertain about the level of support required and we saw that this meant the required support was not offered, putting the person at risk of dehydration.

The care records for another person showed that following a stroke they had been reviewed by the stroke team in April 2016. Their mobility needs had changed to require the assistance of a hoist, full body sling and two carers. The plan in place for mobility was dated September 2015 and the reviews each month stated 'no change'. A new care plan had not been written to reflect this essential, relevant and current guidance for staff. We observed that this person was upset and they told us they had pain in their wrist and arm. They

said their right wrist was pulled by staff when giving personal care and it was very painful. The person's stroke had affected their right arm and needed careful handling by staff. However, there were no written care plans in place to advise and guide staff on the appropriate and safe support the person needed following their stroke.

The care plans for two people with cancer did not give staff an understanding of how to meet their physical, psychological, emotional and end of life needs. One person's dose of pain relief had been increased by healthcare professionals. There was no pain monitoring tool or guidance for staff on signs to look for to indicate pain. This person was living with dementia and at times had difficulty in expressing how they were feeling. They were observed to be very vocal and offensive towards other people and staff at times. We noted that when we spoke with the person they were very pleasant towards us, indicating that their behaviour was manageable and used by them to communicate their anxieties and perhaps pain. Staff had not determined that the person's behaviour may be associated to their health needs and therefore lacked understanding of how best to support them.

Daily care records were very task focussed and gave limited details about people's well-being. The section related to pain and welfare was marked as not applicable on all of the daily notes we looked at. This was despite people telling us how uncomfortable the hot weather was making them feel and some people telling us they were in pain. The welfare check which staff were required to carry out for those they were observing also gave no indication of people's discomfort. The lack of recognition and consideration of how people were feeling was having a direct and negative effect on people's well-being as appropriate support was not offered to make people more comfortable.

The provider states on their website, 'We provide a comfortable and secure environment that is stimulating and preserves and enhances residents' life skills. We do this through reminiscence. By triggering and exploring memories of the past we build self-confidence and most importantly we aim to keep residents engaged and communicating. We found this was not an accurate reflection of the service.

None of the care records looked at contained a care plan that demonstrated how staff responded to individuals differing needs in terms of interests, social activities and meaningful interventions. We observed people being left largely to their own devices on the days of our inspection which resulted in anxiety levels, distress and social isolation escalating. There were limited resources available to assist in the delivery of meaningful activities throughout the day for people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation.

Opportunities to participate in activities were limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference. Staff did not have the time to engage in activities with people to enhance people's well-being. People who spent their time in their bedrooms had little or no stimulation, only that from staff performing a care task. We observed that people were either very restless or withdrawn as they had little to occupy their time throughout the day.

An activities co-ordinator had been recruited but this new position was to be combined with a hostess role, supporting people to receive food and drinks. The member of staff recruited had not yet commenced employment but had no care experience or relevant training and would need a significant amount of support to effectively fulfil the role of an activities co-ordinator. It was unclear how this support would be provided and how the management team planned to change the culture within the service to enable staff to provide a person centred approach to care which focussed on people's whole well-being.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider had a complaints policy and procedure in place which was displayed. There had been no formal complaints received since our previous inspection. However, it was unclear how previous complaints had been responded to, what action had been taken and how feedback received had been used to put things right and make improvements to the service. Given the level of dissatisfaction from people, relatives and others we spoke with about the service we were seriously concerned that this had not been identified by the provider, explored and action taken independently of our inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that the service was not being effectively managed and there was a lack of oversight from the provider. At this inspection we found widespread and significant shortfalls in the way the service was managed and regulations continued to not be met.

Despite our previous concerns the provider continued to fail to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively. The provider had not been proactive in checking that improvements were being made and were largely left unaccountable whilst placing the blame with the failure of senior management. This including those responsible for oversight of quality and training. Despite this a Director of the provider shared that they regularly visited the service and met with the manager. We were seriously concerned that the significant issues we identified were not recognised during these visits and demonstrates a systemic problem at board level through to the daily operation of the service.

We observed that the registered manager spent a large part of their day answering the phone and the front door and was unable to focus on their key role of managing the service and overseeing the staff team. There was no deputy manager in post and although one senior member had been assigned to provide managerial support they told us, "I'm supposed to be trying to support [registered manager] but how can I when I'm on the floor." Another member of staff said, "The manager does the best that [they] can." Staff told us they felt supported by the registered manager. One member of staff told us, "[Registered manager] is always here for us [staff]." Another said, [Registered manager] is a fantastic manager. [They] will step in. However, the provider's senior leadership were unable to demonstrate they had the skills, ability and competency to support the registered manager to ensure that the appropriate quality of care was provided to protect people from the risk of harm.

The provider had failed to provide effective oversight of the service which had led to a failure to address recurring areas of risk to people's health, safety and welfare. Support and resources needed to run the service were not available and the provider was not operating the service in line with their own philosophy of care which stated that, 'Our belief in caring for the elderly is to maintain the highest standards of quality care. Our abiding personal and professional concern is safeguarding the interest and well-being of all residents as well as offering person-centred care.''.

Roles and responsibilities were unclear and staff were unsure what they were accountable for. The culture of the service was not a positive one and staff lacked time, knowledge and understanding. Observation showed there was no effective leadership to oversee and direct staff on each shift and staff did not have the skills and support they needed to support people living in the service.

Audits carried out by the registered manager were in a tick box format as specified by the provider. These audits did not identify where improvements were needed and had therefore failed to be effective in improving the quality of the service provided. For example, a tick box audit of care plans did not look at the

standard and quality of the records to ensure they were detailed, personalised, current and relevant. The registered manager had not been provided with any training or support relating to quality assurance. They told us that the information was sent to the provider but there was never any request for additional information. The results of the audits were not being analysed to establish where the service was failing and where immediate action was needed to make improvements. There was also no long term development plan to show that the provider recognised that there were areas where further investment was needed.

Quality assurance systems had failed to identify the issues we found during our inspection, including shortfalls relating to staffing levels, risk assessment, infection control, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. This meant the provider had missed opportunities to protect people from the risk of receiving inconsistent, inappropriate or unsafe care.

Professionals from other health and social care agencies also expressed significant concern about the provider's ability to ensure the service ran well. Concerns were shared with us from community nurses, social workers, safeguarding officers and quality improvement teams from the local authority.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We immediately informed the provider of the seriousness of our concerns and requested an urgent action plan from them to tell us what they were going to do to make improvements. This was followed up with a meeting with them. We will continue to monitor the service and the provider's action plan.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that was personalised and there was no consistent and planned approach to support people.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not being protected against the risk of unsafe care.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment People were not adequately protected from abuse and improper treatment

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported effectively with their nutritional needs.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had continued to fail to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively. We found widespread and significant shortfalls in the way the service was managed and regulations continued to not be met.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not demonstrate people were receiving effective care and support from staff

	who had the knowledge, skills and competency to carry out their roles and responsibilities.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive care that was personalised and there was no consistent and planned approach to support people.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.