Platinex Limited

Whitewaves Care Home

Inspection report

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Date of inspection visit:
16 January 2018
18 January 2018

Date of publication:
23 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Whitewaves Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Whitewaves Care Home provides support and accommodation for up to19 older people, some of whom were living with dementia. The care home provides accommodation for older people with a passenger lift and stair lift available to access all floors. At the time of our inspection there were eight people living at the home. The service also offered respite care.

We previously inspected the service on the 22 October 2017, following concerns about people's safety which were raised by social services The inspection was focused and looked at the 'key questions' of 'safe' and 'well-led.' At this inspection the service was rated as 'requires improvement' with a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice for this breach. At this inspection we found the required improvements had not been made.

This was an unannounced comprehensive inspection which took place on 16 and 18 January 2018.
There was a registered manager when we completed this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A lack of robust systems and processes, poor management and leadership and ineffective staff training meant that people were not always safeguarded from abuse and avoidable risks to them. Safeguarding concerns had been identified by social services, but these concerns had not been reported to us. Staff at the home had not raised concerns outside of the organisation demonstrating that they did not understand the processes for whistleblowing when care and treatment for people was unsafe or resulted in harm for people.

Risks to people's safety were not always assessed or managed properly. People were not kept safe by suitably skilled or competent staff and training for staff was not always effective. For example, people were not always supported with their mobility needs in a safe way because staff were not adequately trained or aware of managing risks to people in their bets interests.
People did not always experience care and treatment that was in their best interests, because staff did not have a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). An example of this was seen for a person who was assessed that they lacked the mental capacity to consent to their care and treatment. This person suffered a serious injury to their leg due to staff not making appropriate best interests decisions to keep them safe. People and appropriate others, which included advocates and named relatives who may hold relevant legal decision making powers, such as Lasting Power of Attorney (LPoA), were not always involved in the design and review of care plans and risk assessments.

This meant that care and treatment decisions were not always provided in line with peoples own preferences or in their best interests when they may lack the mental capacity to consent for themselves.
Although people were supported to take their medicines in a safe way, there was a lack of detailed 'As required' (PRN) protocols for pain relief for people. People did not always receive their pain control medicine when they needed it, which resulted in a person experiencing pain while being supported to move by staff.
People did not have their nutrition and hydration needs met. There was not enough food for people to eat, and meals were decided on a daily basis rather than being planned in advance. People had limited choice about the food they did eat. The management of the home did not follow national nutritional guidance regarding appropriate foods for people living with dementia despite this being advised by social services. People did not always receive the nutritional supplements that had had been prescribed for them which placed them at risk of malnutrition. People's health and wellbeing was put at risk because they were not supported to eat well.
People were not always protected by safe recruitment systems. The registered manager had not obtained a DBS (Disclosure and Barring Service) check or employment references for one member of staff. This meant that they could not be assured that they were of good character. Staff were not always suitably trained or skilled to provide safe or appropriate care and treatment to people which had resulted in a lack of staff understanding regarding appropriate action to take for people. Delayed contact with appropriate health and social care professionals when people's health had deteriorated was seen. Staff meetings had taken place, although these meetings did not focus upon the serious safeguarding or service quality concerns raised by social services which meant that staff were not informed of the seriousness of concerns about the service provided at Whitewaves Care Home. This left staff feeling confused about the reasons why social services had taken significant action. Social services suspended any new placements to the home and terminated placements for people at the home due to these concerns for people's safety and wellbeing.
Lessons had not been learned by the provider when things had gone wrong regarding the quality and safety of the service provided. Appropriate adjustments were not made and the registered manager did not accept the concerns identified by social services, community healthcare professionals or the Care quality Commission (CQC). Staff had received some supervisions and annual appraisals, although the concerns that surrounded the home were not noted in these which meant that staff did not collectively contribute to the improvements required at the home.
People were not protected by effective infection control systems and processes at the home. We observed that toilet facilities were unclean and cleaning schedules were not established. A staff member was allocated to clean the home but was not at the service with the required frequency to keep the service clean. The staff rota confirmed this. We observed overflowing bins and unclean toilets and scaled shower heads during the inspection which placed people at risk of infection. Areas of the home were also observed by visiting professionals to be damp and dusty. A number of people had experienced serious chest infections whilst at the service. There had been unexpected deaths for people with serious chest infections.
Records for people were not always up to date to reflect their current needs and risks to them. Records were not held securely for people in line with legislative requirements which meant that people could not be assured of the confidentiality of information held about them. We saw end of life care plans that did not reflect that DNAPCR (Do Not Resuscitate) instruction were agreed for people. This meant that people may receive care and treatment at the end of their lives that is not appropriate to meet their wishes or in their best interests. People were not always identified by staff as being at the end of their lives which resulted in people not always receiving timely care and treatment from appropriate healthcare professionals. Staff weren't always clear about which people had DNACPR's in place. Nutrition and mobility records and risk assessments weren't up to date for one person. The staff were seen to be kind and caring towards this person, but did not know how to care for them safely or appropriately. This meant that the person experienced pain and discomfort when being moved inappropriately by staff and were moved urgently by community healthcare professionals to an alternative place of residence where their needs and risks to

them could be met safely.

People were not always supported to take part in stimulating activities that were important to them. An identifiable group of people were observed to be engaged with staff in nail care activities with although another group of people who were not supported to take part in any stimulating activities or engagement with staff. This group of people looked disinterested whilst sat in the lounge area of the home and were seen sleeping for long periods during the inspection.

The provider had not made sure there was a robust quality assurance system in place and had not identified the significant concerns we found at this inspection. Social services terminated the care contracts for three people at the home due to the on-going lack of engagement from the registered manager and lack of improvements made to the service in the required timescales. People were not asked for their views of the service they received in any formalised way. Complaints had not been captured. However, complaints had been received about the service from social services. This indicated that the provider was not monitoring or handling complaints appropriately.

Due to the seriousness of our concerns and the lack of engagement from the registered manager and provider we served an urgent Notice of Decision (NoD) to prevent new people from being admitted or people being readmitted to the service. We also served a Notice of Proposal (NoP) to cancel the registration of this service to prevent regulated activities being provided at this location. We received confirmation from the provider that they were not appealing this proposal notice. We then issued a further Notice of Decision (NoD) to cancel the registration of this service in line with our civil action procedures.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Systems and practices did not always safeguard people from abuse.

Risks to people were not always assessed safely.

Moving and handling equipment was not used safely for people. There were enough staff, but staff were not trained appropriately in the safe moving and handling of people.

Medicines were given safely to people, but people did not always receive their 'as required' medicines for pain relief in a timely way.

People were not always protected from the risks of infection with a lack of systems or processes to effectively monitor and manage the cleanliness of the premises.

Lessons were not learned when things went wrong. The provider did not engage or respond appropriately to external health and social care professional investigations to address required improvements to the service.

Is the service effective?

Inadequate

The service was not always effective.

People's needs were assessed and care plans contained detailed information for people. However, this information was not always up to date which meant that people's current needs were not reflected.

People had not always consented to their care and treatment and staff did not fully understand the principles of the Mental Capacity Act 2005.

Staff did not always receive suitable, effective training to enable them to support people safely. Staff did receive regular supervisions and annual appraisals.

People were offered a choice of some meals but food stocks were low which limited choices for people. Nutritional supplements were not always used appropriately in the best interests of people which placed a person at risk of malnutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

People said that staff were caring. We saw that staff usually communicated with people in a sensitive and caring manner. But we observed people's privacy, dignity and independence not being promoted consistently.

Systems for capturing people's views were not in place and people were not
always involved in making decisions about their care and treatment.

Records for people were not stored securely in line with legislative and best practice requirements.

Relatives were welcomed in the home.

Is the service responsive?

Inadequate

The service was not responsive.

People and their representatives were not actively involved in reviews of care and care plans were not always updated or responsive to people's changing needs.

There was a lack of planned or personalised activities for people.

Concerns and complaints about the service that were raised by health and social care professionals were not used to drive continuous improvement at the service.

End of life care was not always provided in an appropriate way with the service not identifying when people were at the end of their lives. The home did not involve people in decisions about their end of life care consistently.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of strategy or vision for the service and the culture was not open and transparent.

People were not actively engaged or involved with the service delivery and could not influence or direct the service to improve. People's views of the service were not formally captured in a structured or meaningful way.

The service did not work effectively with all health and social care professionals.

Whitewaves Care Home

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 comprehensive inspection took place on the 16 and 18 January 2018 in response to social services concerns raised about the quality and safety of the service. We reviewed the breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we identified at the previous focused inspection. A warning notice was served for this breach. This inspection visit was unannounced, which meant the provider and staff did not know we were coming. Two inspectors and an Expert by Experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service and of people living with dementia.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the provider's information return (PIR). We attended a professionals meeting with health and social care colleagues to review the quality and safety of the service. We considered the information which had been shared with us and looked at safeguarding alerts and complaints which had been made and statutory notifications which had been submitted to us by the provider. A statutory notification is information about important events which the provider is required to tell us about by law.

We spoke with seven people, four care staff, and the administrator who deputised for the registered manager. We spoke with the registered manager who was also the registered provider for this service. We observed care in the communal areas using a Soft Observational Framework for Inspection (SOFI). SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this for themselves because of cognitive or other problems. Records were reviewed for three staff and three people and other records relating to the management of the home, such as policies and procedures, complaints and accident / incident recording and audit reports.

We also spoke with seven healthcare professionals visiting the service during the inspection process.

Inadequate

Is the service safe?

Our findings

People did not always receive safe care and treatment and systems, processes and staff practices did not always safeguard people from abuse. Since our last inspection on 22 October 2017, health and social care professionals had raised significant safeguarding concerns. These safeguarding concerns were not reported to us by the registered manager. We have addressed this within the well-led section of this report.

We raised further safeguarding concerns with social services during this inspection. For example, one person was not having their care needs met in a safe way. This included when they were being supported to move by staff, which resulted in the person experiencing pain, poor pressure area care resulting in harm, undocumented bruising with unknown cause and the inappropriate use of nutritional supplements. We also raised safeguarding concerns about the inappropriate behaviour of the registered manager and the overall management of the service. This behaviour included an observed reluctance to work with healthcare professionals in a constructive and professional manner which resulted in unprofessional conversations being overheard by people living at the service.

Despite our findings, one person told us that they felt safe. However, another person told us, 'I fell over. They [staff] didn't like it of course. The doctor should have come yesterday, but it was Sunday." The person did not receive the medical attention they needed, to rule out an injury following a fall.

These are breaches of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection on 22 October 2017, it was noted that while there were systems in place to manage medicines safely, there was a lack of protocols to support the giving of 'As required' (PRN) medicines such as those to relieve pain. Since our previous inspection, social services had investigated concerns regarding the use of PRN which had been raised by vising healthcare professionals. We were informed by visiting healthcare professionals during the inspection that that one person had not received their prescribed pain relief. We overheard the person experienced significant pain and discomfort when being supported with moving and handling by staff and the registered manager. Professionals stopped the transfer to avoid any further pain to the person. PRN protocols for people were in their care plans but not within their Medicines Administration Records (MAR) folder. The 'As required' protocols did not clearly describe the signs and symptoms of when people may require pain relief medicines. Staff giving medicines to people may not have been aware of when 'As required' medicines would be needed if people were not able to tell them.

Moving and handling techniques were unsafe. Social services reported concerns to us that regarded unsafe moving and handling for one person. We were told that the registered manager was witnessed by a professional 'bear hugging' a person who was unable to weight bear. This is an unsafe technique which is not considered to be best practice as it places people at risk of harm. Social services had arranged for an appropriate healthcare professional to visit the service to observe moving and handling to ensure that unsafe techniques were not used for people. Healthcare professionals visited the service during this

inspection and observed moving and handling techniques and equipment used by staff and the registered manager for the person. Staff did not use equipment safely for the person which resulted in them experiencing pain and discomfort. This person had a large bruise to their forearm for which no explanation could be provided by the registered manager.
The visiting healthcare professional told us and provided us with a statement which indicated they had stopped the moving and handling technique being used by staff and recommended that the person be cared for in bed until more suitable arrangements were made for them in their best interests. Staff had not received practical, suitable training to be able to safely support people when mobilising and staff did not know how to use equipment to move people safely. Staff told us that they had received moving and handling training online. Healthcare professionals observed staff moving and handling practice and deemed that staff were not competent to safely use the equipment required for a person. This equipment included a mobile hoist, handling belt and hoist sling which had not been used appropriately for a person which had resulted in harm.

Risks to people were not properly assessed or managed. For example, one person had received a significant injury because the use of a bedrail had not been assessed or safely managed. Another person had not been appropriately assessed to see if they could use a wheelchair safely. Consideration had not being given to reduce risks associated with poor continence care and pressure area damage for the person who was left sitting for long periods in the wheelchair which was not suitable for their individual needs. This resulted in the person developing a grade two pressure sore.
People's needs were not always assessed to include their physical, mental and social needs and preferences. People's care plans contained detailed information about their needs and risks which initially appeared to reflect person centred content. However, upon more detailed review and cross referencing with other records, observations of people and speaking with people, we found records were out of date and did not always reflect people's current needs and any risks to them. For example, one person's mobility care plan indicated they could move around their walking aid and staff assistance. At the time of the inspection this person was not mobile. People were at risk of receiving unsafe care and treatment from staff if their needs were not clearly documented.

These are breaches of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough suitably skilled staff to meet people's needs safely. The registered manager, who lived next to the service, was on duty every day from 8am to 8pm with regular occasions when they worked overnight. Social services informed us of one occasion when all staff on duty had left the premises for a short period of time, leaving everyone living in the home alone. People were placed at risk of harm and there were no staff present to support or respond to them should they have needed help, or if an emergency had occurred.
Staff were not always suitably deployed and the staff mix meant that some staff did not have the required skills to meet people's needs safely. For example, staff on duty overnight did not have first aid training and were not trained to check the welfare of people throughout the night. Staff looked from the doorways to assess people's wellness during the night. On one occasion a person had passed away during the night and staff had not noticed.
The registered manager told us that people living at the service were not able to physically use the call bells, nor would people 'understand' how to use them. We asked the registered manager what other means people had to call for assistance should they require this. We were told that staff would check people regularly. Records did not reflect that people had been monitored regularly throughout the night or during the day time if they may have been unwell in their bedrooms so we could not see evidence that staff did check people regularly. People's needs were not always met safely or appropriately by suitable staff.

These were breaches of Regulation 18 (staffing) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Recruitment practices were not always safe. One member of staff did not have a completed Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. No references of previous employment or evidence of previous conduct from employment with other vulnerable adults were available for us to review for this staff member. The registered manager could not be assured the member of staff was of good character which may have placed people at risk.
When we spoke to the registered manager about this they told us the DBS check would be available for us to view on the second day of inspection. However, the DBS was not shown to us during or after the inspection.

This is a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by adequate infection control measures. Toilet and washing facilities in people's bedrooms and those within communal areas of the home were dirty. There were no cleaning schedules in place and only one member of staff was allocated to carry out cleaning and housekeeping tasks. However, they were not on duty every day and areas of the home had not been cleaned for a significant period of time. There was a build-up of dust, stained toilet facilities and cobwebs. One staff rota we looked at showed the cleaner only on duty for four out of seven days and only worked from 9am to 1pm when they were on duty. The registered manager did not make sure there were alternative arrangements in place, for when the cleaner was not on duty. Cleanliness and hygiene standards were not maintained and we saw bins overflowing with waste.
Other risks to the environment were not properly managed. For example, a legionella risk assessment had not been fully completed. The provider and registered manager are responsible for health and safety and must take the right precautions to reduce the risks of exposure to legionella. The presence of legionella bacteria can lead to Legionnaire's disease, which is a serious type of pneumonia. Anyone can develop Legionnaires' disease, but the elderly are more at risk. The provider was not monitoring the water quality by sending water samples for testing. Although staff told us they cleaned shower heads regularly, shower heads were covered in lime scale. And the provider did not have a schedule in place for others activities to reduce the risk of legionella.
People were not protected by safe maintenance checks at the service. No water quality monitoring had been completed regarding the presence of Legionella in the water supply and tanks in the home. We saw water temperature records and were told that staff cleaned the shower heads. Our observations found that shower heads were not free from scale. No water quality monitoring policies or procedures or risk assessment existed. The Health and safety Executive (HSE) recommends that, 'water samples should be analysed for Legionella periodically to demonstrate that bacteria counts are acceptable. The frequency should be determined by level of risk, in accordance with the risk assessment.' This was not taking place in the service which meant that people may be placed at risk of harm from Legionnaire's Disease.

This is a breach of Regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not make sure lessons were learned when things went wrong. People were no longer being admitted to the home because of the significant safeguarding concerns raised by social services. Social services issued a termination letter of their individual contract agreements for three people living at the service on the 18 January 2018. This was because of the on-going quality and safety concerns at the service which had not been adequately addressed by the registered manager. The registered manager

did not act on feedback received from professionals to improve the service because they did not believe the service was at fault.

Inadequate

Is the service effective?

Our findings

At our last comprehensive inspection on 18 April 2017, we found that there had been some improvements at the service regarding the registered manager's understanding of the Mental Capacity Act 2005. 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 law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

However, at this inspection we found that these improvements had not been sustained fully and there was a lack of understanding regarding the appropriate support, interventions and management for people whose mental capacity may fluctuate. The registered manager's had a lack of understanding and did not implement relevant risk assessments regarding people's mental capacity. In one particular case a decision the register manger had made had resulted in a person sustaining a significant injury. The person had not fully understood the consequences and risks to themselves of not having padded bed bumpers applied to cover their bedrails at night and the registered manager had not enabled them to understand this risk or mitigated the risk. The registered manager had also not sought appropriate advice and guidance from relevant health and social care professionals regarding this decision. The nominated independent advocate for this person had not been consulted about this decision which was a condition of the Deprivation of Liberty Safeguards (DoLS) application in place for them. We observed that care staff verbally asked people for their consent to give them their medicines. The registered manager told us that people living at the service did not have the mental capacity to make decisions for themselves about aspects of their daily living.

Appropriate decisions or consent to care and treatment in people's best interests was not always sought in line with legislation and best practice, namely the Mental Capacity act 2005, which had placed people at harm.

This is a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of malnutrition. A note handwritten by the registered manager on a 'post it' note, had instructed staff to withhold nutritional supplements for a person, which had been prescribed for them by a healthcare professional due to their identified risk of malnutrition. The registered manager stated within the note that the supplements were making the person "sick", but the registered manager failed to contact healthcare professionals regarding this concern. Daily records did not reflect this instruction for staff. The registered manager stated within the handwritten note that the supplements could be used for "someone else". This is unsafe practice. Medicines must only be given to those people to whom it has been prescribed. The registered manager did not seek professional guidance or

advice to take this course of action and therefore placed the person at greater risk of malnutrition. It was recorded within this person's Deprivation of Liberty Safeguards (DoLS) Best Interests Assessment that they are at risk of being malnourished and dehydrated if supplements were not provided. It was recorded that they were at risk of malnutrition with a Malnutrition Universal Screening Tool (MUST) score of 'one.' The 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. The 'eating' and 'drinking' care plans did not adequately reflect this person's current nutritional needs or the risks of malnutrition. The 'monitoring record' for the person, which monitored their weight, indicated that they had lost weight since the end of October 2017. This meant that they were placed at risk of malnutrition by having their supplements withheld.

During the inspection, people were offered a choice of lunch time meal. Staff approached people with a handwritten note at 11:20am during the first day of inspection to ask people for their meal choices from two possible options. However, we found that the stock and availability of foods within the home was minimal, which meant that people had little choice and no snacks available throughout the day. We asked people what they thought of the food at the home. One person told us, 'It's OK. I don't like slop, I can't eat it.' A person said, 'I get what I'm given.' Another person said, 'I can't grumble with the food. They come round with a list.' During the lunchtime meal we observed that all people were dressed in a 'clothes protector' without their consent being sought. We also observed a member of staff cleaned spilled food from the clothes of two people after lunch. The staff member wiped food from a person's sleeve without asking for consent. Staff also wiped food from a person's jumper above the food protector which had come loose after saying, '[Person's name] 'what a mess you've made'. Staff did this without seeking consent. We observed the person seemed surprised and embarrassed at being suddenly approached and cleaned by staff.

The registered manager told us that all people in the home had jelly and cream for pudding each day with the explanation that this contributed towards people's daily fluid intake. This does not provide people with individual choices or meet their preferred meal preferences. We observed that the fridges and freezers contained only milk, cream and minimal other sauces and preserves. . We asked the registered manager if we could see the menu's for people. We were told that these weren't available because they wrote these up on a daily basis dependent upon the foods available in the home and what people chose to eat. We did not observe people asking for specific meal choices, but being offered one of two options presented by staff. There was no fresh fruit and vegetables available. We raised this concern with the registered manager on the first day of our inspection. By the second day this had not be addressed by them.

The registered manager told us that social services had recommended that they reviewed national nutritional guidance for people living with dementia which ensured that people had a balanced nutritional diet which was appropriate for their needs. We were told that people were living with dementia at this service. However, the registered manager told us that they had refused to do this and said, 'I didn't think they [menus for national best practice] were relevant.' They also said, "They [people] wouldn't be able to eat that.' We asked the registered manager if they had tried to engage people and their relatives with the menu's, by presenting the information in a different format to see if they would chose the suggested foods. The registered manager said, 'No, they [people] wouldn't be able to read them.' The registered manager was not willing to assess the nutritional, individual needs of people in line with recommended best practice for people living with dementia. This meant that people did not always receive suitable and nutritious foods and supplements to meet their needs, choice and preferences.

This is a breach of Regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People did not always receive effective care from staff because staff did not have suitable training to meet people's needs safely. Staff had not been suitably trained to provide appropriate care and treatment for people living at the service. Training was provided online for staff and the registered manager in subjects which included moving and handling. There was no practical training for safe moving and handling and staff did not know how to use a hoist or handling belt safely for a person which resulted in the person experiencing pain and discomfort. At our previous inspection on 22 October 2017, we observed staff using inappropriate moving and handling techniques.

A 'training matrix' for staff listed the online training staff had completed. A Training Matrix is a tool that can be used to track training and skill levels within an organisation. A training matrix has a variety of uses from identifying gaps in training and monitoring staff required and actual knowledge levels and also tracking competency levels. At our previous inspection we found that staff had not received observed assessments of their competency for areas for which they had received training. Observed competencies for staff provide assurance they staff are skilled and able to carry out their duties to meet people's needs safely. At this inspection we found that staff still had not received competency assessments. Staff giving medicines to people had not received observed competency assessments to ensure that they remained competent to give people their medicines.

We saw that staff were not competent in safe moving and handling techniques for people. We reviewed training records for staff and found that a care assistant had provided training to the registered manager in topics including, safeguarding, moving and handling (theory and practical), safe handling of medicines and infection control . The registered manager stated that this staff member had completed a 'Train the Trainer' qualification. We saw that this qualification had been completed online and not in a practical setting which meant that this staff member did not have the practical or appropriate skills to train another person in a practical based training session such as moving and handling. A social services risk assessment for the service stated that the, 'Quality of training observed to be poor', which the registered manager disputed. The training matrix was dated 11 September 2017 and staff training had not been updated since this date. Not all staff on the staff rota appeared on the training matrix and not all staff on the training matrix had completed all mandatory training. This meant that for one staff member no training evidence was provided to us which indicated that they had not received any mandatory training in their role. One member of staff told us that they had not received training regarding the application of the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS) and were not able to clearly tell us when this would apply. Induction training for staff was incomplete. Some newer staff had completed parts of the care certificate but had not finished the workbooks. The Care Certificate is a set of standards that social care and health staff follow when carrying out their professional duties. This meant the training and induction for staff was not clearly structured or delivered appropriately that ensured staff were competent to deliver care to people safely.

Staff received regular supervisions and annual appraisals. We viewed records of staff supervisions and appraisals. Supervisions were completed regularly for staff with staff also receiving an annual appraisal which reflected their past year's achievements. The supervisions we saw were completed on a generic template with minimal content. Supervisions had not taken place since September 2017 for staff which meant that staff may have felt unsupported whether new in their roles or longer standing members of staff who may have wished to have an opportunity to discuss the safeguarding concerns at the home and the action being taken by social services. Staff seemed unaware of the extent of the concerns that had been raised and the registered manager told them that social services had 'got it wrong' [regarding the concerns and safeguarding issues raised]. We spoke to staff. One staff member was unsure of what was happening around the home and asked us if the home was closing. They also stated that they had been expecting something but were unsure what exactly. This meant that despite the fact that staff had received regular

supervisions and appraisals in the past, that the staff were not receiving effective support in their roles at the time of this inspection.

A person told us that they could spend time with their visitors in 'another room'. We saw that bedrooms were decorated in personalised ways. However, for one person we found that they had a television within their room and a large collection of DVD's. They were not able to watch these as the television had not been connected or plugged in for them to use as they wished. We did not see other adaptations that had been made to the premises to support people to engage in meaningful activities for example, but we did see people being taken to a corridor area between the kitchen and communal area behind a closed door when a healthcare professional visited. This was not an appropriate area for people to receive healthcare support directly situated next to the kitchen.

Requires Improvement

Is the service caring?

Our findings

People's personal dignity and privacy were not always respected. We observed the registered manager instructing a person to 'lie on their bed' and to 'wait for staff' to return to support them, which the person did without delay. The two other staff on duty that day were not available to assist the person at this time. The person was sent to lie on their bed with their trousers and undergarments around their lower legs, exposing them in an undignified manner. Their bedroom door was left open and the person was in view of the visiting inspection team. Their bedroom opened into the main communal area of the home. We had to ask the registered manager to take immediate action to protect this person's dignity and privacy.

Staff and the registered manager did not always ensure that conversations about people were respectful or confidential. We heard the registered manager speaking to a member of staff about the care and treatment of a person living at the service whilst sitting in the lounge area of the home. The conversation took place with another person who lived at the home who was sat between the member of staff and registered manager. This meant that confidential information about people was not confidential. On a separate occasion the registered manager was discussing a person's end of life care in the doorway of a person's bedroom. The person was not at the end of their lives at that time. We asked the registered manager to move to a more appropriate location to continue their discussion of the person's needs with a health professional which could not be overheard by the person. The nature of the conversation was not handled sensitively by the registered manager and may have caused distress to the person if overheard by them.

This is a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People could not be assured that their personal information was protected because records were not held securely. We saw records were stored in an unlocked room. Records for staff were held in an unlocked filing cabinet and were accessible. We have addressed this in the well-led section of this report.

People were not supported to express their views of the care and support they received. We observed the community nurse practitioner visiting to review the wellbeing of two people. However, we did not observe the registered manager seeking the consent of these people to be seen by the healthcare professional. One person had an advocate allocated to them to support with decisions about their care and treatment. The advocate was not contacted to inform them of the person's ill health or need for healthcare treatment. This meant that this person's views and decisions were not considered appropriately.

We saw that care staff treated people with kindness and compassion. Care staff showed concern for people's wellbeing. However, we observed the registered manager behaved in an inappropriate manner in the presence of people, care staff and visiting professionals at the service during this inspection. This meant that people overheard inappropriate conversations about the registered manager's negative opinions of visiting professionals. They spoke in a loud voice which could have caused upset to people living at the service.

Inadequate

Is the service responsive?

Our findings

The service was not responsive.

People and others who acted appropriately on people's behalf, were not actively involved in the planning and review of their care and treatment. We observed that the registered manager did not ask people if they wished to be seen by a visiting healthcare professional to the service, so appropriate consent was not always sought. A person's advocate was not involved in the review of care for them. We did not see that care and treatment provided for people was always in accordance with their personal choices and preferences. We saw in each person's care plan record a generic consent form for the use of a 'cloths protector' which was recorded as a choice that all people had made to prevent their clothes from becoming stained. It was noted at our previous inspection that staff had placed a clothes protector around a person's neck without seeking their consent. One person clearly asked us if they could use the toilet facilities. When we relayed this immediately to the registered manager we were told that this person hadn't said that 'for months' and that they were 'doubly incontinent'. This was said in a communal lounge area in front of the person and other people. The person was observed by health professionals later the same day to be heavily soiled in urine. This person's elimination care plan stated that they would like for staff to assist them when they asked staff for help. Personalised care was not therefore provided for this person in accordance with their expressed preference or wishes to use the toilet facilities.

There was a lack of personalised activities for people in the home. We observed that music was played in the lounge for a couple of hours in the morning. The television was then turned on for a short period of time. People were not asked if this was their choice or preference or if they were watching the television. A group of people received one to one nail care with staff. We observed staff engaging positively and sensitively with people. One staff member showed a skilled and patient approach to supporting a person to understand their continence care. The person was overheard to say to the staff member, "Thank you for cheering me up, you always do."
However, we did not observe that all people were actively engaged in activities. An identifiable group of people were clearly excluded and not offered to partake in nail painting or any other activity suitable for their preferences. People who were not engaged in activities with staff were observed to be sleeping in their chairs for long periods of time throughout the daytime. We looked at records for people of any activities attended by them. We saw that no activities for people had been documented since September 2017. We spoke to people in the home and asked them if they took part in any activities and if they enjoyed them. One person said, 'Not really' and 'I like a singsong, but not many of them here do. My Niece is taking me out to dinner in two weeks.' Another person said, 'I can't talk to the other ladies here, they're as deaf as I am.' This meant that the service did not find ways of supporting people with communication needs to be engaged with meaningful activities and interaction with others.

This is a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We reviewed the records of complaints for the service. We were shown that there had been no complaints

recorded for the service so we were unable to assess if complaints had been handled appropriately for complainants or if people knew how to raise concerns of if they were confident to do so. We also asked the registered manager if there were other ways that they asked people for their views of the service. We were told that there weren't any meetings for people to raise their concerns and that people's views hadn't been formerly captured in surveys or feedback forms. We asked the registered manager about the complaints they had received from social services regarding the quality of the service. These had not been recorded as complaints, nor had the concerns been used as opportunities to improve the quality of the services for people. The registered manager said that they received feedback from people verbally and informally on an ongoing basis. We did not see evidence of what actions had been taken following any feedback from people. This meant that people's views were not always sought and opportunities to improve were not embedded in practice.

People were not always supported appropriately at the end of their lives. In December 2017 there had been two unexpected deaths which social services had raised concerns about. These concerns included a lack of appropriate 'DNACPR's' ('Do Not Attempt Resuscitation') for people who may not wish to be resuscitated and also a documented lack of timely response to a person's deteriorating health by the registered manager and staff at the service. There had also been delays with staff providing resuscitation to people. Procedures implemented in the home required staff to find the registered manager before commencing resuscitation which had caused a delay with resuscitation being given and the emergency services being contacted while staff located the registered manager upon discovering a person not breathing. We reviewed care plan records for three people. We found that some people had had DNACPR's put in place by an appropriate healthcare professional, in accordance with their own wishes or in their best interests. The end of life care plans had not been updated to reflect the addition of a DNACPR for one person which meant that there could have been a delay with appropriate treatment being given in the event of a cardiac arrest if instruction for staff was not consistent.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on the 22 October 2017, this service was rated as Requires Improvement for this key question of well-led. A warning notice was issued for a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because there were ineffective quality assurance procedures in place that meant that the quality and safety of the service was not monitored appropriately. At this inspection we found that the requirements of the warning notice had not been met by the provider as the service continued to be in breach of this regulation. We found that no quality assurance checks had taken place since July 2017 which meant that there were inadequate measures in place to effectively monitor the quality and safety of the service provided to people. The lack of effective audit systems and process had also meant that recruitment practices were not safe as systems and checks had not identified that a member of staff did not have the relevant safety checks to work with vulnerable adults in this setting which may have placed people at risk. The lack of service quality monitoring had also been reflected in the continued difficult relationships between the registered manager, visiting healthcare professionals and social services representatives. This had meant that the service continued to be in breach of their contract with social services that resulted in those contracts for people being terminated. This was due to the level of serious concerns regarding the quality and safety of service for people and the registered manager's resistance to work in partnership with external professionals to improve the service as required.

This is an on-going breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The registered manager behaved inappropriately towards visiting professionals during the inspection process. Throughout the inspection the registered manager made comments to professionals and was observed by us to forcefully throw bags that contained personal belongings into a corridor because the items were said to have been in their way. These bags had been packed by healthcare professionals to support a person to move to a more appropriate location to meet their needs. A staff member behaved inappropriately towards professionals during the inspection and were heard to say, 'Are you both going to stand there and watch me?' to healthcare professionals observing their competence to support a person safely. This demonstrated poor leadership and staff that acted in the manner displayed by the registered manager.

The culture of the service did not support staff to be open and transparent with external agencies which meant that concerns may not always be reported appropriately. We were told by health professionals visiting the service on a daily basis that they had to visit the service in 'pairs' due to the 'behaviour' of the registered manager, which they found to be 'intimidating'. Staff did not receive suitable training in how to safeguard people from abuse and had not raised concerns with the appropriate external agencies when care and treatment for people was unsafe. We had not received statutory notifications from the registered manager regarding safeguarding concerns raised by social services, as they are required to do so as a requirement of their registration with us.

This is a breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Records were not stored safely and securely for people, in accordance with legislative requirements. We saw daily notes for people which contained personalised and confidential information. These were placed on a table in a communal area between the lounge and kitchen in the home which meant that they were accessible to people and visitors to the home.
The registered manager was asked about their views of the quality and safety of the service and of the social services suspension regarding any new placements to the home. The registered manager said, 'To me there are no issues but if I'm going to listen to you [CQC] and the county council then there are.' We asked the registered manager if they would agree not to admit privately funded people to the home as verbally agreed with us in December 2017. They said 'I wish to do so if they knock at the door' [admitting new people to the service]. The registered manager did not accept the quality and safety concerns that had been raised by social services, healthcare professionals and the CQC and disputed the verbal agreement made with us to not admit new people to the service until the required improvements had been made. This meant that the registered manager did not recognise or accept the seriousness of the concerns that had been raised by social services or the Care Quality Commission regarding the quality and safety of services for people which may place people at further risks of harm.

Social services had offered support to the registered manager for a period of six months and had provided the service with resources, action plans and training to improve the quality and safety of services for people. Despite the support offered, the registered manager had refused to work positively with the external professionals to improve the service for people which meant that the communication and professional relationships had broken down.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not submit safeguarding notifications to the CQC as they are required to do so in Law. Regulation 18 (1) (2) (5)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received did not always meet their needs and preferences. Regulation 9 (1) (3)

The enforcement action we took:

We issued a Notice of Decision to cancel the registration of 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. Regulation 10 (1) (2)

The enforcement action we took:

We issued a Notice of Decision to cancel the registration of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Appropriate consent was not always sought for people from the relevant person in their best interests. Regulation 11 (1)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment. Regulation 12 (1) (2)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse. Regulation 13 (1) (2) (3) (4) (6) (7)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive nutritional supplements prescribed for them in their best interests. Regulation 14 (1) (2) (3) (4)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were insufficient cleaning and infection control measures to maintain the cleanliness of the premises. Regulation 15 (1) (2)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were either not in place or did not adequately maintain the quality and safety of the service. Regulation 17 (1) (2) (3)

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration

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 did not have systems or assurances to demonstrate that fit and proper persons were employed for the purposes of carrying on a regulated activity. Regulation 19 (1) (2) (3)

The enforcement action we took:

we issued a Notice of Decision to cancel the providers registration