Althea Healthcare Properties Limited

Highcliffe Nursing Home

Inspection report

Tel: **01425 272093**
Website: info@kingsleyhealthcare.com

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 20,22 and 26 May. The inspection was unannounced. Highcliffe Nursing Home is a care home service with nursing. The home is registered to accommodate up to forty six people. The home is not at full occupancy and was accommodating 36 people at the time of the inspection.

At the time of our inspection there was not a registered manager in post. The provider had appointed a manager who had been in post for the previous three weeks. 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 new manager resigned from the post during the inspection.

The service was last inspected on the 14 January 2014 and found to be meeting the required standards. At this inspection we found that the provider was falling to meet the fundamental standards.

The provider did not ensure that there was effective and responsive leadership within the home The provider did not have an effective system to check the quality of care people received at the home. The staff lacked direction

Summary of findings

and guidance from the senior staff and management. The shifts that staff worked were not organised which meant that staff did what they felt was best. This led to people receiving care support when staff felt they needed to.

People were not protected from avoidable harm because the systems in place were not effective in monitoring their well being. Although clinical care records were checked the actual practice of staff giving care was not considered. This meant that whilst the records described what care people should receive there was no system to check that staff adhered to people's plans of care.

People were at risk of malnutrition and dehydration because the systems in place to monitor people's food and fluid intake were not being consistently used. When it was noted that people had lost weight the provider had not ensured that a referral to other health care professional had been made for advice and guidance.

The risks people faced were acknowledged in people's care records but the staff did not ensure that risk was minimised. When people had fallen there was insufficient examination of the person to establish the extent of the injury meaning a person had been left in unnecessary pain.

Staff did not receive or complete the training required for them to meet people's individual needs. Whilst the provider knew what staff had attending training, the system in place to ensure that they could and would put what they had learnt into practice was not effective.

Medicines were not always recorded accurately and this put people at risk. Staff responsible for the administration of medicines did not accurately record when they had given medicines which could lead to people being put at risk.

People could not be confident of receiving care at the time they wished because there was not enough staff to meet people's needs. People either remained in bed hours past the time records stated they wished to get up or were left without social stimulation for long periods of time.

People did not experience personalised positive care. Some staff failed to show compassion when people were distressed. There was insufficient personalised equipment to safely assist people to move by way of a hoist. Where people required specialist chairs these had not been provided and there was insufficient evidence that the provider was addressing this problem.

The provider did not ensure that the risks of fire and evacuation procedures adequately protected people from potential harm. The system used to carry out a fire safety check of the premises failed to recognise potential risks to people and staff at the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to Safe care and treatment, protecting people from harm, staffing, how consent to care was sought, medicines administration and the how quality and risks are monitored.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review.**We are taking further action in relation to this provider and will report on this when it is completed.**

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The medicines administration practices were unsafe and put people at risk of harm.

The risks people faced was not reduced through staff not following plans of care and failing to act when new and emerging risks became apparent.

There was insufficient equipment to support people safely. Where people required specified equipment to support them this was not available.

The building required immediate work to ensure people could exit it in the event of fire. Weekly fire safety checks had not been completed.

There were insufficient staff on duty to meet people's needs safely.

Is the service effective?

Inadequate

The service was not effective at meeting people's needs.

The staff group had not received adequate training to support the people they cared for. The system in place to verify that what staff had learnt was put into practice was ineffective, putting people at risk of poor care.

The service failed to respond professionally and compassionately to people's physical and emotional needs

The staff lacked the knowledge and skills to ensure peoples legal rights were respected.

Is the service caring?

Inadequate

The service was not caring. People were not treated as individuals and the service failed to treat people with respect and dignity.

The service failed to respond professionally and compassionately to people's physical and emotional needs

The provider failed to develop effective and responsive plans of care of care for people deemed to be at the end of their life.

Is the service responsive?

Requires improvement

The service was not responsive. Where people had identified needs the service failed to provide for these needs. Where people had specific goals to maintain independence the service did not plan to meet these needs.

Peoples care records were not consistently kept under review. People could not be assured that they would always receive a responsive service.

Summary of findings

People or those important to them knew how to make a compliant or raise concerns with senior staff. Concerns and complaints were not always recorded making it difficult to evidence that these issues had been addressed in line with the organisations policy.

Is the service well-led?

The service was not well led. There was no registered manager at the home. The senior staff did not provide effective leadership at the home and did not support the staff to carry out their respective roles.

The provider had failed to notify CQC of significant events that affected the wellbeing of the people who lived at the home.

Inadequate

Highcliffe Nursing 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.

We had received concerns about the service from members of the public and from professionals involved in the care of people living at the home

This inspection took place on 20/22/26 May 2015 and was unannounced. The first day of the inspection was carried out by two inspectors and a specialist nurse advisor, on the second day by two inspectors and on the third by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes in the service. At the time of the inspection a Provider Information Record (PIR) had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The people living at the home could not fully explain how they experienced care due to their enduring mental health illness. In order to gain further information about the service we spoke five visiting relatives. We also spoke with 12 members of staff and the providers clinical and operations directors.

We looked around the home and observed care practices throughout the inspection. We looked at ten people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments and quality monitoring records. Observations, where they took place, were from general observations. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before during and after the inspection we spoke with representatives of the local authority's contract monitoring officer and a member of the Clinical Commissioning Group. We also spoke with the chair of the local authorities safeguarding department. During the inspection we spoke with three safeguarding investigators, two occupational therapists, a nutritional specialist, two social workers from the local authority and two fire safety officers from Dorset Fire department. All of these professionals were involved in either the care of people living at the home or their safety.

Inadequate

Is the service safe?

Our findings

We looked at a person's care records and established that a person had been complaining of pain and receiving medicines for relief since 17th May 2015, due to having a pressure ulcer. Whilst observing the medicine round in the morning, the aforementioned person informed the staff member that they were in a lot of pain. The staff member told the person "you can't have anything yet". They explained to us that they were not due any further medicines until 11 pm as the night staff had already dispensed some earlier at 7am. We spoke to the staff member and explained our concerns but they did not consider it necessary to consult with others such as the person's doctor. This meant the pain relief medicines may not be controlling the pain and no other action was considered in ensure the person was comfortable and free from pain. This demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of falls did not have these risk managed. In one person's care records it evidenced that they had fallen eight times this year. There was no recorded evidence in the care records that other professionals such as a falls team had been contacted for advice or guidance on how to minimise the risk of further falls. There was no recorded evidence to indicate that an evaluation of why this person was falling had been made.

One the first day of the inspection we were told that a person had fallen the day before. Their care records had not been updated to reflect this nor did they give staff any further guidance on how to manage the emerging risk. On the second day of the inspection we noted that the person, who was mobile, was unsupervised in the lounge area for long periods of time. We noted that they had lace up shoes which were loose on their feet but they did not have any laces. We asked the staff if the person required support to put their shoes on, they told us that they did. This meant staff had put these shoes on, without laces, putting the person at risk of further falls. We asked the manager to address this without delay. They told us that the person's family had supplied the shoes without laces. On the third day of the inspection we again noted that the same person had shoes on which now had laces, but the laces were not tied. Again they were in the lounge unsupervised. We asked staff why the laces were undone; one answer was "the person must have undone them". The above illustrates that staff did not ensure that safely manage people at risk of falling or take action taken to minimise these risk. This is in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People care and treatment was not delivered in a way that meet their needs. On the first day of the inspection we noted that seven people were not supported to get out of bed. We spoke to three staff about what time these people may be supported to get up. They told us they would not get up today as there was insufficient staff on duty to achieve this. We spoke with health care professionals from the local authority who identified six people were not being supported to get out of bed and their concerns about how this could affect their long term health needs.

A relative had shared concerns with us that their loved one was not being supported to get out of bed. We looked at the person's care records that instructed staff to reposition the person every two to four hours. We asked staff if the person had been repositioned, they told us they had. One staff member told us they had moved the person from laid down to sat up. The care records were not specific about how and what to do to reposition the person to protect them from skin damage. We carried out observations of the person at 9.00, 9.38, 10.07, 10.43, 12.45 on the second day of the inspection and found that they had not been repositioned between these times. We noted that at 13.36 the person position in bed had changed.

We spoke with three staff to find out if the person ever got out of bed. A senior member of staff told us that the day before the inspection the person had been sat in a lounge chair from or most of the afternoon. We asked a senior member of staff if the person was at risk of skin damage, they told us "no". We asked if the chair was suitable for the person given their low weight and body posture, they told us "no" as the person regularly slipped out of the chair. We asked how long they considered it would be safe to keep the person in the chair as the care records illustrated a high of risk of skin damage, they did not answer. They told us "the manager had told them to support them to sit in the chair". Whilst the person's care records clearly identified the risk the person faced the staff did not know this. This illustrated that whilst senior member of staff knew the chair was unsuitable for the person due to slipping out of it, they continued to use it. This meant that that staff had not fully

protected the person from the risk of pressure damage, and had not assessed if the chair was suitable for them. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about their responsibilities in relation to safeguarding vulnerable people. One member of staff was clear about who and when to report any concerns. They demonstrated a good understanding of the provider's policies and the expectations of the local authority. However three other staff struggled to understand the questions asked and only indicated that if they had concerns they would inform the manager. They could not describe what may constitute abuse beyond standard phrases for example; although they knew what neglect was they did not link neglect to actions such as leaving a person in distress with no support or using inappropriate equipment that may put people at risk of harm and potential neglect. These staff struggled to respond to us when we asked who they would report concerns to if the manager was implicated or they did not consider their concerns had been taken seriously. This meant that people may be at risk as staff were not fully aware of who and when they could report concerns too. The above demonstrates a beech of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient equipment to support people safely. An example of this was that on 9 May 2015 a full body sling (used to support a person when they required to be moved from bed to chair) had been discarded. We asked staff if this had been replaced, one told us yes another told us no. A senior member of staff was unsure and took us to the person's room to check what sling was to be used. We found that the sling in use was not a full body sling and so put the person at risk of unnecessary harm because they were assessed as needing a full body sling in order to be able to move the person safely and without harm.. Although we asked senior staff for an explanation as to why this was in use and reassurances that an appropriate sling was available we did not get any answers. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was not safe as the provider had not complied with the requirements of the Regulatory Reform (Fire Safety) Order 2005. On the second day of the inspection the fire department attended a pre-arranged appointment with the manager to carry out a routine fire safety check. We shared with them our concerns that weekly fire safety checks had not been completed, the last one being three months earlier. The fire officers identified that a new fire alarm system was showing a fault in one of the zones. The management of the home were unaware of this fault and could not explain what it related to and which zone (area of the building) was not currently protected (by the fire detection system.) After approximately one hour the fire officers established what the issues were by speaking with the contractors who had installed the alarm. They also found that two fire escapes were unsuitable as the exits to the outside space had a significant drop that put people at risk of falling when exiting the building. The space that the fire escapes led to was also not appropriate due to the surface of the ground. They told the manager to rectify the drop from the fire exits immediately and ensure that exit routes once outside the building were suitable as soon as possible. On third day of the inspection we found the drop from the fire exits had been addressed by installing temporary steps.

There was insufficient staff to meet people's support needs. On the first day of the inspection there were two members of management on duty, two senior clinical members of staff supported by eight care staff responsible for the care and support of the people living at the service. There was also one other carer who supported one person during their waking hours. The rota confirmed this was the normal level of staffing. We observed that at 12.30pm most of the people on the first floor were still in bed. We checked a sample of their care records and established there was no reason why people were in bed. We asked staff why these people were in bed. They told us they do not have time to get everyone up. We asked staff if they had sufficient time to support people some said yes others no. On the first day of the inspection we noted that there were no staff in the main lounge on the ground floor to support or supervise people with the exception of the meal time. We spoke with staff who told us that they don't have time to be in two places at once. We asked if anyone was at risk in the lounge if they were left unsupported, one staff member told us "people are confused, the may be at risk I don't know".

We asked staff what time people would receive lunch and were told about 12.30. We observed the lunch time period on the first day of the inspection. Three people had been supported to tables at 12.15. By 12.35 one person started shouting that they were hungry and wanted something to

Inadequate

Is the service safe?

eat. Staff told them it would be soon. At 1pm the lunch had still not been served, the person who had stated they were hungry was still shouting but staff had stopped reassuring them and ignored them. We asked staff what was the problem with meal time today, one said, “there is not enough staff around at the moment, I am not sure where the others are but they will be here in a minute”. At 1.15 people started to receive their meals. We noted that one person was still in their room in their night clothes. We asked staff if the person needed support to dress and when would they get the support. Staff told us that the person liked to stay in their night clothes, the persons care records did not support their comments.

Following discussions between the local authority and the management of the home it was agreed that the staffing levels should increase by one member of care staff during the day and night. On the third day of the inspection, when staff numbers had been increased, we noted that a person was in bed, with the curtains drawn at 12.35 pm. Their care records stated that they liked to be out of bed between 7 to 8 am every day. There was no indication that the person had any health reasons why they were still in bed. We asked a staff member why the person had not been supported to get up. They told us the person “likes to have lie in bed, but I will deal with them next if you like”. We asked what time the person likes to get up, they told us “any time really, it’s their choice”. We spoke with three other staff about the numbers on duty. They told us its ok if the night shift get people up, if they don’t it’s a struggle. The staff we spoke with were unaware of people’s individual preferences about their waking routine as recorded in their care records, one staff member told us “I get people up when I can”.

There were not enough staff on duty to meet the needs of the people they supported. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff had not received sufficient training to meet the needs of the people they cared for. We spoke with staff about their training, they told us that they have had some face to face training but in the main it had been distance learning materials. We asked staff about their understanding of dementia and how it affected the people they cared for. Three of the staff did not fully understand the questions put to them but after rephrasing the questions several times they were able to tell us some generalised issues such as people being unable to make decisions, confused and anxious. We established these staff had received dementia care training. However they could not tell us about what they did to enable people to make choices or involve them in decisions about their social and emotional needs. One other staff told us that they had received dementia care training but did not consider that it had given them the knowledge to meet the support needs of the people living at the home.

Staff did not demonstrate they could put the training they had received into practice. The provider had a system to identify what training staffed needed together with a system of observation of staff working with people to ensure staff could put into practice what they had learnt, these were not effective. This observational system was not fully or consistently used. Our observations found that staff did not respond to people's emotional needs and at times ignored people who showed distress. When we asked why people stayed in their rooms we were told that was their choice, when people had cold food we were told that was what they liked. Staff did not demonstrate that they supported people with anything else apart from their basic personal care needs. We asked staff if they considered the training was sufficient, they answered no. Two staff explained to us that there had been a drive to ensure everybody had completed their training. They told us that not all staff had completed the on line training themselves. They said staff had been brought on duty to complete the training for some of the staff whose first language was not English or who could not complete the training as required due to insufficient skills. We made the clinical director aware of these allegations. The above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not effectively meet people's health needs. On the first day of the inspection we were informed by senior night staff that a person had fallen at approximately 10 pm and had been hit by a metal chair causing a cut above the eye. The staff described the person's distress as "screaming". They told us that they could not give any pain killers as the person had received them early in the evening. They told us that the person was still screaming at 1am when they gave them some further pain killers. They reported that the person had a settled night after that. We asked the senior night staff what observations and support they had carried out overnight they replied

"we hoisted them back into bed and made them comfortable". The staff told us they had had carried out a blood pressure test at the time of the incident and at 6.30 am, no other professional advice had been considered. The staff did not tell us about any further monitoring or observations during the night. We discussed our concerns with the manager. At approximately 11.30am on the first day of the inspection staff attempted to support the person out of bed and to stand, the person began screaming. A doctor was called and it was noted one of the person's legs was notably shorter than the other indicating a hip injury. Arrangements were then made to move the person to hospital with a suspected broken hip.

We looked at the person's care records to see if 'screaming' was a known behaviour associated with their dementia. The records did not evidence that this was a known behaviour. This meant that the person had not received a thorough examination to consider an explanation for the screaming. There was no evidence that the staff had considered that the person may be in pain due to other injuries other than the cut to the head, nor had they considered calling paramedics who may have been in a position to offer effective pain relief or a second opinion. The above demonstrates a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive adequate support to eat and drink. We observed that one person was served fish and chips in their room at 1pm. We noted at 1.30 they had not started their food and we asked them if everything was ok. They did not reply and started to eat. At 3pm we noted that the person still had their fish and chips in front of them and was just starting to eat again. We raised this with senior staff who told us the person likes their food cold. We looked

at the person's care records that did not inform this was the case. We found that between 9am and 2 pm one person who remained in bed had no drink on a table in front of them, the persons fluid intake record supported out observations. We also observed that three other people had drinks in their room but they were out of reach. We looked at people's food and fluid intake records on the first day of the inspection, these records were incomplete. This meant that the systems in place to ensure people had sufficient food and fluids were not being consistently used putting people at risk of harm.

Where people had significant weight loss the provider had not introduced effective systems to monitor people's well being or take action to address these concerns. We looked at one person's care records that informed that the person had lost 6kg of weight in recent months. There was no plan of care to address the weight loss apart from weighing the person. A referral to a dietician had not been made. Following consultation between the provider's senior management team and the local authority, on the second day of our inspection, the provider agreed to introduce food and fluid charts for all those people at risk of malnutrition or dehydration (the local authority informed us that they would review people's needs in partnership with the home and make the necessary referral's through this process). On the third day of the inspection we noted that the food and fluid records had been completed, but these showed two people with very low food and fluid intakes. We asked one staff member what the expected amount an identified person should receive in a day, they did not know. We looked at care records that did not give staff guidance on the expected amount for each individual. This meant people were at risk of de-hydration or malnutrition. This above demonstrates in breach of regulation14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with one visiting relative who told us "the food is ok but the portions seem to be smaller." They told us their relative complained about being hungry and they had brought in snacks during the day. We noted on the second day of the inspection there were savoury snacks such as crisps in the lounge area. A staff member told us "this is so people can help their self". (The snacks were placed on a cupboard away from the seating area. This meant they would only be available to people who could mobilise without staff support. We observed this was limited to only one person during the inspection). We asked if anyone was at risk of choking, through eating the foods that may cause them harm, they did not know. Whilst it is welcomed that people can access snacks themselves the risk people may face from eating these types of snacks were not known by staff which may put them at risk of harm.

People were offered a choice of food to eat but this was not consistent. We noted on the first day of the inspection people who were sat in the main dining area were offered a choice of meal at lunch time by showing the person two different plates of food. However this was not the case for people who were served food in their own rooms where we observed that no choice was offered. We also observed the tea time meal on day two of the inspection where no one was offered a choice of meal regardless of where they ate their food, in their rooms or in the dining area. We also noted that people were offered a choice of drink to accompany their meal in the main dining room. We saw a person being offered a choice of orange juice or water, the person choose orange juice, the staff returned with water and did not acknowledge they had made a mistake. We also noted that one person was offered orange juice but there was none. The staff offered the person an alternative of blackcurrant which the person agreed too, again there was none. The person settled for water, the only choice left. The staff did not offer an explanation as to why the first two choices were not available.

People living on the first floor of the building had insufficient space to eat in the communal area. There were 15 people living on the first floor. We noted that the only dining table, suitable for four people, had been moved into a small side room off the communal area which did not provide access to people with poor mobility. A senior member of staff told us the table had been moved into the side room and was now used by staff for their lunch. We observed three people have their meals in the main communal area on that floor. The people had a small adjustable table in front of them whilst they sat in a wheelchair. This did not enhance the dining experience or promote a sense of community where people could talk over their meals.

People's legal rights were not fully protected or understood by staff. The people we spoke with could not fully explain how they experienced the care and support offered to them. We spoke with staff about how they ensured that people were listened to and that they acted in people's best interest. Staff told us that people could not tell them

Inadequate

Is the service effective?

how they wished to be cared for. Two staff told us that they consult with relatives but were unclear about what to do if people had no others to assist them. Staff were aware of some legal concepts such as 'power of attorney' but did not fully understand when relatives could make decisions based on these 'powers' for example. A relative told a senior member of staff that their relative looked unwell to which the staff member accompanied them to check the person's wellbeing.

When they returned to the office we asked them if the person was ok. They told us that the relative did not wish to have the doctor called as the person was at the end of their life, they further explained that the relative had power of attorney. We checked the person's care records that informed the relative only had limited powers associated with financial matters and not for health and welfare. Therefore the senior member of staff did not use their clinical experience to assess the person's needs and based their decisions on the wishes of the relative that was not empowered to make the decision.

We spoke with staff about their understanding of the Mental Capacity Act (MCA). Whilst those in management and some senior staff could describe the impact and rights of the people living at the home, not all staff had an understanding of people's rights for example. Some people had MCA assessments. These illustrated that people's capacity to consent had been considered and documented. However when we spoke with staff about the MCA they had little understanding of the act and how to protect people's rights. We noted that a number of Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for but the home was awaiting a response to these applications. However people could not move around the home freely as they needed staff support to access coded door locks or to assist them to open 'child safety gates' (in use to protect people from harm through accessing to the stairs. Child safety gates are designed to protect children and may not be suitable for use to protect adults). DoLS authorisations had not been considered for the people affected by these restrictions. This was pointed out to the manager who acknowledged that further work was required in relation to updating people's MCA and DolS applications and ensuring a risk assessment was available in relation to the use of a child safety gate.. This meant that there was an understanding of the need to carry out further work with regards to ensuring people's legal rights were protected. However the staffs lack of understanding of this legislation means that people's legal rights were not protected. This demonstrates a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

The service was not caring. We observed many instances where people were distressed and received no support or acknowledgement from staff for example. We observed one person was distressed and crying in the lounge. A member of staff wished to move them from an upright position to slightly reclined, the person was clear that they did not want this and said "no". The staff member did not acknowledge this and reclined the headrest. They ignored the person's distress and did not talk with them or offer any support. Other staff were in the area at the time. No staff approached the person or tried to support them. Another example was that we heard a person clearly saying that they did not wish for care support. The staff member continued with their task despite the person stated "no stop". We asked the manager to consider what was happening and intervene if necessary, which they did but did not offer us an explanation. However within minutes the person could be heard asking the staff member to "stop", we pointed this out again to the manager. We looked at the person's records that did not evidence the person was in the habit of refusing help and support. We asked the manager if the person had capacity to make decisions for themselves but they did not give an answer.

We observed that one person who required help to stand from a lounge chair was supported to the toilet before dinner. The staff member who supported them asked them if they would like to go straight to the dinner table on their return, the person agreed. Another member of staff supported the person back to the lounge and despite the person's protests was firmly supported to sit back in the lounge chair. This meant the staff member had not listened to the person or tried to understand what they were being told. The first member of staff then returned, asked the person why they were sitting in the lounge and supported them to move into the dining area.

The staff we spoke with were unaware of people's individual preferences or routines. We looked at people's care records and plans of care. Some of these recorded people's preferences, routines and social history. We spoke with relatives who told us they had been asked questions about people's likes and dislikes and the person's background when the person took up residence. We spoke with staff about the people who had recorded preferences. They could not tell us about what was recorded in the care records but could tell us about the tasks they performed such as providing personal care and support to eat and drink. This meant that although in some cases information was available staff did not have sufficient knowledge of people's preferences.

The service did not effectively plan to ensure people received good care when nearing the end of their life. We spoke with senior staff who identified one person as nearing the end of their life, the person's relative confirmed to us the person was at the end of their life. We looked at the care records that whilst describing the person as very unwell, they did not include an end of life plan. The person's doctor had prescribed pain relieving medicines to be used as and when necessary but there was no guidance to staff with regards to how and when to use these medicines. We spoke to the newly appointed clinical lead about this person's care, who after discussions with staff at the home, informed us the person was not at the end of their life. (This was later confirmed by health care professionals who reviewed this person's care needs). This meant that whilst senior staff believed the person was at the end of life no care plan had been put into place to ensure a comfortable and pain free death. The belief that the person was at the end of their life f was not supported by other health care professionals who considered the person to be very unwell. The above demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

People were not treated with respect or dignity. We observed staff discussing people's needs in the main lounge on the ground floor in front of others. This was observed on all three days of the inspection. This does not treat people with respect and undermines their personal rights to confidentiality. Furthermore we noted that in the shower room on the ground floor was a nylon bag marked 'knickers'. We asked a staff member what was in the bag and why were they hanging in the shower room. They told us "It is for when people are 'wet' (have been incontinent) so these are used to change them, they should not be in here they should be in the laundry". This meant that people may not have their own personal clothing to wear which undermines people's dignity and does not treat them with respect. This demonstrates a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

When people had assessed needs and aspirations the service did not provide for these.. One person's care records stated that they 'wished to improve their mobility' but there was no directions for staff on how they could achieve this. We spoke with staff about the person's mobility. One staff member told us "they can stand with the use of an aid but we use a wheelchair to help them move around the building, it's safer, we have to monitor them if they are walking as they are risk of falling". This meant their aspiration to improve their mobility was not considered and a plan to achieve this had not been made. We also noted in the person's records that they suffer from depression and dementia. There was no care plan to guide staff in how to meet the person's needs when they were depressed. There was no recording that stated how the person would present when they were depressed or what actions to take support them. This means the staff did not have sufficient guidance to meet the person's needs responsively.

Person centred care was not provided at the home. Whilst the care records provided some evidence of developing a person centred approach this was not present in all. However we did not see that staff acted on this information. One relative told us that wished their husband had more activities to enable them to retain what mobility they had. They told us that their husband would play catch with them which helped with hand eye coordination. They told us they had asked staff if they could do this and were told they will pass this on to the activities coordinator. We looked at peoples care records that evidenced the activities coordinator was building up profiles of the people living at the home through discussion with their family and the people living there. We observed the activities coordinator on the second day of the inspection who spent most of their time either talking with or supervising people in the lounge area in order to keep them safe.

Relatives told us they had been consulted about people's needs when their relative moved in however they did not consider they had much input since that time. One of the relatives did comment" I have spoken about my relatives changing needs, I think the staff recorded what we spoke about". Another relative told us, "I gave staff information about our family's history and things that my relative is interested in some time ago, as far as I know this has yet to be put onto the computer system."

Our observations during the inspection evidenced a task centred approach adopted by staff where they completed the tasks that were required such as, help to go to the toilet or get out of bed, but very little that was based on individual choice and preference as recorded in care records for example. One person's care records stated they liked to spend time with a member of staff on a one to one basis, likes music and likes to come into the lounge on Wednesdays. The staff we spoke to were unaware of these people's routines. Staff mitigated their lack of person centred care through the lack of staff or by suggesting that 'what I do is what they like' (with no evidence this was based on the persons recorded preferences) or they prefer to be treated this way. This meant that people may not receive care based on the personal preferences. This is in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at peoples care records which evidenced they were being kept under review. The records demonstrated where people's needs had changed it was recorded but this was not consistent for example, when people risks changed this was not always illustrated in the care records. Whilst care records were reviewed the delivery of and quality of care was not. The manager told us that this was to be addressed but this was not the priority.

People's relatives told us about how the service responded to their concerns and comments of the care provided. We spoke with one relative who told us they were satisfied with the care their relative received at the home. They told us that things had improved but they still do not consider that the staff respond when their relative requires support with their personal care. They told us that "when they call for help (using the call bell) they often have to wait, they don't like this". Another relative told us they were "happy with the care, although their relative is mostly in bed". They told us the staff sometimes support their relative out of bed to sit in a chair going on to say "I would like them to be mobilised more so that I could take them out in a wheelchair."

Relatives told us that they knew how to make a compliant and who to raise issues with. However not all of the relatives could tell us who was in charge of the home but could identify senior members of care staff. One relative

Requires improvement

Is the service responsive?

told us about some complaints they had made about the food and how it was resolved. Another told us about the concerns they had over their relative being in bed with no pyjamas on their bottom half only a continence aid. They told us they had to monitor this as not all staff ensure their relative is appropriately dressed. Another told us told us "I have no real issues here only niggles, they sort it out in time".

One relative told us about their concerns over the support their relative received. They told us they had been talking with management at the home to resolve some equipment issues that would enhance the quality of life of their relative but had yet to resolve this. We looked at the complaints records that did not include this issue or demonstrate how this was going to be resolved, although senior management were aware of the concerns and were in negotiation with the local authority to resolve this issue. This meant concerns and complaints were not always recorded making it difficult to evidence that these issues had been addressed in line with the organisations policy

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post, this has been the case since 24 January 2011. The provider had appointed a manager who had been in post for two weeks when the inspection began. However during our inspection visits the appointed manager resigned. The provider appointed a clinical lead whose first day of work was on 22 May 2015. They were present on the second day of the inspection, this being their first day in their new role. This person had previously worked at the home approximately eight months ago in the role of deputy manager. We met with senior representatives, clinical director and operations director on the third day of the inspection to discuss the service on offer.

The home was not well led. On the first of the inspection we arrived at 7.30am. We spoke to one member of night staff who told us it had been a quiet night with no significant incidents. We sat in on the handover of information between the senior night staff and senior members of the day staff. The hand over lacked detail of the events of the night and only gave brief reference to two serious incidents, these being two falls one on the previous afternoon the other in the night. There was little information as regards to the monitoring of these two people and no recommendations made by night to day staff. This meant people may have unmet needs through the lack of information and guidance passed between the two staff groups.

We then sat in on the handover of information from the senior day staff to the care staff. Again this hand over lacked detail and did not reference any further ongoing monitoring of the two people who had fallen. The staff were told they should ensure everyone was offered a food supplement at 10am. We asked the staff group who was required to have a food supplement. Whilst the staff could name three people there was some discussion as to who actually required it. The senior staff leading the meeting were unclear as to who was actually prescribed or required the supplement.

The senior staff did inform the staff of two people who were allocated as "resident of the day', where the two nominated people, different every day, could expect to receive 'extra care'. We looked at the recording tools which illustrated the extra care people could expect. With the exception of identifying if the person needed to see a chiropodist, mattress condition check and arranging for a haircut was required there was nothing else that you would not expect all people to receive on a daily basis such as ' finger nails clean, clothes clean or facial hair removed or shaved'.

The above illustrates that the senior staff failed to ensure staff understood how to care for people following serious incidents. They did not give staff any guidance on what they should do during the shift or identify anyone that may be at risk of harm through emerging situations. The staff we spoke with following the handover told us they have their routines and know what to do. One staff member told us "I know who I need to get up. If the night staff have not done it I get them up". What was apparent to us was that those staff whose first language was not English struggled to understand our questions and therefore may have found it difficult to understand handover meetings and what was asked of them. One of the directors acknowledged our comments and told us one of the senior staff had themselves arranged to take English lessons.

The provider had not ensured that they had notified the CQC of issues that affect the well being of people. Following a safeguarding meeting on 29 May 2015 we were made aware that one person had a grade 3 pressure ulcer. We checked our records and established that the provider had not made a statutory notification to CQC relating to this issue. We were also made aware that one person had fallen during a moving and handling procedure carried out by staff on 17 March 2015 which resulted in injury. We checked our records and established that the provider had not made a statutory notification to CQC relating to this issue. These two issues demonstrate a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010.

The service did not have effective systems to ensure high quality care at the home. We asked to see any improvement plans that had been made following the providers own quality review of the service on offer. The manager told us about the local authority's contract monitoring report that had been made following their visit on 30 March 2015. They told us they were working through the actions required in this report. We looked at the report that informed 34 actions were required, 16 with immediate effect to be taken to meet the obligations of the contract with the local authority. We asked what progress had been

Is the service well-led?

made. We were told that progress had been made in relation to mental capacity act assessments but little else due to other pressing demands and length of time in post, 3 weeks.

We observed the manager give details of a person's health to a doctor by reading from the person's care records. We asked them how confident they were about using the care records to advise other professionals. They acknowledged our concerns that care records may not be reliable especially around nutrition and dehydration. They told us the provider had asked them to audit all of the records at the service but this had not been their priority. We were shown clinical audits relating to the care of five people. These evidenced people's care records had been checked to ensure they were up to date but the checks did not consider the actual 'hands on care' that was delivered. This meant that whilst people's care records had been checked and found to be satisfactory, the care and support the person received had not.

The fire officers were concerned that although a fire safety audit had recently been carried out in the week before their inspection, by senior management at the home, the issues they identified had not been found during their check. Furthermore a fire risk assessment carried earlier in the year, which had set actions, had been signed off as completed but it was clear the provider had failed to address all the concerns identified putting people at risk of harm. This is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the staff were supported by management to ensure that they offered good quality care. Staff told us they had team meetings and 1:1 supervision with management. We looked at a sample of the supervision records to establish how staff were encouraged and supported to provide good quality care. We looked at the supervision records of one member of staff where there had been concerns regarding their practice. This record detailed the potential consequences if the staff member's practice did not improve but did not contain information as to how they would be supported and trained to improve.

The recording evidenced the supervisor had used the supervision session to reflect on what the supervisee' future professional standing would be due to concerns of their practice. (The issues discussed could have been addressed through training and support). This did not demonstrate a supportive culture between supervisee and supervisor. We looked at the last team meeting which took place following the local authority's contract monitoring report. This references that improvements were necessary but stated that any forthcoming CQC inspection would be a 'doddle'. This evidenced that senior management did not understand the depth and breadth of the problems at the home.

On all three days of the inspection we asked if there were any quality monitoring reports made by the senior management of the provider following their visits to the home. We were not provided with these nor did they provide an explanation as to why we did not have sight of these records.

We looked at the providers website to understand the values and visions of the provider. Under the heading 'clinical governance' it states the provider 'has a robust approach to clinical governance. We have a dedicated team of individuals who are in place to ensure we are maintaining the highest levels of care throughout our homes up and down the country'. Under the heading ' our approach to care' the provider informs that 'In general, life works well when full understanding is achieved between people. At the heart of mutual understanding and, of course, real care is communication: talking and listening. We listen to residents so that we can truly understand their needs and wishes. During this inspection we found that the provider had fallen short of these statements.

All of the above demonstrates there were insufficient systems in place to ensure high quality care at the home. This meant that people may receive inadequate or inappropriate care. This is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.