YMICARE Limited

Pennsylvania House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11, 12 and 14 October 2016 and was unannounced. We carried out this inspection to follow up on concerns raised within a safeguarding process relating to risks to people, the management and control of the risk of the spread of infection and staffing levels at night. We carried out a focussed inspection in February 2016 and found people were not protected from the risks associated with the control and spread of infection, the standard of cleanliness in the home's kitchen was unacceptable and there were not sufficient staff available to meet people's needs at night. Personal emergency evacuation plans (PEEPS) had not been completed for each person who lived at the home. This information would assist staff and emergency services if people needed to be evacuated from the premises. We discussed this with the provider and registered manager at the time who informed us they were in the process of completing a PEEP for each person following recommendations from a fire safety officer. Regulatory breaches around safe care and treatment were identified and the service was judged to be requiring improvement.

We carried out this comprehensive inspection in October 2016 to check whether the above issues had been addressed and whether people using the service were safe and receiving effective, caring and responsive care in a well led service. There were 16 people living at Pennsylvania House at the time of this inspection with one person in hospital and one person receiving short term respite care. The home has remained under whole home safeguarding since February 2016 which means it is being monitored by the local authority safeguarding team. An admissions suspension was placed on the home to prevent the service admitting any new admissions and remains in place. As a protective measure community matrons and safeguarding nurses continued to regularly visit the home to ensure people's needs were being met. We continued to receive concerns arising from these visits, where although the home reacted well to the concerns when told, they did not identify them or put sustainable or safe systems in place to manage the home safely. Concerns included the lack of management of the service, safe medication administration, safe moving and handling, safe staffing levels and supervision of people living at the home and training.

At this inspection we found no improvements had been made other than we received an action plan following the inspection in February 2016 and environmental health visited the home on 18 March 2016 giving a Food Rating of 5, so the cleanliness of the kitchen had improved. There were continuing breaches in relation to the safe care and treatment of people and further breaches in relation to safe staffing levels, application of the Mental Capacity Act 2005, cleanliness and infection control, management of risk, maintenance and meeting people's individual needs.

We continued this inspection for three days due to our concerns and contacted environmental health and the fire safety officer to share our concerns as well as the safeguarding team. For example, a known bed bug infestation had not been well managed by staff who had no clear instructions about what to do. We asked the provider to deal with this issue immediately. As the fire alarm testing records showed no tests for one month and the general maintenance and cleanliness of the building was shabby we asked the fire safety officer to visit with us on the third day. They also found continued evidence of poor fire safety management

despite making recommendations in January 2016. They will be issuing an enforcement notice using their own processes. We spoke to three health professionals visiting the home daily as part of the protection plan arising from the safeguarding meeting discussions. They continued to pick up issues with the correct use of pressure relieving equipment, management of bed bugs and general management. They all said the home and staff appeared unprofessional and shabby, although staff were friendly and helpful, they did not look smart and no staff wore name badges. Staff said they had asked the provider for uniforms and name badges many times.

We found nine breaches relating to seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. The overall rating for this service following this inspection in October 2016 is Inadequate which means it will be placed into special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. We asked the provider to voluntarily agree not to admit further admissions until further notice. The provider agreed to this.CQC is now considering the appropriate regulatory response to resolve the problems we found.

Pennsylvania House is registered to provide accommodation with personal care for up to 25 adults. It offers a service for people who may have dementia, mental health needs or learning disabilities. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the registered manager had moved to the provider's second service and was based there. The provider assured us the two deputy managers at Pennsylvania House supported by the registered manager would be able to safely manage the home. We found this not to be the case, they were not listened to or empowered to make decisions to ensure consistent management.

Risks to people were not always minimised through the effective use of risk assessments. Staff did not follow care plans but relied on verbal information from each other and poor, basic handovers between shifts. There were insufficient suitably trained staff deployed to keep people safe and meet people's care needs in a timely manner. Staff did not always have the knowledge and skills required to meet people's individual care and support. Although they had training in a range of topics, this was not used to deliver care, staff competency was not managed and staff were not regularly supervised to ensure they were able to meet people's needs. The provider had good recruitment and vetting procedures but staff did not always have the induction, training and supervision they needed.

People did not receive care that was personalised and reflected their individual needs and preferences. Staff

did not have the time to deliver personalised care or use information in the care plans to ensure they knew how to meet individual needs. Although activities were organised by the activity co-ordinator their knowledge of people's needs was random, they did not use the care plans or relate people's preferences to activities. They told us they did not feel equipped to manage people with dementia and were restricted by a lack of staff. Staff had little input in managing engagement and stimulation. Although the activity co-ordinator delivered some meaningful activities and one to one sessions with some people they recorded events by activity. This meant some people with more complex needs spent long periods unstimulated and inactive.

People's rights were not protected. Although applications had been made following legislation to prevent people leaving the home for their own safety, the principles of the Mental Capacity Act 2005 were not followed to ensure that people were consenting or being supported to consent to their care and support.

People's medicines were administered and recorded and staff knew what to do but lack of time did not ensure people were taking their medicines safely.

People's right to privacy and dignity was compromised due to lack of staff time and response. Most people were unkempt, wearing soiled clothes and staff were unable to effectively manage people's continence.

Systems in place to monitor the quality of the service were ineffective. The management systems were insufficient to provide leadership and guidance to the care staff. People were at risk of receiving poor, undignified, inconsistent and unsafe care. Little improvements had been made since the last inspection, despite the concerns being known to the provider for some time.

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.

Risks to people's health and wellbeing were not managed in a safe or consistent way.

There were not enough staff deployed to keep people safe and meet people's care needs in an individualised or timely way.

People were at risk of issues relating to infection control due to the poor cleanliness of the home and poor, inconsistent management of bed bugs.

People did not benefit from an environment that was pleasant or well maintained.

Is the service effective?

Inadequate

The service was not effective.

People did not always consent to their care, treatment and support or have their rights protected.

People's nutritional needs and preferences were not always met or in a timely way.

People did not always receive the health care support they needed unless in response to health professional concerns.

Staff did not receive adequate induction, training and supervision to ensure they provided support in a safe, effective way.

Is the service caring?

Inadequate

The service was not caring.

People's privacy and dignity was not always respected.

Institutional routines centred around tasks did not afford people the person centred care they required from staff who were struggling to cope with the work load.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that reflected their needs and preferences.

Leisure and social activities were provided to some people but people with more complex needs were unstimulated and unengaged for long periods.

Is the service well-led?

Inadequate

The service was not well led.

People did not benefit from consistent leadership, the registered manager was not based at the service and management guidance was lacking or re-active.

Staff were not listened too or empowered to provide a good quality service.

Systems the provider had in place to monitor the quality of service were ineffective and effective improvements had not been made since our previous inspection or from findings shared with the provider through the ongoing whole home safeguarding process.

Pennsylvania House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection was unannounced and took place on 11, 12 and 14 October 2016 and was carried out by an adult social care manager and an adult social care inspector with an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held about the service. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with two people who used the service who were able to communicate their experiences. As 13 people were unable to directly tell us about their experiences due to living with dementia we spent time observing their care in communal areas throughout the three days. We spoke with two relatives, eight members of care staff, an agency care worker, two cooks, the deputy managers and the registered manager and provider. We looked at care records relating to the care of six people who used the service. We spoke with the local authority safeguarding team, three visiting health professionals involved in safeguarding protection plan visits, a chiropodist and a district nurse. We also examined records relating to the running of the home such as audits, medicines administration records (MARS), training records, staff recruitment records and staff rotas. We informed environmental health about the continuing bed bug infestation. We contacted the fire safety officer who joined us at the service on the third day to follow up on their review from January 2016 where recommendations were made. Following their visit on 14 October 2016 the fire authority will be issuing an enforcement notice.

Inadequate

Is the service safe?

Our findings

The service was not safe. There were inadequate and inconsistent staffing levels and deployment of staff most days to ensure that people received basic care in a timely manner. During our inspection there were 15 people living at the home. The dependency of people's needs varied depending on which staff we asked but on average there were seven or eight people who required two staff to mobilise, four people who required assistance with all food and fluid intake and 10 people who required two hourly continence management. Some other people also required prompting to maintain their continence. Staff told us that staffing levels on the first day were not usual. There was a deputy manager at 8am and two care staff. A further four care staff arrived at 9am supported by a domestic, cook and activity co-ordinator. We were unable to speak with the deputy manager or other staff throughout the morning except briefly as they were so busy. The senior shift leader had a list of tasks to do as well as the medication round from 08.30 to at least 12.00. Tasks included four staff shift handovers, complete fridge temperature charts, change staff board stating who was working that day, daily menus and calendar, liase with health professionals, laundry, daily staff training at 11.20am and 7pm, room checks to ensure people's rooms were clean and a nice environment and records including food and fluid diaries. Other than medication, liasing with health professionals and laundry, these tasks and checks were not completed because there was not enough time on each shift. From the office diary we saw on most days there was a senior and four care workers in the morning and a senior and three care workers in the afternoon. On some days there was only a senior and three care workers in the morning and staff absence was not covered.

There was a role for a 'floater' care worker with a task sheet. It was unclear who would do these tasks if there was no 'floater' on duty. This task list included hoovering the dining room and lounges, put away laundry, give out teas and coffee, help with care and clean kitchen. A community matron found on 28 September found there was only three care workers on duty in the morning who looked very busy. They shared their concerns with the safeguarding team who contacted the provider to gain reassurance there were enough staff to meet people's needs.

The provider and registered manager confirmed they did not use a particular system or tool to assess staffing levels by considering people's dependencies. Staff told us they had repeatedly told the registered manager and provider there were not enough staff but had been told staffing levels were based on the numbers of people living in the home. The provider said the staffing levels were the same as when the home had been full and therefore should be enough. Staff meeting minutes of August 2016 stated staff had said, "There is a shortage of staff and it is impossible to do all of the care" The registered manager said, "Sickness is letting you down and there are reports of lazy staff" and "'Floaters' (staff who are not allocated to support particular people) should monitor the floor whilst carers are busy". However, no assessment of staffing levels was done.

We saw many examples showing staff did not have time to provide individualised care. We saw lounges and people being left unsupervised for long periods. No-one in these areas could use a call bell due to their dementia. Each day of the inspection one person in particular was visibly distressed and unsupervised. We asked a care worker to support them or move the person's chair so they could see what was going on.

Records did not show how staff should manage their anxiety effectively. Another person having bed rest in their room, unable to use a call bell, was being checked two hourly but we found them cold and uncovered so we had to ask staff to provide care.

People were generally unkempt. This had been raised in a resident's meeting by relatives in March 2016 who had raised people's hygiene as an issue for improvement but felt this had improved once people had settled in. Therefore the provider had known this had been an issue in the past that required monitoring Staff said they only had time to do 'the basics', however we found people's hair needed brushing and washing. People had not had their teeth cleaned, toothbrushes were bone dry in every room, despite records saying oral care had been done. We fed this back to the provider and registered manager and on the third day there was a hand written note on the staff notice board reminding staff to brush people's hair and teeth. This had also been raised in February 2016 and was noted within the service improvement plan.

Many people's clothes look scruffy, staff told us they had told the registered manager that people had worn out clothes but were told by the registered manager people did not have enough money to spend on clothes. No further action had been taken. Staff were unable to tell us if people were wearing the clothes of their choice. One person had a cup of tea spilt down their front. We told a care worker but their clothes were not changed. Another person had visibly stained trousers and another person's shoe required heeling but they were wearing them despite having no bottom part to one of the heels.

On the second day at least three people were wearing the same clothes as the day before. On this day the shift was very short staffed. At 8am there had only been the deputy on duty due to sickness until another care worker came in early. This meant that people could not be assisted to get up. Some people were still getting up and having breakfast at 11am and therefore could not eat all of their lunch at 12pm. Whilst food and fluid records showed where people had declined or had little of their meal, staff did not go back and offer the meal again. Some of these people had been identified as being at risk of losing weight or dehydration.

On the third day, one deputy manager was working as the cook which they were doing as part of a phased return to work following an absence. Three care workers were on duty including one agency care worker to provide care with a senior doing the medication round. One care worker had gone off sick. Staff had attempted to cover the shift unsuccessfully. We rang the registered manager to ensure this gap was covered. Eventually the second deputy manager who was on a day off covered the shift leaving the senior free to provide care. People in the first floor lounge continued to look unkempt and were sitting doing nothing all day. Even when an agency worker was employed to increase staffing numbers the provider had no assessment of the agency worker's knowledge and skills, no induction information, poor handover and no tour of the building or introduction to people, which did not ensure they were safe to work at the home.

There were four people who required assistance to eat. There were only three care workers on duty with the senior doing the medication round from 8.30am until 12pm due to the complexity of people's needs. There were four people who required assistance to eat but because there were only three care workers available one person had to watch while others ate until the activity coordinator came to help later on. Two people who required two staff to assist them to the toilet required help. There were not enough staff to support them both resulting in one person being completely soiled in the lounge. We contacted the registered manager to ensure another care worker was sourced as soon as possible. They arrived just over half an hour later. Staff told us, "Lots of people were wet this morning when we got here." They did not know for how long. Although there was an activity co-ordinator who was providing organised activities for some people, those in the first floor lounge received very little engagement unless it was related to tasks such as having food or managing continence. On all three days at least four people had little stimulation, contact or

conversation with staff unless staff were performing tasks.

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risk assessments were completed but those that we read did not correspond with staff working practices. Therefore, staff were not always following risk assessments in individual care plans. For example, one person had spilt hot tea on their lap in the past. Their risk assessment said they should be monitored but it did not specify how. We saw them left alone for a considerable time with a hot cup of tea in front of them on all three days. We told staff to ensure the person was safe each time as they had not identified the risk themselves.

The registered manager told us there were two waking staff at night. Staff told us there was a waking care worker and a sleeping care worker who was paid less. The sleeping care worker was woken up every two hours to assist with the two people who required two hourly turns to relieve pressure areas. All night records stated the same sentence, 'Settled night, turned two hourly'. Some people had been identified in care records as 'waking at night becoming anxious' or 'continues to be easily distressed'. There were no instructions for staff on how to manage this. However, during the short handover to the morning staff we heard that some people had been awake at night. One person who usually slept in a chair had eventually slept in bed. This was not reflected in their care records and did not show how it had been managed and for how long. In September 2016 records noted this person had fallen, unwitnessed, in the lounge, from their recliner chair. They had taken their feet off the stool, leant forward too much, ending up on the floor. They had a skin tear on their forehead requiring a district nurse visit. Although the home acted appropriately following the event, there was no risk assessment or actions taken other than to 'monitor' and 'encourage to sleep in bed'. This person had fallen before at least five times in a similar way.

Another person's moving and handling risk assessment said they were independent with a frame. However, their records suggested staff had used a hoist on some occasions, 'hanging out of bed, used hoist'. Staff said the person often did this in bed and they required two, sometimes three staff as they were heavy to re-position back in bed.

We looked at risk assessments for falls. These had not been updated since 6 September 2016. The most recent relative meeting minutes included discussions about safeguarding concerns relating to the number of falls. The minutes noted that the ambulance service had "threatened to charge a fee" due to the amount of calls the home made about falls. The minutes said, "We can't stop residents moving around the home… let them do what they want to do". However, risk assessments did not show how to minimise risk especially following an identification of a high risk of falls. Where bed rails were used there were no bed rail assessments to ensure this was appropriate and free from risk. One person had bed rails in place but records showed they had, "attempted to get out of bed in May 2016" which may indicate bed rails were not safe for them. Their individual fall risk assessment also said, "ensure left finger not near face' due to previous skin damage but this was not in the care plan but filed away so staff would not know this information. Individual fall risk assessments written after incidents stated various actions for staff to take but did not give clear instructions. For example, "extra care surrounding moving around home", "monitoring required-yes", "monitoring as per care plan" (no details in care plan), "all staff to keep an eye", "monitoring required- yes climbed out of armchair". Other than these short statements there were no details of actions for staff to take to minimise risk of further falls.

Medicines were held securely and taken to people using the medicines trolley. The deputy manager had received training on the administration of medicines. We were told that only staff who had received this

training were able to administer medicines. The trolley containing medicines was tidy and contained individual drawers containing each person's medicines. The medication administration records (MAR) were signed correctly. Medicines that required additional security were managed appropriately. We had previously had concerns that staff working at night had not had training in medication administration. This was carried out on the second day of our inspection. Previously the registered manager had been 'on-call' should anyone require medication. However, this was not satisfactory as people would have to wait. We observed two medication rounds. These took a long time each day (08.30-12.00) due to the complex needs of people living at Pennsylvania House. The deputy manager said they used to have their medicines in blister packs but the pharmacy now sent then in boxes and liquids. This meant it took longer to for them to be dispensed and administered. Some people were not receiving their medicines at the times prescribed. We saw the deputy manager ensure people had taken their medication before signing as administered. However, this did not always appear to be the case as we found a tablet on the floor in one room and staff told us another person had spat their tablet out some time later so they had told the deputy manager. Another person on the first day was expressing concern that they had something in their hand saying, "I don't know what to do with it". This appeared to be a piece of medication (tablet). The deputy manager said they would get another one but the person did not want one. Visiting health professional reports also had similar issues about tablets not being administered properly. The deputy manager was also taking the home's telephone calls during the medication round and responding to care staff. This meant their focus was not always on the task and could put people at risk.

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We had concerns about infection control and the immediate risk to the health of people as we became aware of the extremely unhygienic physical conditions of the environment. Generally, the whole home was poorly maintained and not clean. There were issues with nearly all the rooms such as dustiness, very stained toilet bowls and sinks, stained sheets, covers, walls and curtains. Lounge chairs had food stains and the backs were covered in hair and carpets were dirty with crumbs throughout the day. One person's trolley was sticky throughout our inspection. Some rooms had full commode pans that were odorous. Drink jugs were uncovered and tablecloths were stained. Personal protection equipment (PPE) such as aprons and gloves were available but we did not always see staff wearing these when assisting people or when in the kitchen. We also found some sheets were old and did not cover the mattress or bed base. Duvets did not have fastenings so plastic covers were visible and many towels were threadbare. The domestic said they did what they could but there was no time and sometimes they had to help assist people with eating. A cleaning report on 10 October said the domestic had to help with breakfast until 09.30 and reported wallpaper hanging in a bathroom and a window sill coming off, which had not been resolved during our inspection. Cleaning records said rooms had been checked but there was no information about what staff were checking. Both deputy managers focussed on checking different things such as if there was a towel and soap. Ineffective cleaning schedules and the lack of infection control procedures meant people who used the service were at risk of cross infection and accommodated in an unhygienic, unpleasant environment.

The deputy manager said any maintenance issues were written on a piece of paper and put under the second office door which was used by the provider and registered manager. The home had access to a maintenance person who had responded to some issues when asked. However, the maintenance system was not effective in ensuring issues were identified and resolved in a timely way. For example, a toilet roll holder was broken, a main light did not work in a bedroom (this had been reported by a relative on our first day but remained broken on our third day), drawers in some people's chests of drawers often did not fit anymore with items spilling out, skirting plastic was loose and wallpaper was ripped. A health professional told us they had asked for one bathroom not to be used the previous week, this continued to be out of order when we left. Paintwork was very scuffed throughout the home giving an uncared for appearance and

carpets were very worn. The seating area outside had milk cartons full of cigarette butts and water. Other areas, in the garden, visible from people's rooms needed weeding. The décor was dark with posters stuck straight onto the wall in the dining room but were coming off. Bare hooks on the wall were seen in the first floor lounge. Therefore people did not live in a safe and pleasant environment.

We heard there had been an infestation of bed bugs over a long period of time. The provider had fumigated some areas of the home and taken advice from environmental health department but clearly the management of bed bugs was not consistent or effective. Staff continued to find dead and alive bed bugs, some in a vacant room, others in occupied rooms. Staff had no written instructions about how to manage this and were unable to tell us what they did, some saying they squashed them. They said they thought they should use bed bug spray and masks which were available but staff did not do this during our visit despite seeing bed bugs. They also mentioned steam cleaning. One care worker had recently told the registered manager there were bed bugs and had been told to get the steam cleaner out, however this had not been done due to the staff member not having any spare time. A interim manager who had recently left the home told us they had seen poor management of the bed bug situation. They had seen a mattress steam cleaned outside and then taken over to the provider's other home. This was not good practice. There were no systems to carry out regular and full checks of the home to ensure the bed bugs were being managed properly. We identified live bed bugs in certain bedrooms during our inspection. We asked the provider to take urgent action which they did for these rooms but the rest of the home was not assessed. We also had to ask the provider to fax over instructions for staff despite the issue being a longer term and known problem.

Due to our concerns relating to fire safety management, we asked a fire safety officer to visit as a matter of urgency. Following their visit on the third day of the inspection, the fire safety officer found a number of issues. These included, lack of training. Staff when asked did not know how to manage a fire. The latest staff training matrix showed total staff numbers as 29. Of these, 17 staff had not completed fire training including both of the night staff on duty the night before our third day of inspection (one night care worker was not on the training list at all). A deputy manager had not had training for at least 18 months and did not know how to use the evacuation chair. There was no equipment to evacuate people who were immobile upstairs. We tested the fire alarm system but some doors essential to create safe lobbies did not close. The fire officer asked staff to ensure they all knew to physically close doors should the alarm sound. Staff said the alarm had not been heard for at least a month and records confirmed no alarm testing since September. The fire evacuation instructions relied on staff knowledge and were confusing as there were two different posters. The alarm system has a list of zones which were complicated and there was no pictoral map to direct staff, especially agency. One staff member said they would leave people upstairs as they had been told. The 'general' worker said they would run. The fire safety officer intended to issue an enforcement notice with a short time scale.

There were no PEEPS (Personal Emergency Evacuation Plans) at all despite a requirement made at our last inspection in February 2016 and included in a previous fire inspection in January 2016. There was no list of who lived in what room so the fire brigade would not know how to manage people or where they were. There were also issues with some door equipment. Doors were wedged open, including a wedge under a broken door guard. However, one person did have a smoking risk assessment that seemed to be working although they had not signed it to agree to their cigarettes being kept locked away.

These issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Three staff recruitment files showed that there were adequate systems in place for the recruitment of staff. People had had a disclosure and barring check (DBS) before starting employment to ensure they were suitable to work with vulnerable people. There were interview notes, photographic identification and two

references including one from a previous employer routinely. We saw that there had been disciplinary procedures put in place for some seven staff in relation to poor moving and handling and medication. However, there was no follow up to see how these staff were managing or putting training into practice.

Since the home had been in a whole home safeguarding monitoring process staff had received training on safeguarding. There had been considerable input from safeguarding nurses and community matrons and the quality assurance team known as QAIT, providing support and information. They had continued to raise issues with staff and the provider within safeguarding review meetings. Staff did know about safeguarding processes such as what constituted potential abuse and knew what to do and who to report it to including external agencies such as "social services and CQC".

Inadequate

Is the service effective?

Our findings

People were not able to benefit from an effective service that ensured their needs were met. We did not see any care staff using care files. They were allocated to floors and named people and used a 'care card' with tasks written on it. However, the deputy manager could not find a copy of these easily and staff did not have them with them. Staff were able to record in the turn charts, topical cream, food and fluid charts but had no inout to care plans. They told the staff member in charge about people's care and the senior then wrote the records. Therefore daily records were repetitive and did not reflect people's needs, how their day was or give meaningful information to inform staff providing care. Although kind, staff were varied in the information they knew about people. For example, one care worker told us how they ensured one person had their make up on as they liked this. They didn't know if other staff did this and we found other staff did not know this information.

Staff shift handovers were done by the senior staff member. The senior tasks list showed four separate staff handovers at 08.00, 09.00, 12.00 and 1.45. The deputy manager had very little time to do these and they admitted they were rushed. We witnessed a very poor handover on the third day. Staff from the previous shift wrote in a handover file and the senior on the next shift interpreted this to give the handover. There was no summary of people's needs, ages, diagnosis only 'slept well', 'need urine sample' and information about bowel movements. This was neither person centred or effective to assist staff to provide individualised care. An agency worker had worked on the second day of our inspection and then on the third day in the morning. The agency worker had no handout showing who was in what room or anything about the people they were caring for. They told us they did not know who had dementia or how to manage risk. They had had no induction, fire information or a tour of the home. They said if they were working there regularly they would give everybody a good wash and clean the home. Therefore, although there was an extra staff member on the premises, they could not be effective or safe.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The DoLS is part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not consistently followed at Pennsylvania House to ensure that people's rights were respected. Referrals for authorising restrictions for most people had been made correctly, although authorisations had not been confirmed as yet. Some people continued to have their rights to freedom and liberty compromised and restricted. There were no best interest decision making documents relating to a range of restrictions intended to keep people safe. For example, bed rail best interest decisions and consent and assessments were lacking, which did not ensure people were safe. Many alarm mats to alert staff when people were moving and a lap belt were in use but there had been no individual best interest decisions or management instructions for staff about when and how to use these in the least restrictive way. One person had a

mattress on the floor by their bed with an alarm mat on top. This person had fallen out of bed on at least two occasions but there were no preventative actions taken such as regular monitoring, other than to use the mattress and mat. People's representatives had not been consulted or signed to say they had been involved in discussions about restrictive practices. This meant some restrictive practices may not be in the person's best interests.

These issues are a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not supported by staff with sufficient knowledge or skills to deliver personalised care. Although there had been a range of training this had generally been in response to concerns found by visiting health professionals. For example, night staff had only received medication administration training when it was raised as an issue. Staff training files contained induction and development plans. However, these had been completed by a deputy manager who had signed all elements of the six page pack headings but there was no evidence of content. We showed staff the home's print outs of the care certificate. This is national guidance about how staff should deliver care following good practice guidelines. Staff had never seen these documents. The induction pack contained a wide range of topics to be completed such as lifting instruction and manual handling equipment, fire drill, care plans, health and safety information, infection control, food hygiene (not completed) and working as a team. Staff told us they did not have time to look at care plans and had no reason to as they verbally fed back care to the senior staff member and only completed monitoring charts. Sometimes a care worker who had not cared for someone filled out the monitoring charts and relied on other care staff remembering what a person had had to eat. This meant that people were at risk of receiving care and support from staff who did not have the necessary skills or experience.

The training matrix showed a range of further mandatory training topics such as first aid, safeguarding, equality and diversity and pressure ulcer care. Most topics showed staff had not all received training in equality and diversity, fire training, infection control, continence awareness and nutrition, dementia care and hydration. There was no process to ensure staff were competent or following information from their training to their practice. For example, on two occasions we heard care staff ask each other why one person had 'double pads' in place. This is not effective continence management. Visiting health professionals continued to raise concerns about inappropriate lack of pressure relieving equipment such as use of a rolled up blanket for support on an air bed. This had prompted them to contact social services for a review of the person's care. Some people had been identified as being at risk of losing weight and were being monitored using a food and fluid chart. Staff completed these during the day but they were not clear about intake targets or what to do if someone reached a certain weight. Food and fluid charts had not been totalled to see if the care was effective. One person regularly had 700mls of fluid per day, whereas their care plan stated they needed at least 1500mls or they were at risk of dehydration (also identified by their relative). The notes said if they did not receive this they would be at risk of a urine infection or 'twitching' due to a chronic condition. We saw this person visibly twitching and receiving very little fluids. They had complex needs and had been assessed by the speech and language therapist. Staff were following their advice but not monitoring progress effectively. Some people were on a food monitoring chart but when people had declined a meal staff did not return later to offer any other foods. However, we did see some people being offered snacks such as yoghurt and bowls of sweets in between meals.

We observed care during a lunch period in the dining room and in the first floor lounge. People who used the service offered mixed views on the food provided. People's comments included, "It's ok but it's not like home" and "Nothing glamorous, but nothing to upset you." Another person said, "The food is good" and when asked about choice responded "I eat anything. I like my food." Some people told us they were asked whilst they are at the dining table what they would like to eat. The cook said they just knew what people

liked. The cook had a list showing what diets people were on, such as diabetic or pureed but there was no regular review of people's likes or what meals they might like. The main meal provided on the first day was pasty, chips and baked beans, with corned beef hash being the optional choice. There was a choice of two homemade desserts, which looked appetising. However, one person did not want the pasty so was given the hash. When they said they did not like hash staff said to just eat the chips. On both mornings, the cook was cooking vegetable for pureeing at 09.30 in the morning and keeping them warm until lunch which is not good practice. The registered manager and some care plans said there were pictures used to assist people with choosing meals. These were not used during our visits.

When people required assistance with eating and drinking we did not always see care staff chatting with people to encourage them or distract people. On the first day, there appeared to be good humour and banter between people and staff in the lounge, with people smiling and laughing at comments. The lunch in the first floor lounge on the second day was almost silent for people, with staff discussing amongst themselves what other tasks were left to do. Food was all mashed together and offered to people without explanation of what it was. Plates and mugs were of a plastic type. We were told this was only for breakfast but we saw staff bringing crockery in from the garage at lunchtime which had clearly not been previously available. Serving food and drinks to all people in plastic may not be respectful, dignified nor treat people as unique individuals. One person able to comment had a china mug of their own. They said, "I don't like the plastic ones." They had biscuits served on a plastic plate.

Staff had little knowledge about how to manage people living with dementia. When two staff were asked what learning they had taken from dementia training and how their practices had changed as a result they could not remember. There was little engagement with people due to lack of time. The environment was not supportive for people living with dementia. There were patterned, worn, carpets that are not recommended for people living with dementia. There were no pictorial aids or clear paintwork colours to promote people's independence, for example to direct them independently to the bathrooms. There was no information to aid orientation to time and place such as working clocks, calendar or information about the season or weather. One person's care plan said the person, whose first language was not English had gone back to using their mother tongue. Rather than finding ways to communicate with the person in their mother tongue, instruction for staff stated they were to remind the person living with dementia to use English. The care plan commented it was difficult for staff to communicate with the person but no solutions had been discussed.

Staff did not wear a uniform. The provider had told staff and the registered manager told us that this was because they wanted the home to be 'homely' for people with dementia. There was a staff dress code which should be dark tops and bottoms and covered shoes. We saw from staff meetings that there was an issue with staff not wearing the correct dress code. For example, staff had worn flip flops in the past. Staff did not look smart, wearing very casual clothes. Staff said they had asked for a uniform many times as they had to buy their own clothes which got dirty. This remained an issue. Staff also did not wear any name badges so no-one, including people living at the home and health professionals, knew who they were. One professional told us they felt the home was "sloppy" and said staff looked "unprofessional" and it was difficult to know who was who and what each staff did as they did not wear name badges.

We found that staff had not received regular one to one supervision. This would give staff individual opportunity to discuss any issues, training needs, personal issues and opportunity for management to ensure staff were carrying out their role effectively. The registered manager said they knew supervision was not up to date despite recent disciplinary action for seven staff. People were at risk of having their care and support provided to them by untrained and unskilled staff.

These issues are a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service caring?

Our findings

Although staff tried to be helpful and kind we had some concerns that the service was not consistently caring as we saw some staffs' working practices were not as caring as they should have been. For example, although staff were following care instructions from the speech and language therapist about how to encourage one person with complex needs to eat, at times the care workers were not as gentle as they could be. People were generally very unkempt. Staff said they were unable to provide care other than to meet basic needs. The agency worker said, "If I worked here regularly I would give everyone a good wash." People's hair needed washing and brushing. Many people did not have socks on, staff were not able to tell us why. Whilst one person had newly varnished fingernails, they were dirty around the nail and quicks. Some staff had also not taken the time to brush or wash some people's hair or clean their teeth and some people had flaked nail polish. We spoke to one person living at the home and they became upset. We said to a member of staff that we were sorry we hadn't meant to upset them. The care worker said, "Oh that's [person's name] for you." There was no further support. People did not know who staff were as they had no uniform or monitored dress code and did not wear name badges. One person who was able said, "It would be nice to have something."

We saw several incidences where the right to people's dignity and respect had not been endorsed. For example, most people need some new clothes. People's clothes were very shabby and worn out. One person wore a pair of shoes that had on no solid bottom and needed heeling. Staff said they had raised this with management. Staff meeting minutes said "Residents need new underwear." Staff were to report to the deputies who would then report to the registered manager. New clothes had not been sourced. Staff did not attend to people's soiled clothes in a timely way. Staff did not always knock on people's bedroom doors before entering. We were talking to one person in their room and a staff member came in to make the bed. They did not ask permission to undertake the tasks carried out although they did ask if they could spray air freshener. One room looked out to the pavement, many people walked past while we were there. Although the person was in hospital it would have been very easy to see in through the window. Equipment used for continence management was on display in most rooms which was not very dignified if people had visitors.

Staff did not ensure that people spent time in a pleasant environment. The first floor lounge had random items on the shelves and two clocks which did not work. There were various items of equipment and charging plugs and leads out. Curtains were drawn and left messy. Clothes were not cared for in people's drawers and wardrobes. They were unfolded or unhung. People's rooms were not homely. Although people had some items of their own, plants and dead flowers were not tended to, surfaces were dirty or dusty, paintwork had continence pad and wipes packaging print rubbed off on them. One person had an unoccupied shared room. This was being used as storage for equipment and another person's cabinet was in there. People's furniture was shabby and some drawers would not shut as they were broken.

Care records spoke of people not being 'co-operative' which does not reflect a person centred approach. Some records did not always use respectful language when describing people's needs. The registered manager said they had told staff about this before and the action taken had been to stop care staff having input to care plans rather than coaching and enabling staff to learn. During tasks such as assisting with

feeding and toileting staff did not always chat to people or tell them what they were about to do or what the meal was. One care worker assisted one person to eat used the teaspoon to wipe up spillage from the person's clothes protector. This meant the person was getting dropped food from their top mixed with other food.

Staff did not think about what people might want. On two occasions we asked staff to move people's chair placements as they were either sitting under the television with their back to it ot in the middle of the room. The person got anxious as they kept asking, "what's that?" as they could not see the people behind them. Another person's records stated they liked the television. From their seat they could not see the screen. When people became anxious staff did not go and reassure people as they were too busy. When we spent time with people with complex needs and little verbal communication we were able to engage with them and people responded positively. People in the first floor lounge were left unsupervised and did not receive any engagement for long periods of time. On all three days at least four people sat in the same place all day with minimal stimulation.

These issues are a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

There was some evidence of involvement with relatives/representatives in people's care plans. For example, in compiling 'All about Me' information although these weren't all dated or reviewed. The notice board was very cluttered, notices pinned on at an angle and covered by others would have been difficult for people to read and would have been too high for anyone in a wheelchair. There had been a residents/relatives meeting in March 2016 but none since. In relation to the bed bugs, families had not been informed. We asked the provider to ensure people were aware and that action was being taken. They asked the deputy manager to do this who had very little time.

Inadequate

Is the service responsive?

Our findings

We received information from the safeguarding process and consequent regular monitoring of the home that raised concerns. They found that the service was not consistently responsive to the needs of people living at Pennsylvania House. Visiting health professionals shared their daily reports with us. We saw that they continued to identify issues that required action and that the staff then responded to address those issues. However, we did not have confidence that staff would identify people's needs and respond in a timely way without prompting from visiting health professionals. When issues were raised, staff did respond well and tried to address them. For example, when the bed bug management was questioned, staff had not thought that people should be moved from their rooms during treatment of the bed bugs, management did not robustly address concerns raised by us and staff about a shortage of care staff and monitoring of people's food and fluid intake was poor.

People did not receive personalised care that was responsive to their individual needs and goals. Care plans contained good information including "All of me" although most were undated, which provided information about a person's needs and their likes and dislikes including their favourite foods. Needs were assessed and guidance was recorded on how to meet those needs. However, care plans reviews were out of date and not had been reviewed since June 2016. Staff showed us that updates to the care plan were done by the registered manager despite them not working at the home. Care plan amendment forms were filled out to show changes to care plans and the registered manager collected them each month to update the computer care plan print outs. This meant there was a risk that important amendments would not be made for a month, we did not see any care staff or manager looking at care plans. The amendment sheets were kept in the handover file, although we also did not see these referred to during handover. The lack of information and daily use of care plans did not ensure people's needs were met.

One person's care plan stated the person was at risk of weight loss, the guidance on how to manage this stated, to weigh them weekly and provide support with all eating and drinking and maintain a record of food and fluids. Weekly weights were maintained but it was noted the person had weighed 55kgs in July and at the last weight was 49kgs. There was no information in the care plan or risk assessment describing at what weight action would need to be taken. We asked staff at what point would they take action. One member of staff told us if they noticed a continuous drop in weight they would inform the senior in charge of the shift who would inform the person's GP. However because these recordings were on A4 sheets, unless the staff looked at the previous sheet it would not always be noticeable to identify a large weight loss. For example, in this particular case the current sheet had four weights recorded which showed the weight steady at approximately 49kgs but the previous sheet showed that only a few months previously they had weighed much more. Therefore there was no system that monitored weight loss over a longer period of time. Whilst a review had been recorded as having taken place on September, it was completed by the registered manager who had completed the review without reading through the daily records, meeting the person or talking with staff. This person's records also stated they need support with oral care, on all days of the inspection, in the morning and the afternoon, we found the two toothbrushes in the person's room to be very hard and dry.

The person also normally wore glasses but an update had been noted they were often refusing to wear them. There was no advice or strategy in place to help staff encourage the person to wear their glasses. Their care plan stated they liked to watch television, we noted one the first day of the inspection they were placed, in their wheelchair, under the television but facing away from the screen. On the second day they were placed at the end of the room where they may have found it difficult to see the television given they were not wearing their glasses. Staff told us they did try to encourage them to wear their glasses but if they refused there was nothing they could do. Another person did not have glasses on and at lunch time staff said, "Where are [person's names] glasses?" Previous staff did not know whether she had glasses or not and no staff went to find out.

In people's records there was also a document called "risk assessment overview", two had blank headings apart from the heading "individual environment room risk". These recorded the same information for each person's room apart from where their room was. For example, in both they stated, "carpet ok, soft furnishings clean and good, basin taps thermostatically controlled, call bell, dynamic mattress leads under bed, pressure mat, no chemicals". We found in one of the bedrooms there were bedbugs and the carpet was stained and had faeces on the floor in two places at 9am and at 3pm when the person was then in bed for a rest. This meant staff supporting the person to bed had not noticed the bedbugs or the faeces on the floor. This element of the risk assessment and checks was consistently not carried out as staff did not notice take action on the overall poor cleanliness and maintenance of the home and the people living in it.

These issues are a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Limited recreational and leisure activities were sometimes available and further improvements were needed to ensure these met everyone's individual needs. External entertainers visited the home weekly to read the newspaper and discuss and provide musical entertainment which people in the ground floor lounge enjoyed. There was also opportunity for some people to attend church services at the home. The service employed an activity co-ordinator in both its homes and these staff worked across the two homes. They did a good job of providing a wide range of activities and games such as bingo and ball games but the focus was often on the activity not people's needs. For example, activity records listed the activity and then the people who had been present. There was no way to ensure each individual received some engagement and stimulation and some people with complex needs received very little across our three days of inspection. We saw people sat in the first floor lounge either watching morning television, sleeping or observing their surroundings with little or no engagement. People were unable to access the community, garden or outside unless they were able to do so alone or with their relatives.

The activity co-ordinator said they were not confident in providing care for people with dementia and could not tell us how they would do this. All, but two people were living with profound dementia at Pennsylvania House. Care records did not include any activities and care staff and activity staff did not consult about people's needs as care staff had no input into activities due to lack of time. Each person had an 'All about Me' but they were not all dated. However, this information was not always used to inform activities in an individualised way. The activity co-ordinator said they did not look at people's care plans and did the best they could, looking ideas up on the internet. They knew one person liked the royal family for example, but had not used this information. They said they tried to take one person out every two weeks as in their care plan, however this had not happened and on one occasion they had been told by the registered manager they could not go out. One person was able to go into the garden but generally did so with their relative.

People did not have consistent opportunities to make choices. For example, staff did not ask people where they wanted to sit or check they had what they needed when they had been placed in the lounge. People

were given tea in the morning with no choice offered and left with a glass of squash and staff chose what biscuit they were having. At least four people stayed in the same place during the day for the three days of our inspection, wearing the same clothes. One person told staff they did not want to get up but staff, who were being very nice, were insistent that they got up as it was very late (10.20am) and they needed to get up. Another person said, "I sit here and do what I'm told". They were unable to have their cigarette as staff were too busy and then spent a long time standing in the corridor waiting. People were not consulted on what trips, outings or entertainment they would like, their preferences and past interests were not taken into account when providing leisure activities.

These issues are a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

There was a lack of good, consistent leadership in the home. This resulted in people receiving poor standards of care and staff feeling unsupported. The provider and registered manager failed to understand how to properly monitor the quality of services provided to people despite ongoing support from the local authority. This had contributed significantly to the failings identified during the inspection.

Following a safeguarding process started in February 2016, the provider told us in August 2016 the registered manager would no longer be fully managing the home but would continue to support the home until a replacement was found. The registered manager was going to be managing another of the provider's homes. However, the registered manager had not completed the de-registration process for the home at the time of this inspection and they continued to make decisions about the day to day running of the home and carry out care plan updates and audits. They were also working in another of the provider's homes as the manager. The provider informed us in August 2016, the two deputy managers would be responsible for the management of Pennsylvania House. However, one of the deputy managers had been off for some time and had only recently returned to work and was only working in the kitchen. The other deputy manager had little time to carry out the jobs they were responsible for.

The deputy manager was unable or did not know if they could make decisions about the day to day running of the home. For example, an activity coordinator wanted to take a person out. Their care plan stated they were to be taken out at least once a fortnight. The activity coordinator had asked the deputy manager if they could take the person out, the deputy manager phoned the registered manager who told the deputy they could not take the person out. During the inspection, the deputy manager had to ring the registered manager to ask if they could move someone to another room as requested by their relative.

The provider had also informed us they had obtained the services of a consultancy service to oversee the work carried out by the deputies and the registered manager. During this inspection we asked the provider for their policy and systems regarding quality assurance and for their last quality monitoring report. They told us they did not have a policy on this and had not completed any report. They told us the manager carried out some audits but these did not link to an overall quality assurance system. We were told the consultancy firm had carried out individual supervision with the manager and deputy but had not monitored the whole home. The provider told us "this would be the next stage". Although falls audits had been carried out by the manager whilst absent from the home until September they did not analyse why falls may be happening or provide advice to staff about minimising risk to prevent further falls effectively. A service improvement plan stated concerns identified in February 2016, and updated in August 2016, such as lack of detail in daily records, care plan reviews not done, lack of continence management and oral care. We found all of these issues remain present at this inspection despite regular input and monitoring from the local authority.

The systems for monitoring the environment to ensure people were living in a safe, clean and well maintained environment were ineffective. For example, the deputy manager was meant to check rooms throughout the home to ensure they were cleaned and well maintained. We found almost every bedroom

was scruffy with peeled paint on window sills and skirting boards, wall paper was peeling from the walls, windows were extremely dirty inside and out, ink print had transferred onto radiator shelves. We also found a sink was coming off the wall, which had been reported some time ago, some soap dispensers were hanging from the wall, the drawers of many people's chest of drawers did not close, many carpets were dirty, many bedrooms were very dusty and toilets were badly stained. Sheets on pressure mattress were too small which meant there was a risk a person would end up sleeping on the plastic mattress, quilt covers did not have closures at the bottom and they did not match with pillow slips.

The home had had a problem with bedbugs for some time but this had not been consistently well managed. They obtained the services of contractor. They treated parts of the home in the summer of 2016 and provided a plan for future treatment. However, staff reported to us there were still live bedbugs everywhere, including in the lounge. We saw many live bed bugs in one unoccupied room. Staff said they had seen one on another person's bed that morning. They said they reported it to the provider and registered manager but nothing was done. They said they were told to use sprays that were provided but they said they were toxic and therefore they did not feel confident to use them. The provider told us that staff should be steam cleaning the rooms as this was the most effective way to manage bedbugs. When asked which staff and when during their busy day were they to do this, the provider was unable to say. On the third day of our inspection we asked the provider to ensure the rooms we had identified were addressed and staff assisted people to move rooms for the day. However, staff still not have any written instructions or roles to manage the bedbugs so we again asked the provider to provide some. We did not see a management plan for the rest of the home.

The provider did not have a system to ensure health and safety monitoring in all areas were carried out. The provider had therefore failed to ensure the fire systems had been tested as required. For example, the weekly fire alarm checks had not been completed since 19 September 2016. The fire safety risk assessments were due to be completed yearly; the last review completed was June 2015. We informed the fire safety officer of this who attended with us to carry out a review of recommendations they had made in January 2016. They found none of these had been addressed and would be issuing an enforcement notice in due course.

The provider did not have a system that monitored staffing levels to ensure they were suitable to meet people's needs and taking into account the environment over three floors. For example, we were told they were providing the same numbers of staffing they had when they had 25 people living in the home. Therefore they felt the levels for the 15 people currently living at the home should be suitable. However, the provider had not spoken with staff or people, or checked the reality of people's needs. Staff told us they were struggling to meet people's needs and our observations confirmed only the most basic care was given with no attention to detail. For example, all toothbrushes on both mornings were solid and completely dry, indicating no oral care had been given. Staff told us they had been asking for more staff for a while but did not feel they were listened to but "told off" when they could not deliver good quality care.

We spoke with a person who had taken on the role of the manager for two weeks and then left. They told us they had asked the provider for more staff, explaining why. They said they felt they were not listened to and decided they could not work under those circumstances and left.

Due to safeguarding issues, the local authority had arranged for community matrons, to visit the home daily and check people's care. A community matron told us that the deputy manager and staff, had been extremely reactive to any instructions or guidance given. The deputy manager had also, on occasions, identified some issues to the nurse. However, there remained a risk that without these checks being carried out, some people may be at risk of inappropriate care because staff were not always skilled enough or pro-

active enough to recognise risks. The provider told us they felt they may no longer be able to meet the needs of some people and had planned to discuss this with the local authority, which they did.

The provider did not have an effective monitoring system that ensured people's records held accurate information. For example, the deputy manager told us that any changes in people's care or risks were reported to them by care staff. The deputy manager would then report these changes to the registered manager. They would then update the care plan every month to reflect these changes. However, these updates were completed without the registered manager being physically present in the home, without seeing the person the update was about, or without talking to care staff or consulting with people and/or their relatives. This meant the registered manager had failed to involve people in decisions about their ongoing care and the provider had no method of checking the registered manager's work.

The provider told us their vision for the service was to provide excellent care. They said staff were told this at staff meetings. However, the minutes of staff meetings did not reflect this. The minutes suggested much of what was discussed was about what must be done rather than relating it to the visions. The minutes did not reflect an open, positive or encouraging culture and spoke of laziness of staff, what staff must not do and discussions about on-going sickness absences. There was reference to staff not using derogatory language around people living at the home however the 'floater' task card for a care worker stated, "support all doubles with carers" referring to people who required assistance from two staff and "start your list including baths" followed by a list of names which was not respectful or person centred. Staff told us they did not feel listened to, particularly when discussing staffing levels.

A quality assurance survey had taken place in 2015 but there had been no surveys since. Ten responses had been gathered in 2015 but did not include the views of health professionals or staff. This survey had a positive response with few negative comments. The action plan in 2015 included points raised from a previous survey such as "more structure and impromptu" activities and said staff were more involved and continued activities when the activity co-ordinator was not at the home. This was not happening. Another point said concerns had been raised about outings for people. The action taken said "outings were now organised on a regular basis alongside our sister home." This was not happening. It was indicated improvements could be made relating to general cleanliness and tidiness. It stated an ongoing programme was in place. This was not working. Indications were made about concerns relating to the environment especially communal areas, maintenance and decoration. Again an ongoing programme was said to be in place. Therefore, the provider had had these issues raised at least a year ago with no effective action taken. However, a steam cleaner had been purchased and parking made available to visitors as a result which was positive.

The provider did not have up to date knowledge of good practices relating to dementia care. Whilst staff and the registered manager had received training on this subject, the care for people with dementia remained the same. Two care staff were unable to remember the learning from this training and could not provide any examples of how their practices had changed as a result. We found everyone in the home received drinks and food on brightly coloured plastics cups and plates. The registered manager told us they thought that china type crockery was too heavy for people and they kept getting broken. When we looked at the china cups in the home, they were extremely heavy; however no research had been completed to find a more suitable type of crockery to meet people's needs. We were told that the main meal of the day was served on china plates but none were in the kitchen. Before lunch we observed the cook going to the outside storage garage to bring china plates into the kitchen. We noted that all staff drank from china cups and mugs. The activity coordinator told us they had obtained a national vocational qualification about activities. However they felt they needed more training relating to providing social stimulation for people with dementia. They said they often felt at a loss on what to do that was meaningful to the person. We observed them spending

time with people talking and providing some activities that people who took part seemed to enjoy.

These issues are a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.