Ms Diane Langdon

Mayfair Residential Home

Inspection report

25 The Avenue
Minehead
Somerset
TA24 5AY

Tel: 01643706816

Date of inspection visit:
25 March 2019
26 March 2019

Date of publication:
16 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

•Mayfair Residential Home is a care home registered to provide personal care and accommodation to up to 16 people. The home specialises in the care of people who have mental health needs. At the time of the inspection 13 people lived at Mayfair Residential Home.

People's experience of using this service:

•Some staff had not been provided with safeguarding training and risks to people had not always been assessed, monitored or reviewed. Where risks to people were identified, detailed management plans were not always in place and people were not always protected from environmental risks. The provider did not keep any records of legionella testing in the home even though there were several unused water outlets.

•Safe practice was not followed to ensure people's medicines were safely administered. The provider did not have a competency assessment process to determine if staff were competent to administer medicine safely. Staff told us they did an on-line training module and that was not refreshed once completed.

•The home was not clean or well maintained. Toilet seats were broken and coated in faeces. People did not have working showers in their rooms. People told us, "No, it's (the home) not cleaned enough. I can't remember when they cleaned my room".

•There were not enough staff to meet the needs of the people living at Mayfair Residential Home. Recruitment processes did not minimise the risk of employing unsuitable staff.

•Staff did not have a clear understanding of the Mental Capacity Act, (MCA). The provider had not completed specific capacity assessments for people.

•People were not always fully involved in their care and support. Care plans were not person-centred and lacked information about people's needs, wishes and preferences and confidential information was not stored securely.

•The provider had not ensured there was an effective management structure in place to monitor the care provided. They had also failed to ensure staff were given the support they required to provide safe, effective, responsive care.

•We saw some positive interactions during the inspection, with most staff being kind and friendly when supporting people.

•The provider was trying to make improvements with limited resources available. Following the inspection,

the provider sent us an action plan of how the planned to improve the service.

More information about the detailed findings can be found below.

Rating at last inspection:

•At the last inspection the service was rated as Requires Improvement (May 2018). At this inspection we found the service had deteriorated in several areas. The home has therefore been rated as inadequate overall.

Why we inspected:

•This inspection was a scheduled inspection based on the previous rating and aimed to follow up on concerns we found in May 2018.

Enforcement

•During the inspection we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the ongoing failings.

•Full information about CQCs regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

•Ensure that the provider found to be providing inadequate care, significantly improves.

•Provide a framework within which we use our enforcement powers in response to inadequate care, and work with, or signpost to, other organisations in the system to ensure improvements are made.

•Provide a clear timeframe within which the provider must improve the quality of care they provide, or we will seek to take further action, for example cancel their registration.

•If the provider does not demonstrate enough improvement is made within this timeframe, and there is still a rating of inadequate for any key question or overall, we will act 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.

•Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the rating of this service improves to at least Good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Mayfair Residential Home

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

•On day one of the inspection, one adult social care inspector, one registered nurse, who had experience of working with older adults in care homes, and one expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two of the inspection, two adult social care inspectors carried out the inspection.

Service and service type:

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

•The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.' The registered manager was also the owner of the business, for this report we use the word, provider, when we talk about the registered manager.

Notice of inspection:

•The inspection was unannounced on the first day. The inspection site activity started on 25 March 2019. The second day inspection site activity was announced and took place on 26 March 2019.

What we did:

•Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

•We looked at the information in the PIR and other information we held about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

•During the inspection, we spoke with nine people who lived at Mayfair Residential Home. We also spoke with one family member who was closely involved in their relative's care and support. We met with the provider and spoke with four staff members. Following the inspection, we contacted three health and social care professionals for feedback, one responded.

•We looked around the premises, and reviewed five peoples care and support plans. We also looked at records associated with people's care and support such as daily care notes, risk management plans and six medicine records. We reviewed records relevant to the management of the service, including staffing rotas, policies, incident and accident records, six recruitment files, training records, meeting minutes and quality assurance audits.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At the last inspection in May 2018 we found the provider had failed to effectively assess the risks to people's health and safety. Action had not been taken to mitigate risks. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there were continued shortfalls. We also identified further concerns which included poor cleanliness of the home and unsafe management of medicines. Therefore, the rating has deteriorated to inadequate.

•Systems and processes to safeguard people from the risk of abuse. People had mixed views about whether they felt safe living at Mayfair Residential Home. Comments from people included, "Yes, no problem, happy here." Although three people raised concerns that they were unable to lock their doors and worried that people might come in their rooms uninvited.

•Some staff had not been provided with safeguarding training. Records dated 2018 confirmed three out of 10 staff had not completed any training in safeguarding. The whistle blowing policy was not signed or dated for review, the policy stated it should be part of the induction training, but when we looked at the most recent induction records it was not covered which meant the provider could not be sure staff fully understood how to keep people safe. One staff member told us "I haven't had safeguarding training in ages."

•The provider was aware of their responsibility to inform the local authority and the CQC about any safeguarding concerns and staff demonstrated an understanding of what constituted abuse. One staff member said, "I would report it to the manager, I'm happy they would take the right action." Adding, "If not I would go to CQC, I've never had to here."

Assessing risk, safety monitoring and management

•Risks to people had not always been assessed, monitored or reviewed. One person's care plan included contradictory information about a person's mental health needs.

•Staff also told us two people living at Mayfair Residential Home had a history of depression and suicidal thoughts. Staff had not completed a risk assessment for these people in relation to risks posed to them at the home.

•Where risks were identified, detailed management plans were not always in place. For example, one person was identified as being a moderate fire risk when they were in their bedroom. The management plan to reduce the risk of fire stated, "Staff to tidy regularly and to monitor". There were no further details regarding

what staff should be monitoring or how often. When we spoke to staff they told us, "We just keep an eye on them". But they did not know why they were fire risk and how they could work with the person to reduce the risk.

•All five risk assessments and care plans we looked at were not reviewed on a regular basis and did not contain all the information required to enable staff to support people with their care and treatment. For example, one person was at risk of developing pressure sores and had a risk assessment in place. This had not been reviewed since 20 September 2018 and staff were not aware if this person had a pressure sore or not. This meant there was not always clear information for staff to follow to reduce risks to people.

•People were not always protected from environmental risks. The provider had an outside company in to assess the environment following concerns found at the last inspection. This audit, dated 19 June 2018, raised several high-risk concerns. For example, the report recommended an asbestos survey was carried out as a high priority, but the provider had not completed the action. Another high-risk priority was to arrange for a legionella risk assessment to be completed as soon as possible. The provider had not completed this and did not keep any records of legionella testing in the home even though there were several unused water outlets.

•In February 2018 a fire officer reviewed the home. Several recommendations were made regarding fire safety. The provider had not completed all the recommendations. Those that had been completed were not maintained. For example, the fire door was held open by a catch attaching it to the outside banister, and fire extinguisher checks were two months out of date.

•People smoked in their bedrooms and on the wooden fire escape. One person with poor mobility had their bedroom on the second floor next to the wooden fire escape and on the same corridor as one person who smoked in their room, there were no smoking risk assessments in place. We asked the provider how staff would get this person out of the building in the event of a fire and they told us there was a fire mat available for staff to drag the person down the stairs. However, this mat was not accessible as it was on the first floor. This meant there was a risk that people may not be safely evacuated in the event of a fire.

Using medicines safely

•Safe practice was not followed to ensure people's medicines were safely administered.

•The keys to the medicine trolley were not kept securely. The temperature had not been recorded to ensure that medicine, and those requiring refrigeration were stored at appropriate temperatures to ensure they remain effective. There was mould growing on the bottom shelf of the fridge.

•Medicine Administration Records had not been maintained appropriately. For example, one person's MAR chart did not have the dose of medicine recorded on it. This meant staff could not be certain they were administering the correct dosage. There were gaps in recording and stock balances were inaccurate, therefore it was not possible to determine whether people had received their medicines as prescribed.

•One person had a nutrition drink prescribed, we observed staff get it out of the fridge and give it to the person. This was not recorded on the MAR. We asked staff why it was not recorded as it was prescribed. This staff member said, "Good point I don't know force of habit I guess."

•Stock levels of drugs were not well managed. For example, one person had three different packets of the same medicine all in use in the medicine trolley. One packet had been dispensed 14/8/2017, one packet

dispensed 29/12/2018 and one packet dispensed 29/1/ 2019. The stock balance stated that there were 115 tablets in total but there were 215 when the inspection team counted them.

•Safe processes were not in place for people who self-administered prescribed medicine. For example, one person had three different medicines that they were self-administering, and there was no risk assessment in place to assess whether they could do this safely. When we spoke with this person we found they had two different open tubes of the same medicated cream in use.

•There were no monitoring systems in place to ensure that peoples creams were safely administered and still 'in date'. One person had their medicated cream stored in the medicines fridge, it was opened on the 10 March 2019. However, the application record on the MAR chart was blank and there was no reference to a skin infection in her care plan. On the day of the inspection a cream was found to have expired in 2018 in one person's room.

•The provider did not have a competency assessment process to determine if staff were competent to administer medicine safely. Staff told us they did an on-line training module and that was not refreshed once completed.

•Action had not been taken to address shortfalls in medicine management. When the external medicine audit for 2019 was compared with that undertaken in 2018, similar issues were identified however at the time of our inspection the shortfalls remained. We discussed this with the provider who told us, "It was (staff members name) responsibility) I thought they did it."

Preventing and controlling infection

People were not protected from avoidable risks from infection because the environment was not clean.

•The home was not clean. Bedrooms and communal areas had cobwebs hanging from ceilings and cupboards were dirty and sticky.

•Two chairs in the living room were covered with Kylies. Kylies are washable blankets used for people who are incontinent. One of the chairs that had a Kylie on it was damaged, the leather covering was torn and the foam underneath was exposed. This chair had been covered by a black plastic bag and a Kylie. The chair smelt strongly of urine.

•One person's toilet seat was broken and coated in faeces. Within en suite bathrooms people did not have towels to dry their hands or toilet roll holders. Several toilet rolls were contaminated with faeces.

•Six people did not have working showers in their rooms. There was only one communal bathroom on the second floor. On the day of the inspection the bath was not clean. Staff had not completed any bathroom checks since February 2019.

•People told us, "No, it's (the home) not cleaned enough. I can't remember when they cleaned my room. I have to ask them to change my sheets." And, "Could be better, hygiene could be better."

•The kitchen did not have adequate fly screens across the open windows and the one that was in place was visibly dirty with flies attached. The electric fly killer did not work. A large container of teabags was uncovered sitting on a dirty floor. There were wires hanging from the ceiling, rusty pipes next to uncovered food and water damage to the ceiling in the pantry.

•A mouse control poison box was on the floor in the kitchen pantry. The kitchen surfaces were not clean and the metal shelving where utensils were kept were full of rust. The milk cooler was also rusty. One staff member told us, "It's one thing I do moan about, I do my best but just don't have the time to keep it clean".

•We discussed the cleanliness of the home with the provider who told us they had a cleaner but there was no cleaning schedule in place. They also acknowledged the cleanliness of the home was not of a good standard.

•Staff had received training on infection control but did not understood their role in preventing the spread of infection within the home. Staff were provided with PPE (personal protective equipment) such as gloves, hand gel and aprons.

Learning lessons when things go wrong

•Lessons had not always been learnt when things went wrong. Staff knew the reporting process for any accidents or incidents but anything reported was not recorded and the provider was not able to demonstrate actions being completed, changes being made to reduce the risk of a re-occurrence of the incident or how lessons learned were shared with staff.

Staffing and recruitment

•There were not enough staff to meet the needs of the people living at Mayfair Residential Home. Staff told us, "Some days there are only two staff on shift and one of the staff members was responsible for the cooking". Another staff member said," We do all the washing as well." Adding, "It's much easier if there is a cook we can get on with the care."

•People told us, "It could be better, sometimes my shower is cancelled because staff have had to take someone to an appointment or they're just short. I haven't had a shower for two weeks." And another person said, "Not enough at weekends, I used to go to church but now I need someone to take me but not enough staff."

•The provider told us they did not have a specific tool to decide how many staff were required to meet the needs of the service, but they expected three care staff on each shift. However, an analysis of the last four week's duty rotas showed only two care workers were on shift, six out of seven weekdays, and at weekends there were two staff available on each shift. We discussed this with the provider who couldn't assure us that staffing was safe.

The above concerns demonstrated a continued failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

•Recruitment processes did not minimise the risk of employing unsuitable staff. Three staff files out of six we reviewed did not have references. One did not have an application form and two did not explore gaps in employment history. Checks had been completed with the Disclosure and Barring Service. For one staff member this had not been renewed every three years in accordance with the provider's policy. The provider assured us they would update all DBS checks over three years old.

The failure to operate a robust recruitment process to ensure suitable staff are employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At the last inspection in May 2018 we found improvements were needed to ensure the building was well maintained. Some areas required redecoration or refurbishment. The provider had identified areas for redecoration and repair and outside contractors were carrying out this work. Bedrooms and en-suite facilities required refurbishment to make sure they were fully functioning and hygienic.

At this inspection we found there were ongoing shortfalls. We also identified further concerns which included lack of staff skills. The provider had not assessed people's capacity to make decisions appropriately. Therefore, the rating has deteriorated to inadequate.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•Assessments had been carried out by the person making the placement and sent to the provider when people moved in. The provider told us they did not carry out further assessments of people's needs. Care plans were in place, but there was no guidance ensure staff knew how people chose to be supported. Staff told us, "Care plans are developed from social worker assessments."

•We asked people if they felt they had choices in their care and received mixed comments from people that included, 'I don't like it, not like home." "I feel institutionalised." And, "Some staff are bossy". "One member of staff tends to do it their way, doesn't give me a choice." And, "They give me instructions and I don't like that."

Staff support: induction, training, skills and experience

•The provider had a basic induction check list for staff to complete when they started working at Mayfair Residential Home. The list did not cover everything the induction policy said it should. Staff spoken with had not recently received an induction as they had been working for the service for some time. They told us the process they went through when they started included; training, reading care plans, shadowing more experienced staff and being observed by staff.

•People were supported by staff who knew them well but had not always received up to date training. The provider told us their mandatory training was First Aid, Safeguarding, DoLs, Fire Safety, Medication and Manual handling. We reviewed the training matrix, the first aid training update due in 2018 was cancelled, six staff were out of date and no further training dates were booked.

•When asked about training in mental health one staff member said, "I did mental health awareness training a long time ago." Another commented "I would like to do more." Mental health training is online staff read a book, answer questions and send it off for marking. One staff member told us, "Staff don't get sufficient mental health training considering we support people with complex needs."

•We discussed with the provider how up to date training would help to ensure that staff were caring for people in accordance with current best practice guidelines and legislation. The provider assured us they would investigate alternative and more appropriate training for staff.

•Staff told us they did not have regular one to one supervision with the provider. However, staff did say they felt supported and able to request a supervision if needed. One staff member said, "Supervision is supposed to be every six months, I haven't had one for a while." They added, "I could go to the provider, you can talk to them and I do feel supported." Staff had not had an annual appraisal.

Supporting people to eat and drink enough to maintain a balanced diet

•People did not have free access to the kitchen, staff said this was because there were sharp knives in the kitchen. Although they also told us people currently living in the home were "Low risk." We asked the provider why people were not allowed in the kitchen, they replied, "Because they might hurt them self".

•There was a kitchenette, the provider said people could make a hot drink in there. However, on both days of the inspection there were no facilities to make any drinks, staff did not offer to make people drinks and there were no snacks available. There were no jugs of water in bedrooms or in the lounge or dining room during the day. People told us, "I just go to the shop and buy my own." And, "They will make it if I ask."

•People could choose to eat in the dining room, the lounge, or their own room. We observed meals being served in the dining room. People interacted with each other and the cook chatted to the people throughout the meal. Two people asked for a fried egg which cook went and got for them.

•There were two choices of main at lunch time and the food looked appetising, but the evening meal was sandwiches every day. People told us, "I am fed up with sandwiches every night." And, "Some days better than others." Another person said, "The quality depends who's on and we never have fresh greens."

•Staff weighed everyone weekly, whether or not they had an identified need for their weight to be monitored. Staff recorded people's weight but were not aware of the Malnutrition Universal Screening Toll (MUST). This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. One person had a risk assessment in place regarding their nutritional intake and staff supported this person to understand the potential consequences of their dietary choices through using easy read and accessible information. This helped the person to make choices about their lifestyle.

We recommend people have their nutritional needs assessed in line with current best practice and legislation.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

•We found oral health assessment tools in people's care records in line with guidance for care homes in relation to oral health, but these had not been completed. The guidance recommends that people have an

oral health assessment on admission. Although there was some information in peoples care plan relating to their oral healthcare this was not consistent with that expected in the guidance

•People did access health care professionals such as GPs, District nurses and psychologists. Some people could make their own arrangements to attend appointments. One person told us, "I go on my own to any appointment." Another person told us, " Staff take me to the doctors when I need to go, I don't like going alone". The provider told us they have good links with the local community mental health teams.

Adapting service, design, decoration to meet people's needs

•The building was not well maintained. The provider had identified areas for redecoration and repair following the last inspection in 2018. However, actions recommended had not been completed. We found six en-suite facilities that had wires hanging out of the walls where the showers should be. There was a broken window pane in the communal hallway. Wires hanging from the kitchen ceiling. Two covered radiators on the second-floor were leaking. There was water damage in four rooms, toilet seats not attached to toilets and several rooms requiring re decoration.

•One person told us "The toilet seat has been broken downstairs for months which means I have to go two floors up every time I want to use the toilet." When we spoke with people one person told us, I have to use the communal bathroom which is on the second floor, I like to wash my hair in my sink, but I can't because my sink is too small.

•People did have access to outside space but to get to it they had to walk through one person's private space. The outside area was used by staff and people who smoked which meant there was nowhere for people to go if they did not smoke.

Ensuring consent to care and treatment in line with law and guidance

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

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

•We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met."

•Staff did not have a clear understanding of the Mental Capacity Act, (MCA). One staff member told us they had not received training in the subject, another said, "That rings a bell I can't remember it's been two years since I've had the training." The provider said, "I have never done a DoLs but we have two people here who I think I should put an application in for."

•The provider had not completed capacity assessments for people, even though staff told us two people did not have specific capacity to make decisions around their finances and medical care.

The failure to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At the last inspection in May 2018 we found the service was caring and awarded a rating of good. At this inspection we found this had not continued, and reduced the rating to requires improvement.

Ensuring people are well treated and supported; respecting equality and diversity

•People told us that most staff were kind and caring. Comments included; "Yes, kind and friendly." "This is a very happy home here." We also heard one person say to staff, "You are a darling, you angel" when the staff member was supporting them.

•However, one person approached the inspection team on the day of the inspection very upset because a staff member had sworn at them. They told us, "They do it all the time, swearing, it's not right it upsets me". The provider was present when this happened and told us they would investigate.

•Nobody we spoke with said they felt they had been subject to any discriminatory practice for example, on the grounds of their gender, race, sexuality, disability or age.

Supporting people to express their views and be involved in making decisions about their care

•People were not always fully involved in their care and support. One person said, "I just do as they say". Another person said, "Sometimes I get a say it depends who's on duty really". Other people couldn't remember or didn't understand what a care plan meant. A relative told us, "I was invited to a family meeting once".

•People's views were not always respected. One person had requested not to be checked at night, despite this staff told us night staff checked on the person every two hours. Staff had recorded in the persons daily notes 21 times in March 2019 they had requested not to be checked.

•Staff described how they made an arranged time with one person to support them to tidy their room. However for another person however they described how they waited until the person was having their lunch so staff could, "Go in and do their cleaning." This was without the person's knowledge.

The failure to provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

•People had mixed views about whether staff treated them with respect and protected their dignity, comments included, "Some staff knock on my door before entering, some don't." "They always close the window when I am having a bath." "There's a male carer but I don't mind. I am not embarrassed."

•One person had been allocated a private area in the home because they liked to be alone. They had set it up with their personal belongings and created their own sitting room. However, the area was a walk way for people and staff to access the laundry room and outside space where the smoking hut was. Therefore, this person's privacy was disrupted several times a day which meant the provider was not fully meeting their needs.

•One person chose not to allow staff or visitors into their room and staff respected this decision. Staff told us they had an agreement that if they needed to see this person they would make an appointment with them. This person told us they wished to maintain their privacy but accepted that there may be times when staff needed to enter their bedroom, in the interests of health and safety.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

At the last inspection in May 2018 we found Improvements were needed to make sure people who were not able to occupy their time had access to meaningful social stimulation and occupation.

At this inspection we found there were continued shortfalls. Therefore, the rating has remained as requires improvement.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•Care plans were not person-centred and lacked information about people's needs, wishes and preferences. For example, one person had been diagnosed with very complex mental health needs. The care plan identified when they became unwell they could become, "Very angry." The care plan stated when the person was showing signs of becoming unwell, staff were to "Record and report to the manager of the home." There was no guidance relating to how this person wanted to be supported by staff when they became unwell or what the risks were.

•Another person's care plan stated they could sometimes become withdrawn and quite upset in certain situations and they had suffered from severe depression in the past. The care plan guides staff to offer support at times of distress and monitor when necessary. However, there were no details of how staff should support this person when they did become distressed.

•Staff told us one person could become confused and unaware of the time, day or month. Staff said this caused them anxiety so they put a calendar in their room to help them. However, at the time of the inspection the calendar had been removed from the room. We asked staff why they did not have a calendar in their room, staff told us, "We took it out to decorate and haven't replaced it."

•There was a lack of stimulation and occupation for people using the service. People told us they were bored. Care records did not contain details of people's past hobbies and interests which meant they did not have the opportunity to engage in old hobbies or develop new ones. One staff member told us, "(Persons name) gets bored easily, we take them out for coffee, go for a walk, there is more to do in the summer I feel bad for them in the winter it is so boring." One person we spoke with said, "I don't do anything, I can go to the shop".

Improving care quality in response to complaints or concerns

•We viewed the complaints file and saw that no complaints had been recorded to date However, people had raised concerns. For example, one person told us, "Staff come into my room at 2am and make me go to the

toilet. I have said I don't like it and it's not necessary, but they still do it." Their feedback had not been acted upon.

•There was a complaints policy on the board in the hallway when we asked four people if they knew where the complaints policy was, they did not know it was on the board. One person told us, "Staff listen but don't always act on it."

End of life care and support

•At the time of the inspection no one was receiving end of life care. We discussed this with the provider who told us people did not have end of life care plans in place. This meant that staff would not know how people would like to be cared for if people needed end of their life care.

The failure to provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection May 2018, we found the provider had failed to implement systems and arrangements to ensure people received a safe and effective service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there were still significant shortfalls in the overall governance of this service. The providers oversight did not assure the delivery of high-quality care and the rating had deteriorated to inadequate.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•Leadership did not ensure person-centred, high quality care was delivered. The provider had failed to ensure there was sufficient oversight and governance at the service.

Systems had not been used effectively to identify shortfalls and unsafe practices. As a result, standards had not improved since our last inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•The service had experienced an unsettled period due to a change in management. The impact of this had not been adequately assessed or planned for by the provider to ensure people received safe, effective, responsive care.

•The provider had taken on the role of registered manager in June 2018. The provider did not have the resources available to them to make the necessary improvements. They told us, "They felt overwhelmed by the number of things that needed to be sorted out".

•The provider had not ensured there was an effective management structure in place to monitor the care provided. They had also failed to ensure staff were given the support they required to provide safe, effective, responsive care.

•Lack of effective oversight meant people were living in an environment which was poorly maintained. For example, the provider had failed to secure wires hanging loose where shower should be or carry out

legionella testing.

•Confidential information was not stored securely. Care files and staff files were kept in unlocked drawers. Information about people and staff was not stored securely to ensure their right to confidentiality.

•At this inspection we found the quality assurance processes continued to be ineffective and did not pick up on the issues identified during the inspection. These included concerns with, risk management, staffing and a lack of person centred care.

•Some audits were in place but these were a tick lists and did not contain any identified actions. Medicine audits did not identify the concerns we found with medicines management.

•Accident and incident audits were tick lists and accidents and incidents were not analysed so trends or patterns could be identified. There were no other completed audits in place.

•People did not know who managed the home, they told us staff just tell them what to do. They did know who the owner was but hadn't realised they were the registered manager. One person said, "Don't see them that often."
The shortfalls in assessing and monitoring the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•It is a legal requirement that each service registered with the CQC displays their current rating. The rating awarded at the last inspection and a summary of the report was on display in the entrance.

•The provider was aware of their responsibility to inform us of events including significant incidents and safeguarding concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•Feedback was sought from people living at the home and concerns had been raised, but there was no recorded action about how improvements had been made. We discussed this with the provider who told us, "They go in the file but we don't follow up anything". This meant that the views from people involved with the service had not been considered or acted upon to make improvements.

Continuous learning and improving care

•Following the last inspection, the provider had failed to act fully where recommendations were made or breaches were identified, in areas such as, risk management and quality assurance.

•At this inspection we found additional concerns around person centred care, medicines management, and overall governance of the service.

•Governance systems and arrangements were still not robust enough to assess, monitor and improve the quality and safety of the service.

•The provider had failed to ensure people received formal assessments of their needs, this had led to people living in an environment that was unsuitable and staff could not fully meet their needs.

•Systems in place to seek feedback from staff, relatives, and people who used the service were not robust. For example, staff did not attend staff meeting and resident meetings were not regular, which meant people did not have a say in how their home was run.

•Trends from complaints were not used to improve the quality of care and support at the service.

The above concerns are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

•The service worked in partnership with other organisations to support care provision. For example, district nurses visited people regularly. The provider told us, "We do work closely with the local community mental health teams and psychologists".

•Visits from healthcare professionals were recorded in peoples care plans. One professional told us, "Staff are friendly, and very helpful." They added, "It's not an average care home it's younger people who have been there a long-time. Staff appreciate they are stuck in their ways and work with them." They also said, "I've never seen anything untoward."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to make sure that the person who obtains peoples consent has the necessary knowledge and understanding of the care or treatment that they are asking consent for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate a robust recruitment process to ensure suitable staff are employed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks and avoidable harm. The management of people's medicines was not always safe. People were not adequately protected from the risk of infection. People were not adequately protected from the risk of fire.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of governance were not operated effectively to assess, monitor and continually improve the quality of the service

The enforcement action we took:

Warning Notice