Galfrie Limited

The Old Hall Residential Home

Inspection report

Old Hall Street
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13 September 2017
26 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 6, 13 and 26 September 2017. All our visits to the service were unannounced. The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. Information shared with CQC about the incident indicated potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

The Old Hall residential service is registered to provide accommodation and personal care for up to 16 older people. At the time of our inspection there were 11 people living at the service.

The service had 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.

At the last comprehensive inspection on 24 and 25 January 2017 we found a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider's quality assurance systems were not effective. We asked the registered provider to take action to make improvements in this area.

After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breach identified. They informed us they would meet all the relevant legal requirements by 31 May 2017. This inspection found a continued breach of Regulation 17 and in addition a breach of Regulations 10, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

Staff had been employed following appropriate recruitment checks that ensured they were suitable to work in health and social care. Since our last visit the needs of people living at the service had significantly changed. However, staffing levels in place at the service were not sufficient to protect people from the risk of harm. When we arrived at the service there were only two staff on duty. People were left unsupervised and with no access to staff for periods of up to 40 minutes. Inspectors were required to intervene with one person to prevent them from the risk of falling. The registered manager confirmed that the staffing levels were too low. We asked the registered provider to take immediate action to address safe staffing levels during our visit.

Quality assurance systems in place were not effective, they failed to identify areas of concern we highlighted during our inspection. Where action plans had been put in place to address the improvements needed, we found no evidence that these had been completed by the registered manager or registered provider. There was a lack of management oversight to ensure that robust checks were carried out as required across the

different areas of the service. Records were not properly maintained to make sure they were accurate and fully complete. Care plans did not always contain accurate information regarding people's care needs and failed to clearly record the care people had received.

Accidents and incidents were recorded by staff, however there was a lack of evidence within audits to demonstrate that a robust analysis of falls, patterns or trends were identified. There were no recorded actions completed for people who had experienced multiple falls to state what had done to prevent and minimise the risk of further harm/occurrences.

People were not always protected from the risk of malnutrition and dehydration. There was a lack of action taken when it was identified that one person had lost a significant amount of weight over a short period of time. Weight monitoring charts showed that they had lost 4.7kg between June and August 2017. There was no evidence that the person was referred onto a dietician for their input. Supplementary charts required to monitor food and fluid intake could not be found by the registered manager. Care records relating to the monitoring of peoples skin integrity were not always kept up to date.

People told us and we observed that they received their medication at their preferred times. However, we found that the management of medicines was not always safe. Medication stock checks were not always accurately recorded on people's medication administration records (MARs). This meant that the registered person would not be able to clearly identify from the stock levels if people had received their medicines as prescribed. The registered manager confirmed that she was responsible for the management and recording of stock received and leaving the service. Care plans for PRN (as required) medication were not always in place for staff guidance. Appropriate guidance from relevant health professionals had not always been sought where changes to medication had been required. We asked the registered manager to take immediate action to address these concerns.

Risks to people's health and safety were not always safely managed. Where people had required the use of equipment to assist with moving and handling, the registered manager had not sought advice or guidance from relevant professionals. Where people had been assessed as requiring the use of assistive technology to minimise any risk of harm, we found that the relevant equipment was not always working or in place. Care plans contained out of date information relating to the current care needs and risks to people's health and safety.

Staff received supervision and attended team meetings as required. However, the registered provider training matrix identified that training in relation to moving and handling was not up to date for all staff working at the service. In addition training in areas such as safeguarding adults from abuse and the Mental Capacity Act 2005 required updating. The registered manager confirmed that as of now only staff that had up to date moving and handling training would carry out this practice at the service. We asked them to take action to ensure staff were provided with relevant training.

People's privacy was not ensured as records were not held securely at the service. People's rights to choice, privacy and dignity were not always respected.

The registered provider had not displayed their ratings from the previous inspection.

People were supported throughout our visits to make a number of choices regarding how they received their care. Staff understood the importance of seeking consent from people and we observed this on most occasions where support was offered. Care plans contained decision specific capacity assessments and where required, best interest meetings had been held. However the review dates for these assessments set

by the registered manager had not been met. Family members confirmed that were appropriate they had been consulted on any decision making regarding their relatives care.

People knew how and who to raise any complaint to. People were complimentary about the service and the support they received from staff. Staff were described as "Kind", "Caring" and "Patient." Family members described the service as "Warm", "Welcoming" and "Homely".

The CQC were notified as required about incidents and events which had occurred at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months.

The expectation is that registered 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 registered 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 registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient levels of staff working at the service to safely meet the needs of people supported.

The management of medicines was not always safe.

Accident and incident records were completed at the service. However, a robust analysis of incidents was not completed.

People were not protected from the risk of harm as care plans and risk assessments were not always up to date and accurate.

Is the service effective?

Requires Improvement

The service was not always effective.

People received support from staff who had not completed appropriate training to undertake their role.

Staff were not always actively listened to or supported by the registered manager.

Appropriate referrals to health and social care professionals had not always been undertaken.

Care plans contained decision specific mental capacity assessments and best interest meetings where required. However, review dates had not been met.

Is the service caring?

Requires Improvement

The service was not always caring.

Language used in care records about people was not always dignified and respectful.

Peoples rights to choice, privacy and dignity was not always maintained.

People described staff as being kind, friendly and caring.

Is the service responsive?

Inadequate

The service was not responsive.

Food and fluid charts were not always introduced as required. Where in place they were not accurately completed, reviewed or analysed. People were not protected from the risk of dehydration and malnutrition.

There was a lack of robust monitoring of people's skin integrity.

Care plans and risk assessments were not always updated or reviewed as required. Accurate information regarding people's care needs was not always recorded.

People knew how and who to make a complaint to.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager and registered provider lacked knowledge of the Health and Social Care Act 2008.

The registered provider's quality assurance systems were not effective. There was a lack of management oversight to ensure audits were robust and highlighted areas of improvement.

The registered provider had failed to display their ratings as required.

Records were not held securely at the service.

The Old Hall Residential Home

Detailed findings

Background to this inspection

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

We visited the service unannounced on 6, 13 and 26 September 2017. The inspection team consisted of one adult social care inspector on the first day and two adult social care inspectors on the second and third days.

Before the inspection, we received concerns regarding the provision of care at the service. We therefore decided to bring forward our inspection. We reviewed information provided by the Local Authority and Safeguarding teams. We also reviewed other information we held about the service including notifications of incidents that the registered provider sent us since the last inspection, including complaints and safeguarding information.

We spoke with six people who lived at the service and three of their family members. We also spoke with six members of staff and the registered manager and registered provider. We looked at the care records relating to five people living at the service, which included, care plans, daily records and medication administration records. We observed interaction between people who lived at the service and staff.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service. They told us, "The staff here do their best to keep us safe. I can't complain really, they look after us well" and "I have this button when I am in my room. If I press it, the staff come and see me. I feel safe having this with me".

Prior to and during our inspection visit CQC received information of concern regarding unsafe care and poor practice undertaken at the service. We looked at those concerns as part of this inspection.

During our last comprehensive inspection in January 2017 we identified improvements were required in the recording of information relating to fire safety and legionella checks. This inspection visit found that improvements had been made in these areas, however we identified further concerns relating to staffing, medicines management and failure to adequately protect people from the risk of harm.

Staff had been employed following appropriate recruitment checks that ensured they were suitable to work in health and social care. However, on the first day of our visit we found that there was insufficient staff on duty to adequately protect people from the risk of harm. On arrival to the service we found that there were only two staff available to support eleven people. Through discussions with the registered manager and a review of records we identified that two people required the support of two staff to mobilise safely. People were left in the lounge and conservatory unsupervised for periods of up to 40 minutes whilst staff offered support to people in their bedrooms. During these periods inspectors were required to intervene with one person who mobilised using a zimmer frame. On three different occasions the person attempted to enter a toilet area located in the conservatory which had a slight step in place on entering the room. The person was unsteady on their feet and struggled to access and leave the room and gauge where or how deep the step was. Inspectors had to guide the person safely over the step to ensure they did not fall or lose their balance. The person's care plans stated that they must be observed at all times by staff when using their zimmer frame. This was due to the fact that the person was both unsteady on their feet and at risk of falls and could also at times forget to use their zimmer frame when mobilising.

Two people commented to the inspector at 10.10am that they had still not received their breakfast. Both people stated they had received a hot drink, but that they were hungry and would welcome some food. The registered manager confirmed that people had eaten earlier in the morning and may not recall this due to living with dementia. No consideration had been taken into account that the person may still have felt hungry when they stated they would welcome some food. Staff were not available in the lounge to meet these people's needs as they were busy helping other people out of bed. Two people also asked us on a number of occasions where staff were and who was on duty as they hadn't seen anyone for a while. Staff did not re-enter the lounge until 10.37am to check on the safety of the five people who were sat in there. People did not have access to a call safety alarm to raise the attention of staff in case of an emergency. Following the inspection the registered provider advised that a call safety alarm was in place in the lounge. However, people living at the service that had a diagnosis or signs of early onset dementia where not aware of a call alarm system when asked during our visit. In addition those who presented with mobility difficulties and required the assistance of staff and/or equipment to mobilise could not gain access to the call alarm. Access

to a safety alarm as described by the provider, as 'on the wall of the lounge next to the door', was not sufficient to keep people safe when staff were not available for periods of time'.

Staff who worked at the service were required to undertake a number of ancillary tasks alongside providing care to people. This included cooking and preparation of meals and snacks, laundering of clothing and bedding and some cleaning tasks. At 10:20am inspectors entered the kitchen which was unsupervised and saw a large pot of boiling water on the main cooker. Staff were busy assisting people out of bed and others with their morning routines. Staff entered the kitchen at 10:35am to check on it. The deployment of staff exposed people to the risk of harm.

We immediately raised our concerns about unsafe staffing levels with the registered manager. The registered manager confirmed to us that they agreed the staffing levels were too low. They told us that three staff had recently left employment at the service and that they had commenced recruitment processes for new staff. Despite this we found that a lack of action had been taken to address the shortage of staff in order to mitigate the risk of harm to people. We asked the registered manager and registered provider to take immediate action to ensure staffing levels were sufficient to keep people safe. Following our visit we received confirmation that staffing levels were increased from two to three in the morning and evening.

During our evening visit on the 13th September 2017, the increase in staffing levels had been maintained. However we observed periods of up to fifteen minutes were the lounge area was occupied and left without any staff supervision. We spoke again with the registered manager about the importance of staff undertaking regular checks and observations to ensure people remained safe. The manager confirmed that they would be undertaking a 'dependency assessment' for each person to ensure that staffing levels were sufficient to keep them safe.

Rotas we viewed did not clearly identify how many staff were on duty and the times that staff started and finished their shifts. Rotas dated the 6 September 2017 identified that there were only two staff on duty during the hours of 7am and 9pm and between the hours of 9pm and 10pm the rotas evidenced only one staff member on duty. The registered manager stated that they or the registered provider were not always recorded on the rotas but present in the building as part of the staffing numbers. In addition the working hours of waking and sleep in staff on duty at night were not clearly recorded on the rota. We asked the registered manager to address this immediately. Following our inspection visit we received an amended and updated copy of the rota which contained this information.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were placed at risk of harm and receiving unsafe care and treatment as there was insufficient levels of staff to meet people's individual needs in a timely manner.

The management of medicines was not always robust. Medicines available were checked against the medication administration records (MARs) and we found that stock levels were not always correct. We reviewed MARs for three people and found that accurate stock levels were not recorded. Medication stock had been entered at the beginning of the MAR cycle including medicines carried forward. However when we counted the medicines that had been administered and the remaining medicines available at the service these did not tally. This meant that an accurate stock of medicines was not maintained. The registered manager confirmed that they were responsible for the medication stock management and the auditing of medicines at the service but had not always accurately recorded the medicines stock balance as required.

'When required' (PRN) medication, is usually prescribed to treat short term or intermittent medical conditions, sometimes with varying dosages. Some people had PRN medication to help manage their

anxiety or pain relief. There was no guidance in place to indicate what alternative strategies were to be attempted before medication was administered. Where people had pain relief, there was no record of symptoms or signs for staff to look out for which would indicate the person required PRN medication, if they were unable to inform staff themselves. This meant that there was limited information available to guide staff as to when PRN medicines should be given. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently and with regard to their individual needs and preferences.

One person had been prescribed medication to assist them with sleeping. The GP had prescribed a dose of 7.5mg to be taken in the form of one and a half tablets at 10pm each night. MAR charts identified that only one tablet had been given on a regular basis. When spoken with the registered manager informed us that the full dose was not required at all times as it was observed that it could make the person overly drowsy the following day. However, we found that no actions had been taken to reassess this medication with the GP and to reduce the prescribed dose. The registered manager confirmed they had made the decision independently to reduce the dose (when required) based on their observations. We found no guidelines in place for staff to follow to assess whether one or one and a half tablets were required by the person. We asked them to speak with the person's GP following our visit to reassess their need for this medication. The registered manager confirmed by the second day of our visit that the GP had undertaken a review and prescribed the medication as a variable dose to the person to be taken 'when required' (PRN).

Information written in medication care plans did not always coincide with the medicines people were prescribed. We noted that information relating to medicines for the treatment of constipation was incorrect. Care plans for one person identified that Movicol should be used to support bowel movements, however the person's MAR chart identified laxido was prescribed for constipation. Another person's MAR chart identified that 'proshield creams' should be applied twice a day to protect them from risk of damage to their skin from moisture. However, the person's care plan stated that prescribed creams should be applied three times a day. This meant that people were at risk of incorrectly receiving medications if a staff member less familiar with the service undertook shifts.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have a proper and safe system in place for the management of medicines.

Staff had a good understanding of what people's needs were in relation to medicine administration. They were able to describe when and how different medicines were required and how they would monitor for any signs of change in a person's health and well-being and raise this with the registered manager. Medicines were ordered and disposed of as per the registered providers policies and procedures. Where appropriate, medicines which needed to be kept cool were stored in a designated fridge, to ensure their effectiveness. Medication fridge temperatures were checked regularly to ensure they were at the correct level.

Care plans for four people living at the service who were at high risk of falls, identified that to ensure safety is maintained at night the use of assistive technology was required. This was in the form of pressure alarm mats placed next to beds and/or a door sensor alarms to alert staff of people's movements. However, we found that this equipment was not in place as described for two people. Staff told us that the pressure alarm mat for one person had been broken 'for some time' and this had been reported to the registered manager. The registered manager stated that the persons needs had significantly changed and the equipment was no longer required. However, this was not recorded in the persons care plan and staff were not aware of the changes. In addition we found that there was no door alarm sensor in place for one person. This meant people were not adequately protected from the risk of falls or harm. Following our visit the registered

provider confirmed that care plans had been updated to accurately reflect the equipment people required.

During our visit we observed in the lounge area the registered manager and another member of staff supporting a person onto a stand aid. Stand aids are designed to support people who may not be able to fully weight bare to transfer from a sitting to a standing position. They are also used to rotate a person from one seated position to another. The registered manager undertook the transfer while the second member of staff collected a wheelchair from the adjoining dining room. All people who were assessed as requiring the use of a stand aid were identified as requiring two staff to assist to ensure they were kept safe. Whilst the person did not come to harm, they were exposed to the risk of harm such as tipping over or falling which was not recognised by the registered manager. When spoken with regarding this practice the registered manager stated that she did not feel it necessary for two staff to stand over a person during a transfer.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider and registered manager failed to keep people safe from the risk of harm.

Accident and incident records had been completed as required when events had occurred at the service. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. However, we found that where people had experienced regular falls, the management team had not undertaken effective review or analysis of incidents. This meant that people were at risk of not receiving appropriate support in the management and prevention of falls. We have further reported on the analysis of accident and incidents in the well led section of this report.

Certificates were in place to show that there had been routine servicing and inspections carried out on items of equipment such as hoists and electrical and gas installation. Service contracts were in place to ensure these were renewed in line with safety and manufacturers guidance. Fire records held at the service were up to date and completed. However, we contacted Cheshire Fire Service to seek advice in relation to the current fire risk assessment which stipulated service evacuation time of 4.5 minutes. We have asked the fire service to review safe practice in line with current staffing levels at the service, particularly at night. Staff knew where to locate emergency equipment such as firefighting equipment and first aid equipment.

Staff knew where to access safeguarding information, including the registered providers safeguarding policy and procedure. They knew what was meant by abuse and they gave examples of the different types and signs and symptoms of abuse. They understood their responsibilities to report any concerns about abuse and told us they were confident to do so. Whilst staff had a good understanding of safeguarding we noted that up to date training had not been accessed. This meant that people could be at risk due to staff not keeping up to date with changes in good practice and current legislation. Staff told us they understood about whistleblowing and felt that they could raise any concerns and knew the procedure for this. Whistleblowing is where staff can raise any concerns inside or outside the organisations without fear of reprisals.

Requires Improvement

Is the service effective?

Our findings

People told us, "The staff seem to know what they are doing" and "They will call the doctor for me if I let them know I feel under the weather", "The food is mostly good. You get the odd day when you are not fussed, but overall its good" and "I like the food, it is home cooked and hearty. There is always something else if you don't like what is on the menu."

People confirmed that they had attended routine healthcare appointments to keep them healthy and this was confirmed by family members. Staff explained their role and responsibilities and how they would report any concerns they had about a person's health or wellbeing to the registered manager. However, we found that appropriate and timely referrals had not always been made to other health and social care services. Where people required the use of specialist equipment for moving and handling or a change in their mobility needs advice had not been sought from occupational or physiotherapists. Where people had experienced changes in their intake of food and fluids that had led to weight loss, referrals to dieticians or the person's GP had not been made in a timely manner. We have reported on this further in our safe and responsive domains.

The registered provider gave us a copy of their staff training matrix for our review. Staff told us that they had attended a number training sessions and updates since our last inspection. The matrix showed training undertaken by staff included; moving and handling, medication, fire safety, first aid and the safe thickening of fluids. However, records showed that the registered manager had not completed moving and handling training since 2014. The manager confirmed that both theirs and one other staff members training in this area was no longer in date. We raised concerns regarding the competency and qualification of both parties to undertake moving and handling procedures at the service. The registered manager advised that any staff who had not received up to date training in this area would cease practice immediately until retrained. This was poor practice and placed people at risk of avoidable harm.

Supervision records identified that a member of staff who had been working at the service since 11 July 2017 had not undertaken moving and handling training. The staff member had been shown by the registered provider how to use equipment such as stand aids and this had been recorded in their supervision. The staff member had reported not feeling confident using the hoist or stand aid. However, the staff member was regularly identified on the rotas as the second member of two staff on duty. This placed people at unnecessary risk of harm due to the risk of poor moving and handling techniques. We raised this concern with the registered manager at the time of our visit who advised she would ensure that the staff member was not left as a second person on duty. In addition they stated that they would revisit and address competency and confidence in using the mobility aids.

Staff supervisions and team meetings had been completed as required. Records evidenced that discussions were held in relation to training required, concerns regarding the service and people's individual needs. We noted that staff had raised concerns regarding the staffing levels at the service particularly at weekends. However we saw no evidence of follow up from the registered manager to address these concerns. Concerns regarding staff confidence of using the stand aid had not been given appropriate consideration by the

registered manager. Actions had not been taken to address the concerns staff had raised. Staff had not received annual appraisals. This meant staff did not receive the support they needed to enable them to carry out their job effectively.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations as the registered provider had not ensured that staff received appropriate and ongoing support, training and professional development

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Decision specific mental capacity assessments remained in place for people and where required, best interest meetings had been held. However, we noted that review dates of these records had not been met by the registered manager. Family members confirmed that were appropriate they had been consulted on any decision making regarding their relatives care. It was clear through practice we observed that staff asked people for their consent before carrying out any activities and knew that they needed to assist people to make choices where possible. Whilst staff had a good understanding of consent and capacity we noted that up to date training had not been accessed. This meant that people could be at risk due to staff not keeping up to date with changes in good practice and current legislation.

The manager demonstrated that applications had been made to the local authority on behalf of people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations.

People told us and observations showed that they were offered choices at mealtimes and a variety or regular snacks and drinks throughout our visits. Support at mealtimes was provided sensitively and staff gave people sufficient time to enjoy their food. Where people required assistance, staff sat next to them and helped, guided and encouraged them to eat independently wherever possible. However, we noted that there were no condiments in place for people to use in the dining room and the tables were not well presented. The registered manager advised that one person living at the service could 'over use' condiments such as salt on their meals, therefore this was not made accessible in the dining room. This meant that people's choice to season their food independently was restricted. A discussion regarding alternative methods of introducing condiments was held. We spoke with the registered manager regarding the mealtime experience who stated that improvements were required to be made to promote a pleasant experience.

People told us, "I like the homely environment here. It's warm and cosy in the lounge and I have all my own things in my room" and "It could do with a lick of paint, but it's homely." The environment at the service was clean and tidy, however in a number of areas the décor looked tired and in need of refreshing. The service had a large conservatory leading off the main lounge and we noted that the reinforced glass in the roof area had some cracks present. Following our visit the registered provider confirmed that the replacement of the conservatory had commenced in October 2017. The registered provider confirmed that due to the service

being a converted barn decoration and replacement works would be an ongoing consideration.

Requires Improvement

Is the service caring?

Our findings

People living at the service told us that staff were kind and caring. They told us, "They are such a lovely bunch of people. So kind, patient and they are always trying to help me" and "Oh, I can't say a bad word against the girls. They are all just so lovely." Family members confirmed that staff were always welcoming, friendly and very kind to their relatives.

Care plans included language which was not always person centred. Person centred care is a way of thinking and doing things that gives people as much choice and control as possible over their lives. However the language used in care plans such as 'allow' the person and 'tell' the person did not reflect a person centred approach as they were instructions which did not take account of people's choices and decisions. Care plans for one person living with dementia described them as 'aimlessly wandering' when they walked around the service. Care plans did not always clearly evidence how staff should promote people's choice and independence and they did not promote a person's dignity.

At 7.15pm during our evening visit to the service on the 13 September 2017 we observed a staff member in the lounge serving cups of tea to people. When asked if they would like a drink, two people responded that they would prefer a cup of coffee to tea. The staff member responded by saying that if they drank coffee at that time it would keep them awake and continued to serve both people tea. Whilst the staff member explained that they had the person's best interests in mind, they failed to respect the person's choice.

Information located on the manager's office wall evidenced that a 'bathing list/rota' was used at the service. The 'bath list' identified specific days in the week where people would be allocated time to have a bath or shower. This was institutionalised practice.

People's privacy and confidentiality was compromised as records were taken away from the service by the registered manager. This meant there was a risk that personal and confidential information could have been accessed by unauthorised people.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people's rights to choice, privacy and dignity were not always respected.

During the lunchtime service on the 6 September 2017 two people sitting at the dining table began arguing and insulting each other. Other people in the vicinity became distressed at the level of noise. There were no staff available in the dining area for a five minute period to diffuse the situation. We spoke with the registered manager who advised that this was not a regular occurrence and staff would usually be available in the dining room. They advised that they would review staffing levels at meal times following our visit.

People looked relaxed and happy in the company of the day and night staff who throughout our visits appeared attentive in their work. People received care from a majority of staff that had worked at the service for many years and knew and understood their needs. Staff were able to describe people's character, routines, personal preferences, health and support needs. Observations showed that most staff took time

with people and were kind in their approach and manner. Staff were observed explaining to people what they were going to be doing before offering support. Staff were observed knocking on people's bedroom doors and waiting to be invited into the room (where appropriate). This showed that staff understood the importance of respecting people's privacy.

One person told us, "I don't like to go to bed too early. The staff are great, I never feel rushed and I stay up as late as I wish." During our evening visit on 13 September 2017 we observed people requesting for staff to support them to bed. The last person was supported to bed at 10:45pm. Staff respected people's choices of when they wished to get up and go to bed. People had their own bedrooms and had been encouraged to personalise them with their own furniture, pictures, photos and paintings. This helped people to be comfortable and feel their room was personal to them.

Family members told us they felt they could visit or contact the Old Hall at any time of the day. They told us, "I'm always made welcome when I visit. I can come any time of day or evening." Throughout our inspection we observed family members and other visitors being welcomed at the service.

The service had received a number of compliments which included comments such as, "Thank you all very much for the love and care you gave to my lovely mum. I can't speak highly enough of you all" and "I would like to show my appreciation for the hard work, dedication, kindness and caring your staff have shown my relative." These reflected that staff had treated people with kindness and showed concern for their wellbeing.

The manager confirmed that at the time of our inspection that no one was receiving end of life care. Care records contained the relevant paperwork for those people who did not want to be resuscitated in the event of their death. This information was placed prominently at the front of the care record so that staff could easily access this information if they needed to. Staff were able to describe the importance of ensuring that people and their family members received dignified and appropriate support during this time.

Inadequate

Is the service responsive?

Our findings

People had mixed views with regards to the level of activities taking place in the service. They told us, "It seems to have slowed up recently" and "When we do have something on, it's great." The registered manager confirmed that with the recent changes to staff, the focus had shifted to ensuring peoples care needs were met as a priority. They confirmed that once staffing increased activities would become a more prominent focus on a daily basis.

Three people living at the service required the use of a stand aid to support them to stand and transfer. We reviewed each person's risk assessments and care plans. Assessments had been completed by the registered manager for both the use of the stand aid and to assess which 'sling' was required for each person. The registered manager confirmed that they did not hold the relevant qualifications to safely make these assessments. Through discussions with staff we identified that only one sling was in use for all three people. This posed an infection control and safety risk. The registered manager confirmed that she had made the assessment based on each person's weight and height and had not sought expert advice from relevant health professionals regarding this. Concerns relating to this practice had been raised with the Local Authority and CQC were informed that occupational therapists would be in attendance to review and assess people's needs following our inspection visit. This placed people at risk of unnecessary harm as appropriate professional advice had not been sought in relation to safe moving and handling of people living at the service.

Observations showed that staff regularly supported people to eat and drink throughout our visits. However, we found that one person's records identified a weight loss of 4.7kg between June and August 2017. An entry on the persons 'Record of Doctors visits' identified that a discussion was held with the district nursing teams on the 25 August 2017 regarding the persons weight loss and they advised that they would speak to the GP. However, through a further review of records, we identified that no further actions had been taken by the registered manager to address the person's ongoing risk of weight loss. The manager confirmed that the service had received no feedback from the district nursing team and the GP had not contacted the service to undertake a review as necessary. Furthermore the registered manager confirmed that they had not contacted the GP or made a referral to the dietician. Daily record entries clearly evidenced on-going concerns in relation to poor appetite and a decrease in the intake of food and fluids since 21 August 2017. The person's care plan stated that if weight loss occurred food and fluid intake must be monitored. Inspectors requested a copy of all of the food and fluid charts for the person and were presented with records dated the 5 and 6 September 2017. The registered manager stated that she could not find any other records regarding food and fluid intake records. We noted that these records were not totalled or monitored as required. The persons Malnutrition Universal Screening Tool (MUST) assessment was last updated on the 31 July 2017 and had identified the person as a medium risk only. The poor practice evidenced at the service had failed to adequately protect the person from the risk of malnutrition and dehydration.

Waterlow assessment records dated 31 July 2017 identified one person as being at high risk of the development of pressure ulcers due to poor skin integrity. Staff were able to describe to inspectors any recent changes in the person's skin condition and the use of any medicines as prescribed by the GP. Skin

integrity care plans dated 11 May 2017 stated that each morning staff were to document the condition of the person's skin integrity to monitor changes accordingly. A review of the daily records evidenced that this practice was not consistently completed. Entries specifically relating to skin integrity were sporadically written by staff. Daily records evidenced that on the 29 August 2017 the person had developed a small break to the skin on their bottom. The registered manager stated that this had occurred as staff had not placed the person on their bed in the afternoon to support pressure relief. Care plans written in relation to skin integrity gave no guidance to staff about the person spending time on their bed in the afternoon to aid pressure relief. No consideration had been undertaken by the registered manager or registered provider in relation to the possible risks or impact that poor food and fluid intake and weight loss may pose in relation to the person's skin integrity.

Another person's daily records dated 19 August 2017 identified that a pressure blister had been located on their heel. Staff were able to describe what support they had implemented to prevent deterioration on the person's skin integrity. However, the person's 'skin integrity' care plan dated 29 August 2017 contained no information regarding the change to the person's skin condition. The care plan provided no written guidance to staff on how to prevent further deterioration. This meant people were not adequately protected from the risk of pressure ulcers.

This was a breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to ensure that robust records were kept in relation to monitoring people's food and fluid intake and pressure care. People were not adequately protected from the risk of malnutrition and dehydration and the development of pressure ulcers.

The registered manager informed us that they took responsibility for updating, reviewing and sharing changes to care plans with the staff team. Care plans and risk assessments were in place for each person supported. However, we noted that records had not been updated as required when significant changes had occurred to people's needs. Where changes had been identified in relation to people's mobility, eating and drinking, weight and skin integrity, records evidenced limited effective reviews had taken place to assess and review how people's needs were required to be met. An example of this was one person's mobility care plan dated 16 April 2017 stated that '[name] continues to weight bare but is unable to mobilise'. However the persons 'skin integrity' care plan dated 29 August 2017 stated, '[name] should be supervised when mobilising around the Old Hall'. The registered manager and staff confirmed that the person was no longer able to mobilise independently.

Care plans for two people identified that two hourly night time checks should be completed to ensure they remained safe. Staff confirmed that they undertook these checks however, they were not recorded or evidenced as having taken place in daily records. Records of checks had been implemented by our visit on the 13 September 2017. Where people required the use of bed rails, the registered providers safety checklists were not always completed in full. Records identified that they were to be signed 'AM' and 'PM'. We found missing signatures for periods of up to 11 days were this had not been completed. We raised this with the registered manager who advised they would address this practice with staff. On checking bed rails we found no concerns regarding the equipment that was in use.

Care plans and supporting documentation, did not accurately reflect the care needs of people. This meant that people were not protected from the risk of harm as records were not adequately reviewed and staff did not have access to up to date and accurate information about an individual. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's ongoing monitoring of the care provided at the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider did not ensure that accurate and contemporaneous records were held in respect of people supported.

People told us, "I can't complain really. It's like being at home here. The staff are always so kind, they are very busy but they always stop to help if we need something." Family members told us, "I really like my relative being here. Yes, it's old looking and a bit tired, but the staff are genuine and care about people and you can always get hold of the top person to speak to. That's my priority for my relative." The registered provider had a complaints policy and procedure in place, a copy of which was provided to people and their family members when they moved into the service. No complaints had been recorded as received since our last visit in January 2017.

Inadequate

Is the service well-led?

Our findings

The service had a manager who was registered with CQC since 2014. People told us, "We know the lady who runs the place and we get to see her most days here" and "Yes, I know who the manager is, she is always checking if we are ok."

At our last comprehensive inspection in January 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the registered provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. During this inspection we found a number of ongoing concerns relating to the effective use of the registered providers audit systems.

Medication audits were not robust. The registered manager had highlighted a number of concerns relating to the management and administration of medicines in the audits dated 31 August 2017 and 05 July 2017 including low medication stock levels and missing signatures on MARs. Actions to be taken in response to the areas of improvement were recorded by the registered manager as, 'All audits will be discussed on a one to one basis with staff'. We found no evidence to show that discussions with staff had taken place following the audits completed on July and August 2017. A team meeting dated 4 May 2017 raised similar issues in relation to missing signatures on MARs, however these concerns continued at the service. The registered manager failed to address concerns as identified through the audit process.

The registered provider's infection control audit was not robust. The registered manager had highlighted a number of areas of improvement relating to the prevention and control of infection in audits dated 02 August 2017 and 16 July 2017. Comments recorded included that food hygiene certificates for some staff were out of date and the kitchen bin was broken and needed to be replaced. However, we saw that none of the actions had been signed off and some had not been completed. Actions recorded included that 'all points will be discussed in individual supervision and in the general staff meeting'. We found no evidence that discussions with staff had taken place following the audits completed in July and August 2017.

Accident and incident audits were not robust. There was a lack of analysis of trends, patterns and actions taken in response to the overarching findings of the accidents/incidents that had occurred. Risks we identified from a review of records had not been addressed or mitigated in care plans. Records evidenced that one person had three falls during the night. There was no evidence of recorded actions taken to prevent further risks occurring. Another person who was known to be at high risk of falls, had experienced three separate falls since March 2017. However during our visit on the 6 September 2017 we identified that the equipment documented in the person's care plans to protect them from the risk of harm had not been implemented as required. The registered manager confirmed that they had not updated care plans as required or identified and recorded trends or patterns in relation to accidents and incidents that had occurred. A review of records confirmed that no actions had been recorded on either the registered provider audit documentation or people's individual care plans.

Audits completed at the service did not capture all of the issues we identified as part of our inspection. We

identified that risk assessments and care plans had not been updated when people's needs had changed and that they contained inaccurate and out of date information. Where incidents had occurred at the service, appropriate reassessment of people's needs had not been undertaken. Concerns relating to the lack of recording of food and fluid charts for people who were at risk of dehydration, malnutrition and weight loss had not been identified by the registered provider or registered manager. Records relating to the monitoring and prevention of the development of pressure ulcers were not adequately maintained.

We noted that refresher training in relation to safeguarding adults, the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS) had not been completed since 2015 for most staff working at the service. We raised this with the registered manager who advised they had been in contact with the local authority to request the training some time ago. They confirmed they had not followed this up further when they did not receive a reply.

The lack of robust quality assurance was discussed with the registered provider and registered manager during our visit in January 2017. They advised that they would ensure that all effective auditing and analysis of all areas such as records, accident and incidents, medicines management would be completed and reviewed appropriately following our inspection. It is of concern that feedback given on 19 September 2017 to the both the registered manager and registered provider identified continued poor practice relating to quality assurance. In particular the lack of action taken in response to accident and incidents that have occurred at the service. This demonstrates that the registered provider's quality monitoring systems are not effective.

This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems in place to assess, monitor and improve the quality and safety of the service were not effective.

People's confidentiality was not always respected as personal information about them was not secure. Files which contained confidential information about care interventions were removed from the service by the registered manager. At 9.10am on the 26 September inspectors discovered that care plans relating to nine people who lived at the service had been removed from the service on the evening of the 25 September 2017. Staff on duty confirmed that they had not been aware that the records had been removed from the service. We requested that all records relating to the care of people were immediately returned to the service and this was completed. This meant that information regarding people's care needs was not accessible to staff or health professionals in case of emergency for a period of approximately 14 hours. Both CQC and the local authority had raised concerns previously with the registered manager regarding Data Protection and the removal of records from the service.

This is a breach of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's privacy was not ensured and records were not held securely at the service.

The registered provider had failed to display their ratings from the previous inspection. On the 6 September 2017 inspectors found a copy of the previous inspection report and ratings displayed at the service. The registered provider's website was reviewed prior to the inspection and the current ratings and CQC report were not available for public viewing. We raised this with the registered manager to address.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to discuss some key policies and procedures with us that helped and supported them to

undertake their role. At our last inspection visit in January 2017 the registered provider had introduced a comprehensive set of policies and procedures for the service. The registered manager informed us that they would review and adapt the new policies to reflect the service. This had not been completed. Policies are an important guide to aid staff to follow current legislation and best practice and to ensure that staff have access to up to date information and guidance.

Through discussions it was clear that the registered provider and registered manager had a lack of understanding of the Health and Social Care Act 2008, the purpose of regulation and their responsibilities in line with this. The registered manager stated that they had not kept up to date with changes in care provision and that they had not thought about reaching out to external agencies for additional support. Evidence reported in the safe, effective, caring, responsive and well led domains of this report identify issues of continued non-compliance. The Registered provider has continued to fail to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that they attended team meetings 'every now and then' to discuss the service. They also stated that due to being a smaller staff team, the manager spoke with them on a day to day basis as required. In addition staff felt confident that they regularly shared important information regarding any changes to people's needs or practice with each other as required.

The service had informed the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

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 10 HSCA RA Regulations 2014 Dignity and respect People's rights to choice, privacy and dignity were not respected

The enforcement action we took:

We issued a Notice of Decision to cancel both the Registered Manager and Registered Provider at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider and registered manager failed to protect people from the risk of harm. Systems in place for the management of medicines were not safe.

The enforcement action we took:

We issued a Notice of Decision to cancel both the Registered Manager and Registered Provider at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective. Accurate and contemporaneous records were not held in respect of people supported and were not held securely at the service.

The enforcement action we took:

We issued a Notice of Decision to cancel both the Registered Manager and Registered Provider at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were placed at risk of harm and receiving unsafe care and treatment as there was

insufficient levels of staff to meet people's individual needs in a timely manner. Staff had not received appropriate support, training and professional development.

The enforcement action we took:

We issued an Urgent Notice of Decision to the registered provider to take immediate action to ensure suitable staffing levels were implemented at the service.