Mrs Bimla Purmah

Angel Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 August 2017 and was unannounced. A final day of inspection was completed on 11 September 2017 to see if the provider had taken the action they had outlined to us in order to protect the people living at the service. At the last inspection completed in March 2016 we found the provider was meeting all of the legal requirements. We identified some improvements were required under the key question of 'is the service effective?'. At this inspection we found these improvements had not been made and more significant improvements were now needed across the service.

Angel Court Residential Home provides accommodation and personal care for up to 30 people. At the time of the inspection there were 28 people living at the service, most of whom were older people living with dementia. There was a registered manager in post. The registered manager was the same individual as the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had failed to ensure people were sufficiently protected from the risk of harm to both their physical and emotional well-being. Safeguarding concerns were not always identified and investigated appropriately. People were exposed to the risk of harm such as injury due to inadequate risk management processes. People were not protected due to inadequately maintained premises and equipment.

People were not supported by sufficient numbers of care staff. People were not being supported by care staff who had the training, skills and knowledge to support them effectively. Pre-employment checks were completed for new care staff although some improvements could be made.

People received medicines such as tablets as prescribed by their doctor. We were not able to confirm people received their creams as needed due to the administration of these medicines not being recorded.

People's rights were not protected by the effective use of the Mental Capacity Act 2005. The risks associated with people's nutritional needs were not always monitored and effectively managed. People did have contact with healthcare professionals to maintain their health, however, this was not consistent and people sometimes did not receive interventions as required.

People were not supporting in a kind and caring way. Their dignity and independence was not protected and promoted. People were not supported to be actively involved in choices around their care.

People were not involved in developing their care plans and care provided did not always meet their needs and preferences. People were not enabled to access meaningful leisure opportunities and to choose how they wanted to spend their time.

People did not feel they were able to raise complaints. People did not feel their complaints were heard and addressed appropriately.

People were not protected by effective quality assurance systems that identified areas of improvement and ensured the required actions were taken. People were not sufficiently involved in the development of the service and discussing issues that affected them. People did not feel their views were heard.

People were being cared for by a staff team who felt unsupported in their roles. The culture within the service was not open and transparent.

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 provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The provider was not meeting the requirements of the law relating to person centred care, dignity and respect, consent, safe care and treatment, safeguarding people, nutrition, premises and equipment, complaints, staffing levels, staff training and the effective management and governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had failed to ensure people were sufficiently protected from the risk of harm to both their physical and emotional well-being. People were not protected due to inadequately maintained premises and equipment.

People were not supported by sufficient numbers of suitably trained and skilled care staff.

People received tablet medicines as prescribed. The administration of topical creams was not recorded.

Is the service effective?

Inadequate

The service was not effective.

People were not being supported by care staff who had the training, skills and knowledge to support them effectively.

People's rights were not protected by the effective use of the Mental Capacity Act 2005.

The risks associated with people's nutritional needs were not always monitored and effectively managed. People did not always receive medical intervention or support from healthcare professionals when needed.

Is the service caring?

Inadequate

The service was not caring.

People were not supporting in a kind and caring way. Their dignity and independence was not protected and promoted. People were not supported to be actively involved in choices around their care.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in developing their care plans and care provided did not always meet their needs and preferences. People were not enabled to access meaningful leisure opportunities and to choose how they wanted to spend their time.

People did not feel they were able to raise complaints. People did not feel their complaints were heard and addressed appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by effective quality assurance systems that identified areas of improvement and ensured the required actions were taken. People were not sufficiently involved in the development of the service and discussing issues that affected them.

People were being cared for by a staff team who felt unsupported in their roles.

The culture within the service was not open and transparent.

Angel Court 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 23 August 2017 and was unannounced. A final day of inspection was completed on 11 September 2017 to see if the provider had taken the action they had outlined to us in order to protect the people living at the service. The inspection team consisted of one inspector, a Specialist Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Specialist Advisor was a qualified nurse with experience working with older people and people living with dementia.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. They can advise us of areas of good practice and outline improvements needed within their service. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 12 people who used the service and two relatives. We spoke with the registered manager, the cook and nine care staff. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out further observations across the service regarding the quality of care people received. We reviewed records relating to 12 people's medicines, seven people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

People told us they did not always feel safe in their environment due to other people wandering into their bedrooms. One person told us, "I don't feel very safe at night, or sometimes in the day. I don't have a lock on my room. The other people walk in and sit in my chair or wander round my room. I find it quite frightening if I wake up in the night and someone's in here". Another person told us, "I don't like those others keep coming in my room but they [staff] say it's not safe for me to lock my door in case they need to get into me". A third person said, "There's some [people] on this floor in and out of my room all the time. They take my stuff". One of these people indicated a serious safeguarding concern had arisen as a result of people entering their room. We referred this to the local safeguarding authority for investigation following our inspection. We saw people entering the bedrooms of others during our inspection and care staff confirmed they were aware that people wandered, especially at night. They told us sometimes people could be guided out of bedrooms although at other times staff found this more challenging. We saw care staff recording in daily records instances of people wandering into people's bedrooms, however, the registered manager told us they were not aware of these concerns when asked.

While we found staff we spoke with were able to describe signs of potential abuse and how they would report concerns, we saw the concerns raised by people we spoke with and seen by care staff had not been identified as safeguarding concerns. For example, people being frightened by others entering their bedroom. We saw that other safeguarding concerns had been identified and referred to the local safeguarding authority. However, the provider did not have effective safeguarding processes in place to ensure that all incidents that had caused people distress and harm had been identified and managed appropriately. This had resulted in a failure to complete appropriate investigations and to ensure plans were put in place to protect people from further harm. On the final day of our inspection we found the provider had failed to take the required action to protect people. We found further incidents had arisen since our initial visit which had resulted in people being harmed or put at risk at harm. We reported these concerns to the local safeguarding authority for investigation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People told us they did not always feel they were protected from the risk of harm such as injury due to the availability of equipment such as their call bell and walking frame. One person said, "I worry about not being able to get to my buzzer there on the wall [pointed to side of bed] now I have to be in my room. I'm very wobbly and my hand is numb. It's not much good. I have a frame but can't get far on my own". Another person told us, "I have to be careful because I sometimes fall backwards and if I'm sitting here [pointed to chair] and I need someone, my box [call bell] is over there". The person indicated to their call bell at the other side of the room next to their bed. A third person told us, "One of the residents keeps taking my walker when I'm downstairs and they [staff] know I can't get around without it but they just say the other person can't help it and to stop moaning". People also told us the environment in the home didn't make them feel safe. A person said, "I've got my walker and I do try to get out to the loo but I'm a bit wary because it's at the top of the stairs. I don't like the commode". We saw two people trying to mobilise with their walking frames

without staff being present to provide support. These people were seen on four separate occasions to be trying to lift their frames down small flights of stairs in corridors increasing the risk of injury due to accidents such as falls.

People were not always being supported to move in a way that minimised the risk of injury to them. We saw one person being supported in a wheelchair without foot rests and their feet were dragging along the floor. We were required to intervene to alert the staff member to the risk of potential harm. The staff member failed to recognise they should have checked this prior to assisting the person and said to them, "Why aren't your footrests on [person's name]?". There was no risk assessment available to staff to advise how to mobilise this person safely in a wheelchair. We saw from records and information available to us prior to the inspection that this person had fallen and fractured their shoulder approximately two months prior to the inspection. Staff we spoke with told us they could no longer walk independently with a frame and now required support using a wheelchair. Multiple staff members told us they supported the person to stand by holding the person under their arms and lifting. This method of support increased the risk of injuries such as skin tears, dislocation or fracture; in particular due to the prior injury. Care staff we spoke with were not all aware of the prior fracture and how to support the person in a way that would minimise the risk of further injury. Care staff we spoke with also had differing views on the person's ability to bear weight in their legs while standing. We found the person had experienced a further fall from bed in the week prior to the inspection. No measures had been put in place since this time to reduce the risk of further occurrences. This person's risk assessment and care records had not been revised to reflect the steps staff needed to take to protect this person from harm. We also found over half of the care staff working in the service had not received training in how to safely support people to move. The remaining care staff had not received training since 2013. In response to our concerns raised the registered manager arranged for a moving and handling trainer to attend the service to provide training to staff at the end of the second day of our inspection.

We identified further concerns around the registered manager's ability to effectively assess and manage the risks to people living at the service. For example; care staff we spoke with were not aware of risks highlighted by the local authority for one person they were supporting. These risks included pressure areas and a history of falls. One member of staff told us, "I haven't read her care plan". We saw from information provided by the local authority that this person had a visual impairment and had been required to move to residential care due to the high number of falls they were experiencing. We saw this person was cared for in their room which was located at the top of an open set of stairs. They received minimal supervision as their room was located in an area of the service where there was no permanent presence of staff. There no risk assessments in place to advise staff how to mitigate the risk of the open stairs or how to safely support the person in a stair lift which was the person's only form of getting downstairs. The person was confused and unaware of their surroundings yet the only risk management strategy in place to reduce the risk of falls in risk assessments and shared with us by care staff was to ask the person to remember to use their call bell before trying to move. We asked care staff if they were aware of how to protect this person's pressure areas. They told us there were no red or broken areas of skin on the person. Some care staff also told us they were not aware of the systems they should use to monitor any concerns about skin and to prevent the deterioration of skin into pressure ulcers. Care staff later confirmed they had rechecked the person as we had noted the local authority's plan identified a pressure sore. Care staff found a red area with broken skin that had previously not been identified. The registered manager had not ensured that staff had sufficient training and skills to recognise concerns with people's skin integrity. The registered manager had failed to ensure that risks to this person were sufficiently identified and managed to prevent any potential harm.

We identified concerns with the environment within the service that compromised people's safety. We found that emergency plans to be used in the event of a fire were not robust. We received conflicting information

from the registered manager and risk assessments around whether people should be evacuated, remain in their rooms or be moved to two floors away from a fire if it arose. We found identified fire exits in one area within the building were locked. The registered manager told us specific staff members held keys to these doors, however, we identified these care staff were not always present which could pose a risk in the event of a fire. We found the integrity of an internal fire door next to the kitchen had been compromised due the door furniture used. This resulted in a hole being present in the door which would reduce the levels of protection served in the event of a fire. We notified the local fire officer of the concerns we identified during the inspection. We identified further environmental risks such as building work taking place without appropriate risk assessments or plans to mitigate the impact on people living at the service. We saw people walking into rooms that were being occupied by workmen due to the lack of signage and risk management processes. We saw corridors, bathrooms, bedrooms and landing areas cluttered with items such as equipment including wheelchairs, hoists, broken chairs, unpacked cardboard boxes and other items. This increased the risk of injuries to people such as trips and falls. We saw cleaning materials including items such as bleach stored in bathrooms next to toilets and on window ledges despite the registered manager's policies stating that these items should be locked away. We saw people who were confused and not aware of their surroundings wandering into bathrooms containing clutter and cleaning products with no staff present. This increased the risk of harm to these individuals.

During our final day of inspection we saw the provider had failed to take the required action to protect people. We saw building work remained ongoing and specific risk assessments were not in place to ensure people were kept safe. We found significant quantities of plaster dust being created and spreading into the kitchen and communal areas without the associated risks being managed. We also saw concerns relating to issues such as cleaning products had not been addressed and products remained left in some bathroom areas within the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

People told us care staff were not always available to provide them with support when they needed it. One person told us, "They [staff] are nice enough but I'd say there aren't enough of them. Not anymore. When I press my bell I sometimes have to wait a bit at night. I've had accidents, you know, wet myself waiting. That makes me upset". Another person told us, "I have had to wait sometimes for a long time after I pressed my buzzer…I worry about there being staff to come to me though, especially at night". A third person said, "I press my buzzer for the carers…if I'm near to it but they [staff] don't always come straight away… Sometimes I just wait for the staff to come along and then shout out". A further person said, "I wanted my hair washing… but the staff say they haven't got time. There just aren't enough of them. They are nice enough but they are run off their feet".

Staff also told us there were not enough staff available to support people. Some staff told us they felt an additional staff member was required during the afternoon, evenings and night. Staff told us issues with staffing were made worse by some staff not having the skills needed and high levels of staff sickness. During the inspection we saw two staff members were absent due to sickness and the registered manager had requested additional cover from another service they operated. People also confirmed there were high levels of staff sickness. One person said, "Half of them phone in sick…They're working with two to three staff and there should be four to five". The registered manager had not kept clear records of which staff had been absent so we were unable to view this information historically to confirm the levels of staff absence. The registered manager also confirmed they did not have any staffing tools or formal methods of assessing capacity in order to ensure they had sufficient numbers of staff available to support people. They told us they used feedback from staff to determine staffing levels.

We saw during the inspection that staff were not always available to provide support to people. For example, we saw staff struggling to provide sufficient support to people in the dining room at lunchtime while also supporting people who required support in their bedrooms with meals. One staff member was heard to say, "We can't do everyone down here and feed them upstairs at the same time". A person was heard saying at this time, "I think maybe they are short again today and serving the residents upstairs first". We saw people sitting in lounge and dining areas for extended periods of time without staff presence or interaction. We saw people waiting for their lunch for extended periods of time up to one hour. We saw people at risk due to the lack of staff available to support them. We saw one person trying to mobilise without their frame with no staff available to support. This person's care plan outlined they needed supervision by staff when they mobilised. We saw other people who lived at the service stepping in to provide support in the absence of staff members.

During our final day of inspection we found the provider had failed to address these concerns and staffing levels had not been increased since our first visits. We heard one person shouting downstairs for staff to assist him with getting up and dressed at 9.30am. They were saying they were sick of waiting and it would be time for them to go to bed again by the time they were up and dressed. Staffing levels were reviewed during this final day of inspection and as a result the provider increased staffing levels both during the day and the night by one member of staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

We found the registered manager had not ensured that premises and equipment were clean and suitably maintained. We identified extensive concerns with the cleanliness of the service during our inspection in addition to concerns with following recommended infection control guidelines. Multiple areas of the service were visibly unclean, soap and paper towels were not always available in toilets and some bins did not have closed lids. We saw kitchen areas were not appropriately clean and the cook was not able to evidence cleaning schedules had been completed for over a week prior to the inspection. We saw soiled flannels in a bath and the laundry area did not have clearly segregated areas for clean and dirty washing. The registered manager acknowledged there were issues with the cleanliness of the service and confirmed that appropriate cleaning schedules had not been in place.

We saw multiple areas of the service were in a poor state of repair. For example, we saw cracked and missing tiles in toilet and kitchen areas, a missing toilet seat and rusty handrails. We saw there had been a leak in the dining area resulting in a large area of exposed brick and plasterboard. We saw some decoration work was taking place in the service in the lounge area. The registered manager also arranged for work to begin on repairing the leak during the inspection. We asked the registered manager for a clear schedule of planned work with deadlines for completion, however, this had not been developed. The registered manager had identified some areas of work needed for the current calendar month but they had not extended this plan further and addressed all areas of concern within the service.

We found equipment had not been serviced to ensure it was safe as required by law. There were two bath hoists in operation within the service that had not been serviced. The registered manager informed us that they felt as they were manually operated they did not need to be serviced professionally. They told us that one bath hoist had come from another care home and had been fitted by their maintenance person; therefore they felt it was safe for use. We saw that only one of two available hoists had been serviced. The registered manager provided assurances that only one of these hoists were in operation. However, we saw that both hoists were stored together with no signage on the 'out of use' hoist to inform staff that it should not be used. We saw safety checks had not been completed on fire extinguishers and these had been due in

the month prior to the inspection. We also saw that the electrical safety certificates had expired in 2016. The registered manager provided information to confirm that some upgrade work was taking place with the electrics but not that the safety had been checked. The registered manager began to address some of these concerns during the inspection, however, they had not ensured the premises and equipment was suitable for use.

During the final day of our inspection we found the provider had failed to address the concerns identified. We found significant concerns with the cleanliness of the service remained. We found equipment remained unserviced. The provider arranged for an organisation to complete service checks of equipment during our final visit. This resulted in one bath hoist being deemed as unsafe for use. We saw work was underway to complete upgrades on the electrical system within the service. This needed to be completed before the electrics could be certified as safe.

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

We looked at how the registered manager ensured that people received their medicines as prescribed. We saw that medicines such as tablets were secured in a locked trolley. Some medicines such as creams and nutritional supplements were not always stored securely. We saw one cream in a communal toilet without a dispensing label in addition to nutritional supplements kept in an unlocked cabinet which could be accessed by people or relatives. We did see that care staff completed medicines administration charts for medicines such as tablets. These medicines appeared to be administered safely and as prescribed by the person's GP. We found care staff were aware of how to administer medicines with specific instructions. For example they knew that one person's medicines required them to remain seated upright for half an hour after taking their medicine prior to consuming any food or drink. We were unable to review whether people's creams had been administered and applied as needed by people and as prescribed due to a lack of records. Care staff confirmed that no records for the administration of topical creams had been maintained. The registered manager was not aware these records had not been kept.

We looked at how the registered manager ensured that staff were recruited safely to ensure they were appropriate to work with vulnerable people. We saw that a range of pre-employment checks were completed including identity, reference and Disclosure and Barring Service (DBS) checks. DBS checks enable the provider to review a staff member's potential criminal history to ensure they are suitable for employment. We did see that some improvements were needed in the completion of these checks. For example; the registered manager had not always ensured that gaps in employment history were checked, that the appropriate documentation was in place around staff member's right to work in the UK or that referees were appropriate and references in place before the staff member started work. The registered manager took steps during and following the inspection to resolve some of the issues identified.

Inadequate

Is the service effective?

Our findings

At the last inspection we identified concerns around the monitoring of weight loss and communication with healthcare professionals such as the dietician or doctor. At this inspection we found the required improvements had not been made.

People told us they liked the food that was available to them. One person said, "I have a full English in a morning. I like my bacon and eggs. The food is always hot and very tasty". Another person said, "It's lovely food. There's always a choice". We saw that two choices of meal were available to people at lunchtime although some improvements could be made to choices offered. For example; we saw juice was poured into cups in front of people at lunchtime without a choice or explanation being offered and gravy served on dinners without choice provided to people. We also saw one person leave their meal saying they had not asked for fish and did not want it. Their plate was seen to be removed and no alternative meal was offered. We found where people required special diets such as soft or pureed diets, staff were aware of these needs and appropriate meals were offered. However, consideration was not made to the presentation of food in order to enhance the person's dining experience. For example we saw a meal being pureed. All food items were mixed together in a blender rather than each food item being blended separately to enhance the presentation and taste of the meal.

We found care staff were not aware of which people had experienced weight loss. We asked care staff about two people who had lost weight according to their weight charts and they were not aware of these losses. We found all people living in the service were weighed routinely once a month. Where risks were identified, for example with people gaining or losing weight, people's weights were not always monitored more frequently to ensure the risks were monitored. We saw care staff were not always following instructions given by the dietician or doctor and advice was not always sought when needed. For example; we saw one person had been on a nutritional plan to help them increase weight. The person had successfully gained weight and their target weight had been achieved in December 2016. The person had continued to gain a further 9.3kg over their target weight, however, the registered manager had failed to seek advice from their doctor regarding adjusting their nutritional plan until the LA intervened and identified this weight gain in July 2017. We identified a further person who had a very low BMI which increased the risk of harm to their health. Care staff had sought advice from a dietician and a plan was in place to assist the person in gaining weight. However, we found these instructions were not always being followed and the registered manager had failed to identify this and take steps to protect the person. Care staff told us it was difficult to get the person to eat and we saw from food charts the person was not always eating their meals. Care staff had not followed instructions from the dietician to ensure the person was given a milky drink and biscuits when they did not eat as required. The person was also refusing some of their nutritional supplements and the recommended steps outlined by the dietician had not been followed. The registered manager weighed the person during the inspection and confirmed they had not lost any further weight. However, the risks to this person had not been appropriately monitored and managed. The registered manager told us they had not felt they needed to increase the monitoring of this person's weight as their low weight was due to refusal to eat rather than due to a medical condition.

During our final day of inspection we found the provider had failed to take sufficient action to address these concerns. We found the provider had continued to fail to ensure that sufficient action was taken to protect people at risk of malnutrition. We saw they continue to fail to take appropriate action regarding the concerns around one person's food and drink intake outlined above. We notified the local safeguarding authority of individuals that were identified as being at risk of malnutrition to ensure appropriate action was being taken to safeguard these people from the risk of harm.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs

People were not always supported by care staff with the appropriate skills and knowledge to support them effectively. Care staff told us told us there was a need for further staff training. One staff member said, "Staff need training more than anything". Staff told us that most of their training had been done through workbooks. They felt this training did not give them the skills needed and they lacked practical, hands on training. Some staff were unable to recall the last training they had received. We found care staff were not supporting people safely and effectively in numerous areas and found training in these areas had not been sufficient. For example; we saw people moved in a way that increased the risk of injury to them. We found over half of the care staff had not received moving and handling training and the remaining staff had not received training in four years. We found care staff did not always have the skills to work effectively with people with dementia. We saw that communication around choices needed improvement in addition to managing distressed behaviours. We found despite 16 people being diagnosed with dementia, eight staff had not received training in this area since 2013 with some staff not having had received training at all. We found concerns around recognising and reporting some safeguarding incidents and 10 staff had not received training since 2013. We found care staff had not received training in areas such as catheter care and pressure areas despite people living at the service requiring support in these areas. The registered manager was not able to demonstrate that she had checked the competency of care staff to ensure they were being equipped with the skills needed and were applying these in their roles.

While some staff told us they were supported in their roles and received regular one to one meetings with their line manager, most told us they did not receive the support they needed. Some care staff told us they did have supervision meetings but they did not find them to be supportive or helpful. They did not feel their personal development was discussed and said supervisions were used to give them information and to talk about things such as uniform. We did see that new staff were required to undergo an induction which consisted of shadowing the work of existing care staff. However, as the existing care staff team had not always been equipped with the skills needed we could not be certain that shadowing would give the new staff the knowledge they required to support people effectively. The registered manager had not yet ensured their induction processes were in line with the Care Certificate. Therefore they were not able to demonstrate that staff skills and competency was being assessed in line with recommended national standards. The Care Certificate is a national standard that outlines the basic skills and knowledge required by staff working in health and social care.

During our final day of inspection we found the provider had begun to ensure training was delivered to care staff within the service. It was not yet clear how the provider would ensure training was effective and embedded in staff practice although we could see some work had begun.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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.

Care staff were not always able to describe the basic principles of the MCA. Not all care staff were aware of the two stage test or knew how to make decisions in people's best interests in line with the Act. Care staff had a mixed understanding re different people's capacity to make certain decisions. Some care staff felt certain people had capacity to make decisions whereas others did not. We found that decisions were being made on behalf of people who staff or relatives had confirmed they felt did not have capacity. For example; around people's food and drink, the restriction of people's movements, the use of sensor mats, shared bedrooms and the use of CCTV. These decisions were being made without the steps required by the MCA having been followed; for example testing their capacity and making appropriate best interests decisions. We found that no capacity tests or best interests decisions were being recorded in people's care plans. We also found that 10 staff had not received any training in the MCA since 2013. The poor understanding of staff and management around the MCA meant that some risks to people had not been sufficiently considered and mitigated. For example; staff had not recognised that one person's confusion and disorientation may reduce their ability to remember instructions such as the requirement to call for staff before they attempted to mobilise. We also saw where one person had refused nutritional supplements and was deemed to lack capacity to understand the risks to themselves, no action had been taken in line with the MCA.

We saw one person with dementia had completed a form five years ago stating they were vegetarian. Different care staff within the service had differing views around whether this person remained a vegetarian or whether they now ate meat. Some staff told us the person was given meat and others told us they felt she still wanted to follow a vegetarian diet. The registered manager confirmed the person was now eating meat, however, they had not considered this person had dementia and reduced capacity. They had not considered this person's needs in line with the MCA and made a decision on their behalf in line with the requirements of the Act.

During the final day of inspection we found the provider had failed to demonstrate an understanding of the requirements of the Mental Capacity Act 2005. We saw a capacity assessment that had been completed. However, this was not relating to specific decision and was not in line with the requirements of the Act. We also found the provider had accepted documentation relating to a person's power of attorney. This power of attorney was making decisions about the person's health and welfare. However, the document authorised the representative to make decisions about the person's financial affairs and not their health and welfare. This demonstrated that people's rights continued not to be upheld in line with the Act.

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

We saw the registered manager had made applications to the local authority to deprive people of their liberty in order to protect their safety and well-being by law. Some of these applications had been approved although staff were not aware of who had an authorised DoLS in place. One staff member said, "I'm not 100% sure on the DoLS". Staff gave us names of people who they felt had a DoLS in place, however, this differed between staff members and was not consistent with the information provided by the registered

manager. We found staff and management did not have a clear understanding of people's capacity and DoLS. For example; the registered manager told us one person had capacity as their DoLS application had been rejected by the local authority. They did not understand that this person may lack capacity to make certain decisions and may require support under the MCA despite the application to deprive them of liberty being declined. Another staff member told us they did not think they could consider measures to prevent someone from falling from bed such as bed rails without a DoLS being in place. Due to the poor application of the MCA and staff knowledge we could not be certain that all required applications to deprive people of their liberty had been submitted in line with the law.

One person told us care staff ensured they were able to see a doctor immediately when needed. They told us, "They're [care staff] on the phone straight away". However, two people told us they had not seen a doctor when they were unwell and others were not able to recall when they had last seen their doctor. While care records indicated people were able to see their doctor regularly we identified situations in which the doctor was not consulted as appropriate. For example, one person had been discharged from hospital in the days leading up the inspection. This person was displaying behaviours during the inspection that staff described were out of character; such as mobilising unaided, displaying distressed behaviours and not eating as normal. Care staff were not aware of the issues seen by other staff due to poor communication systems and therefore an overall picture of the concerns about this person had not been identified until raised by the inspection team. Care staff had not considered whether this person may need to be assessed by a healthcare professional or whether there was a link to the concerns relating to their recent hospital admission. A senior member of care staff advised they would address these concerns immediately. We found contact with some healthcare professionals was conducted regularly, such as the chiropodist. However, we found only two people had seen a dentist since 2015. The registered manager advised they were in the process of registering people with a new dental surgery.

Inadequate

Is the service caring?

Our findings

Most people told us their autonomy and independence was not promoted within the service. One person told us, "In this place, you ask about things and you are told what to do. There's no debate it's 'the rules'". People told us they did not get a choice around whether they spent time in their own room or within the lounge areas. One person told us, "When it suited them, they said I couldn't stay up here because there weren't enough people to keep an eye on me up here but now it suits them for me to be up here. But I never see anyone really other than meal at times". Another person told us, "They [staff] don't really like you in your room during the day. They prefer you to be downstairs where they can keep an eye on you". We saw a person seeking consent from the registered manager to take a visitor to their room. We heard the registered manager responding, "Yes but come back downstairs when [visitor's name] goes". This demonstrated that people were not given independence and autonomy around when they spent time in their own rooms. We saw one person walk out of the lounge to go upstairs. A staff member stopped the person from going upstairs and directed them back to their seat. The staff member told us the person was normally able to go upstairs without supervision however they felt they were unwell that day and make trip or fall. We spoke to registered manager who advised that the person was in fact restricted from going upstairs without supervision. They told us this directive had been given by a representative. The person's care plan and risk assessment contained no information about why it was in the person's best interests to restrict them in this way and no evidence was held of the representative's legal authority to make this decision. The person's care plan outlined they were able to mobilise freely although staff were to supervise and bring them back to the lounge if they went upstairs. People gave us further examples of where their independence was restricted. One person told us they were not able to wash independently as they were not left with a towel. They told us, "The boss says it's the carer's job to wash me so the staff aren't allowed to leave me a towel. Sometimes I'm awake quite early…but I have to wait for a wash and a shave because I've got no towel". We saw there were no towels available in this person's room.

While care staff could describe ways in which they would protect people's dignity during care; such as by shutting doors, knocking before entering rooms and ensuring consent was sought before providing support, we saw this was not always carried out in practice. For example; we saw staff including the registered manager entering people's bedrooms without knocking and seeking consent. We saw an example of a member of staff enter the dining room, reach over a person's shoulder and from behind dip their fork into food and feed the person. This resulted in the person being startled and pushing the food away. We saw multiple examples of people's dignity being compromised during the inspection. For example; we saw one person sitting in the lounge area with their trousers down for a period of two and a half hours. During this time the inspection team had intervened twice to raise their concerns about the person's dignity and staff had failed to act. At certain points the person had lifted their top and exposed their genitals. Other people and staff were moving freely in and out of the area in which the person was sitting during this time. Some care staff told us the person needed care staff to assist them to stand although we later confirmed the person had no issues with their mobility. Other care staff said a male member of staff was required. We saw a male member of staff asking the person to stand so they could assist with their trousers. When the person refused to stand, care staff made the person a cup of tea but still failed to protect his dignity. We saw a senior member of care staff finally put a blanket over the person's lap. We also saw a person walking into the

lounge with their dress unbuttoned, wearing no bra, resulting in the person exposing their chest to seven other people who were present. We saw that for a period of 15 minutes staff including the registered manager had entered the lounge and all failed to assist the person and protect their dignity.

Where people demonstrated distressed behaviours care staff did not recognise when they were responding in an uncaring way. We saw one person being treated in an undignified and disrespectful way when they became distressed looking for a 'handbag'. We saw care staff using language and a dismissive approach which was not respectful and further agitated the person. For example, "[Person's name] what are you doing? Sit up to the table, your dinner will be here in a minute. You're going to fall" and "I don't know what you're going on about. You don't have a handbag. You've never had one. What's the matter with you today?". People were not treated in a respectful way that promoted their dignity and independence within the service.

During the final day of our inspection we found people's independence and dignity remained compromised in certain aspects of their care. For example; we saw people were not able to move freely around the service during building work and had not been consulted about how they wanted to spend their time while this work was completed. We also saw an example of one person using a dirty toilet due to the poor cleanliness of the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

People gave us mixed views around the caring nature of the support they received from staff. One person told us, "Some [care staff] aren't very nice in the night if you ring them, a bit sharp you know in the night. The [care staff] in the day are quite gentle but very busy all the time. I like a chat but there's no time". Another person however said, "The [care staff] are lovely with me. I like them. While we observed some caring interactions between staff and people, this was not seen to be consistent. We found care staff had good intentions towards people but had not been given the skills and knowledge by the registered manager to recognise when care delivered was not kind and caring. Some staff were not able to articulate how they would support people in a caring way. Where care staff were able to describe how they made people feel valued and important we found they were only able to describe how to meet people's basic needs. For example, a staff member said, "We speak friendly with them" and told us they would make sure people are washed and dressed.

We saw people were visibly distressed and were not always treated in a kind and caring way during maintenance work. For example; we saw two people try to enter a room being decorated and were told, "You can't come in here, go on, we are working in here. Go on, get out". We also saw a maintenance person taking ladders into the lounge area that was in use and moving chairs around in order to fix some curtains. The registered manager did not ensure that people were informed of what was happened or addressed as the maintenance person entered the room. One person was seen to put their head into their hands as the noise created by the ladders and moving chairs upset them. The registered manager had not ensured people were not impacted by the presence of maintenance people within the service.

We saw people were not always supported to make choices about their day to day care in a positive way. For example; we saw people were offered choices around their meals from a list with no assistance from pictures or other forms of communication. A member of staff told us, "We ask them and if they can't speak or choose we either give them soft or we choose for them". Staff we spoke with did not have an understanding of how conditions such as dementia would impact on someone's ability to make choices in this way. One person living at the service told us, "I can never remember what I've ordered so it's always a bit of a

surprise". We saw further examples of where care staff failed to offer choices to people. For example, where they sat or how they spent their time. One person described to us they were not able to make choices around where they sat in their bedroom. They told us, "If I get back into bed, which I like to do to have a rest, and they catch me they say I have to get out and stay in my chair because it's better for me". People were not enabled to be actively involved in the choices around their care and how they spent their time.

Inadequate

Is the service responsive?

Our findings

People told us they did not always feel able to make a complaint about the service or the care they received. One person told us, "My [relative] wanted to [complain] but I don't want to make too much fuss in case it makes things worse". Another person said, "I did complain to the [care staff] but nothing came of it". Other people told us they were concerned they would be made to move from the service if they made a 'fuss' or raised a complaint. People told us about concerns they'd raised in a number of areas such as people going into their rooms and wanting locks on their doors. They all told us they did not feel their concerns had been responded to and were not sure of how to raise a formal complaint other than by raising concerns with care staff. People were not aware of the provider's complaints policy. We looked at the complaints record held by the registered manager and found only one complaint was recorded. The record stated that an explanation had been offered to the complainant but did not outline any improvements made as a result of the concerns raised. The registered manager told us they were unaware of any other concerns held by people. This demonstrated the registered manager had not developed effective systems to ensure people's complaints were heard and responded to appropriately.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 Receiving and acting on complaints

People told us they had not met with anyone to agree how they wanted to be cared for. One person told us, "I just came here in an ambulance, was shown my room and that was that. I don't have a folder or anything about the place". Another person told us, "I didn't have a meeting or anything about my care". The registered manager and care staff told us that people were involved in the development of their care plans. However, this was not reflected in what people told us and there was no evidence in care plans of people's involvement in decision making. We found the registered manager was not ensuring that care delivered met people's preferences. For example, care staff told us the policy for personal care within the service was that everyone had a full body wash each day. They told us a deputy manager held a 'bath rota' and this determined when people could have a bath. Staff told us, "We try to get so many baths done a week. We go on the dates they last had one. We look at the personal care record to see who has gone the longest without one. We try to get them done once a week". They did advise that people were asked if they wanted to have a bath or shower. We identified one person had moved from another service and had previously enjoyed showers both at home and within the prior service on a regular basis. Since arriving at the service in the prior week they had only received a full body wash. The registered manager advised this person did not like showers. However we confirmed in the person's care records from the prior service and from speaking with their relative that this was not the case. We also identified a feedback survey that indicated people would like more frequent baths. We discussed our concerns with the registered manager who acknowledged that they would review people's preferences around how they received their personal care.

We identified further examples of where people's needs were not always identified and met both in terms of their care needs and environment. We saw in one person's local authority plan that they were aiming to build their walking ability to four metres a day. This was not known to the registered manager or care staff when asked and had not been included as part of their care plan within the service. Another person told us

they were not happy with the environment in their room. They told us, "I've got none of my stuff [from my prior home]. None of this in here is my stuff and there are boxes everywhere. It's a mess. I have complained to [the registered manager]". We found communication systems and handovers were not always effective in ensuring concerns about people were shared with the next staff team. For example; we found concerns about one person acting out of character and not eating well had not been shared at handover.

People's needs were also not met with regards to the leisure opportunities available to them or how they liked to spend their time. One person told us, "There's nothing to do here other than sleep or watch the telly. One of the old carers used to get me a paper. I like a paper. But she's gone now". Another person told us, "You just sit here all day…Imagine sitting here 24 hours staring at that [object]". A third person said, "I like to be active. It's hard in here, can't even go into the garden on my own'". A fourth told us, "I prefer being up here in my room and when they said I couldn't go downstairs now because there wasn't room because they were doing the other lounge out I thought, thank goodness. I never liked having to go down there". A fifth said, "I don't always like what they have on TV [in the lounge] and there's nothing to do anyway". Some staff told us they didn't feel there was always sufficient activities for people to do. One staff member told us, "We need an activity coordinator". They also said, "[Care staff have] put the films on for them today as we're so busy". While we did see care staff at intervals making attempts to engage with people by discussing a book or painting their nails. However, for most of the inspection we saw people sitting without interaction or activity appearing to be disengaged, staring into space, closing their eyes or playing with their clothing. We saw care staff assuming people were watching TV however we saw very few people were actually watching the TV when it was on. We saw two conflicting activities timetables were advertised within the service but none of the activities on either schedule took place. The registered manager told us they recognised the need to enhance the leisure opportunities available to people. They told us a new apprentice who was currently completing shadow shifts within the service was to be trained as an activities coordinator.

During the final day of our inspection we found improvements had not been made in this area. We saw people continued to sit in lounge areas for extended periods without staff interaction. One person told us, "There's nothing to do. You just sit here all day". We saw people remained in receipt of care they were not actively involved in making decisions about and their preferences were not sought and upheld wherever possible.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care

Inadequate

Is the service well-led?

Our findings

The registered manager had not developed effective systems to ensure people felt heard. They had not ensured people were involved in actively sharing their feedback about the service and contributing to the development of the service. People told us they did not feel their views were sought, heard and acted upon. People did tell us there were meetings held in the service although they told us they were not always effective. One person said, "We had to go to a meeting downstairs the other week. It was something to do with food but I couldn't hear what they were talking about because two residents were shouting at each other and [the registered manager] was shouting at them and saying, 'shut up [person's name] and you too [person's name]' you know, so how can you hear over that". We were told by the registered manager that they planned to stop cooking hot meals 'in house' and were bringing in an external catering company. They told us a meeting had been held in the week's prior to the inspection to inform people of this change and to show them a brochure. While the registered manager told us people had been involved in this decision, this was not reflected in what people told us and the recorded minutes of the recent meeting. A further person had said, "I've heard they are changing the menu but I don't know what's on the new one". We saw feedback surveys received indicated improvements were needed in the environment of the service, activities and frequency of bathing. However, insufficient action had been taken to address these issues and we identified further concerns in all of these areas during our inspection. Following the inspection the provider gave us a written letter from one relative outlining they had been involved in a meeting where they had been fully consulted about building work, proposed changes to activities and meals within the service.

The registered manager had not developed effective auditing and governance systems within the service. We found auditing systems were either not in place or were not effective at identifying areas of improvement required within the service. We found the registered manager had not identified that there were extensive gaps in the skills and knowledge and care staff. They were aware that training needed to be improved although insufficient action had been taken to ensure training was provided as required. Audits and systems did not identify that care being delivered did not always meet people's needs, nor did they identify that people were at risk of harm. For example; due to safeguarding concerns and instructions from healthcare professionals not been followed as instructed. Monitoring systems did not identify where people were at risk and ensure that care staff were aware of these risks and how people needed to be protected from harm.

Where audits had identified actions required, sufficient action had not been taken to make the required improvements. While there were no internal medicines audits completed within the service, an audit was completed by the local pharmacy in the month prior to the inspection; however, the identified actions had not yet been implemented. We found audits had identified fire extinguishers needed to be serviced, however, action was not taken by the registered manager to ensure these safety checks were completed until we highlighted this concern during the inspection. We saw the deputy manager of another service owned by the provider had identified extensive work needed to be done to the environment in the service in April 2017. While some work had commenced on decorating areas of the service, insufficient action had been taken to ensure the issues identified had been addressed. We found there was not a clear maintenance plan available that outlined when the identified issues would be addressed. Nor were there risk assessments for work carried out or plans to reduce the impact of any improvement works on people living at the service.

Systems to ensure cleaning was effective and infection control processes were in place were not present. The registered manager told us that a deputy manager was the nominated infection control lead although staff were not aware of this. The registered manager had failed to ensure daily cleaning schedules were in place and completed despite there being significant issues with the cleanliness of the service. The registered manager provided assurances that checks including mattress audits were completed although the most recent audits available were dated from January 2016. During our final inspection visit we found the provider had completed further auditing of mattresses. However, they were not able to evidence they had taken action to correct issues identified.

We found further issues with the registered manager's recording systems. For example; where people had a Power of Attorney appointed, the provider had not ensured they held a copy of the required documentation. Where some people had DoLS applications, we found authorisations had expired prior to new applications having been submitted. We also found issues with the recording of some recruitment checks that were completed, including holding evidence of staff member's right to work within the UK.

The registered manager had not ensured that their own policies were embedded and carried out in practice. For example; their recruitment policy stated that a job offer should not be made without a DBS and two references having been obtained; this includes the last employer and a discussion with the employer. This had not been consistently followed. We also found their MCA policy outlined templates and guidance around MCA capacity tests and best interest decision making. This had not been followed. We saw risk assessments were in place around the use of wheelchairs that stated footplates should always be in use and staff should have up to date training in moving and handling. We found footplates were not always used and staff did not have up to date moving and handling training. This exposed people to the increased risk of harm.

The registered manager was also not aware of their legal responsibilities. We found they had been operating CCTV within the service without the required legal steps having been followed. The registered manager confirmed they had read guidance on the CQC website regarding the use of CCTV. However, we found they had failed to take action in line with this guidance to ensure their legal obligations were met. We found where people had suffered serious injury such as a fracture; they had not reported these accidents to the Health and Safety Executive under RIDDOR as required by law. While the provider understood their responsibilities to notified CQC of significant events, we found they had not developed systems to ensure all incidents were captured and notified due to poor reporting and recording systems.

During the final day of our inspection we saw the provider had failed to ensure sufficient action had been taken to develop and enhance systems within the service to ensure people were protected from the risk of harm. We saw that some audits had been completed but it was not clear what the resulting actions were and if these actions were being completed. We saw the provider continued to fail to identify the areas of improvement required within the service and to take the required action to ensure people living at the service were sufficiently protected.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

We found the provider had failed to notify the commission of certain safeguarding incidents that were arising within the service. We found incidents were occurring when people were either harming or attempting to harm other service users within the service. These incidents had not been recognised by the provider and CQC had not been informed as required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

Some care staff told us they felt the management of the service was good. One staff member said, "Management is supportive". However, most staff told us they did not feel the service was well managed and they did not feel supported. Care staff told us they were worried about sharing their concerns with us for fear of repercussions and potentially losing their jobs. One staff member said, "I'm too scared to say". Some staff told us they felt the deputies were effective but were not supported by the registered manager. Other care staff felt the registered manager needed to ensure the management team as a whole were more effective. Most staff told us they felt unsupported and unheard by the management team. One staff member said, "We say a lot of things [that need improving] but it don't happen". They also said, "We do too much work for too little appreciation". We found the culture within the service was not open and transparent. We found the registered manager had failed to take responsibility for the failings within the service as both the provider and manager. As a result the quality of care being delivered to people was compromised and people were exposed to the risk of harm to their physical and emotional wellbeing.