Kings Cottage Residential Home Limited

Kings Cottage Residential Home

Inspection report

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Date of inspection visit:
27 January 2016
28 January 2016
03 February 2016

Date of publication:
19 August 2016

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

We inspected this service on 27, 28 January and 3 February 2016. The last full inspection of this service was in July 2013 when the service was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In March 2014 we carried out a follow up inspection to check that improvements had been made in respect of this regulation and we found that they had.

Kings Cottage Residential Home is a care home which provides accommodation and personal care and support for up to 26 older people, some of whom have dementia. There were 20 people living at the home on the first day of our inspection. The building was split over two floors and people with varying needs lived on each floor.

A registered manager was in post who had been registered with the Care Quality Commission (CQC) since October 2010. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 registered manager and provider were present at the service throughout our inspection and assisted us with our enquiries.

Staffing levels were low within the service and in order to cover vacant posts the provider and manager were working a variety of roles. No agency staff were being used at the start of our inspection but the provider made arrangements for this support on the last day that we visited so that both the manager and provider could dedicate more time to managing and governing the service. Vacancies existed in key roles across the service. Staff told us they were very tired.

Although staff had received training in key areas they reported that it was not always of a good standard and training could be better. We found staff did not always apply what they had learned. Staff competencies were not checked to ensure that the care delivered was appropriate and safe, and staff received appropriate support.

There was evidence that vulnerable adults were not always protected from unsafe or inappropriate treatment. For example, people were moved and handled unsafely and inappropriately and external specialist input into their care had not been sought by the provider or manager.

Medicines were not appropriately managed particularly those medicines that were prescribed to be administered 'as and when required' (PRN medicines). People did not have medication care plans in place, including plans for PRN medicines, to inform staff about how people needed their medicines to be administered and any personal preferences that they may have had. Recording around the application of topical medicines such as creams and ointments was not robust.

The manager and provider did not recognise or respond to risk. No actions had been taken for example to

mitigate against the risks of, for example, people falling or receiving inappropriate moving and handling. One person presented as unwell during our inspection but this had not been identified and acted upon. People living with dementia had not been supported with their behaviours and there was little information in care plans for staff about how to provide effective care to meet such needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. Other than for one person, applications had not been made to the relevant authorising body to assess whether certain individuals qualified to be lawfully deprived of their liberty. There was a lack of documented evidence to demonstrate that care and treatment was delivered in line with the MCA where necessary. This meant we could not be sure that people's rights to make particular decisions had not been protected, and that decisions made on their behalf had been taken in line with the 'best interest' framework of the MCA.

Staff displayed caring attitudes but they delivered care in line with routines that were institutionalised and not caring or respectful. People's human rights were removed and they were controlled in terms of their activities of daily living, especially those people living with dementia. There was a lack of choice in the service and activities were minimal. Care was not person-centred and there was little evidence of people's involvement in their care, especially those people with dementia care needs.

The culture within the home was one of routine and controlling practices. Staff reported that they did not have a voice and they had concerns about people's care. Throughout our inspection we identified concerns relating to a lack of oversight and management. Auditing and other elements of quality assurance that were carried out within the service to assess and monitor the quality of the care and services delivered were limited. The multiple issues we identified at this inspection had not been identified through the providers own quality assurance systems and there was no evidence that monitoring of the service had been on-going since September 2015. We discovered serious shortfalls in the maintenance of records and some people did not have care plans and risk assessments in place to guide staff about how to deliver safe and effective care.

We identified 11 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. We also found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 relating to the notification of other incidents. We are dealing with this breach outside of the inspection process.

Due to the serious shortfalls in all aspects of the service, we wrote to the provider to request an urgent action plan which stated what actions they would immediately take to improve. We visited the service again on 3 February 2016 and found that sufficient improvements had been made to ensure people's immediate health, safety and wellbeing at that time. We will continue to monitor the provider's progress against their action plan and will revisit the service to ensure that people's health, safety and wellbeing is protected and promoted.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures are 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 and 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.

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 suitably qualified and experienced staff employed and deployed to meet people's needs.

Safeguarding incidents had occurred in the home which had not been dealt with appropriately. Staff had not reported inappropriate moving and handling and other concerns.

Medicines management was not robust and people's needs were not always met.

The manager did not appropriately assess risks to people's health and welfare, in respect of their care and the environment in which they lived.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported to develop the skills, knowledge and experience to provide care to meet the needs of the people who used the service.

The requirements of the Mental Capacity Act 2005 were not met.

People did not receive a varied diet and where people had steadily lost weight no action was taken to mitigate the risks of them becoming malnourished.

Referrals to health and social care professionals were not always carried out in a timely manner to ensure people's needs were met.

Is the service caring?

Inadequate

The service was not always caring.

The staff team displayed caring attitudes towards people, but people were not always respected and their dignity was not always promoted. People did not have freedom of movement

and choices were made for them without their involvement.

There was little evidence that people and their representatives were involved in the planning of their care.

People's independence was restricted due to institutionalised practices.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care that was responsive to their needs.

Records were poor and important information about people's care did not get passed to staff by management. When staff shifts changed the transfer of information relied on staff remembering details.

People's care records were out of date and had not been reviewed for several months.

There was little evidence that the provider proactively sought feedback from people and their representatives.

Is the service well-led?

Inadequate

The service was not well led.

A culture of control, restriction and routine existed within the service.

There was a lack of management oversight of care delivery and other aspects of the service and a lack of direction and guidance for staff. The manager and provider were working shifts in order to cover gaps in staffing and not managing or governing the service and care delivery.

Basic and limited audits had been carried by the provider and manager, but these were not detailed and did not highlight the failings that we identified at this inspection.

There were serious shortfalls in the maintenance of records relating to people and the management of the service.

The provider had not always submitted notifications to us in line with their responsibilities and legal requirements.

Kings Cottage 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.

We visited the home on 27, 28 January and 3 February 2016. All visits were unannounced except the one on 28 January 2016. The inspection team consisted of three inspectors.

Prior to our inspection the provider submitted a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service, how it is meeting the five domain areas of safe, effective, caring, responsive and well-led and what future improvements they plan to make to the service. We checked our systems and reviewed notifications that the provider had sent us over the twelve months prior to our inspection. We contacted Northumberland safeguarding adult's team, Northumberland contracts team and Northumberland Clinical Commissioning Group (CCG) to gather feedback about the service. We used all of the information that we gathered to inform the planning of our inspection.

We spoke with the provider, the manager of the service, eight care workers and three relatives who were visiting the home. We looked at 19 people's care records plus a range of records related to the operation of the service including staff recruitment and training files.

During our inspection we spoke with a visiting healthcare professional and we liaised with Northumberland safeguarding and Northumberland contracts/commissioning team to share our findings and concerns. We referred ten people to Northumberland safeguarding adults team during our inspection as we identified concerns about their health and well being, due to the care and treatment they received.

Inadequate

Is the service safe?

Our findings

At our inspection we found serious failings in respect of the care and treatment that people received and concluded that people were not safe.

Staff told us and records showed that they had received training in safeguarding people from abuse and they demonstrated knowledge of the different types of abuse that people could be exposed to. However, they had not used this knowledge to safeguard vulnerable people in practice. We observed that people who could not weight bear were moved and handled inappropriately. Staff told us they were instructed to move people in this way without using equipment. Staff had not applied what they had been taught in relation to safeguarding, as they had not reported their concerns regarding people's safety and treatment to the local authority safeguarding team. This meant people were not protected from harm or abuse.

Records related to safeguarding incidents were very limited, just being a small entry in a notebook. For example, one entry was only one sentence in length and did not give the full details of the incident when we clarified this with the manager.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safeguarding people from abuse and improper treatment.

Northumberland local authority placed the service into 'organisational' safeguarding during our inspection. This meant they were monitoring the whole home since there were concerns that vulnerable people were at risk. CQC has continued to monitor the actions the provider has taken to keep people safe since our inspection. Prior to the publication of this report, the service was removed from 'organisational' safeguarding by Northumberland local authority Safeguarding Adults team.

Risks that people were exposed to in their daily lives had not always been assessed, managed and mitigated against. For example, one person was at risk of having seizures but there was no care plan or risk assessment in place around the management of this. We observed the manager partake in an inappropriate moving and handling procedure where a person was moved from their wheelchair to a chair without any equipment being used.

Several people were at high risk of falling but the manager had not sought advice from external healthcare professionals and no falls prevention equipment was in use to minimise the risks of serious injury. Additionally, one person presented as unwell during our inspection and was having breathing difficulties. This had not been recognised by the manager and no medical intervention had been sought. When we raised this with the provider and manager, a doctor was called and the person received medical attention.

Accidents and incidents that occurred within the home were monitored but proactive action was not taken where people were, for example, regularly falling. Records showed that people were told by management to wait for a care worker to support them before they mobilised, but there was no evidence that external specialist input into their care had been sought to reduce the risk of them falling. The manager confirmed

that she had not done this.

Some people had behavioural needs and the risks associated with their behaviours had not been appropriately assessed and mitigated against. For example, records showed that one person displayed physical aggression towards staff. Staff told us they were not trained to support the person appropriately. We saw there was a behavioural care plan in place but the content of this was minimal and there was no linked risk assessment to provide information on how to support the person with their behaviours.

Safety checks were carried out within the home, but not all environmental risks had been assessed. For example, there was no legionella risk assessment to help reduce the risk of Legionnaires disease developing in the water systems within the home. In addition, we found a number of window restrictors on the first floor of the home did not meet standards set in the Health and Safety Executive publication entitled 'Health and Safety in care homes'. There was a risk that people may be able to easily override the window restrictors and then fall from height and sustain a serious injury.

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

There was also no security or control on the entry of visitors to the home as the main door was unlocked. We observed visitors entered the premises freely throughout the day and at times there were no staff or people present. This meant visitors could enter the home undetected. Staff told us the door was locked in the evening and at night; when we visited the home early one morning, we found this to be the case.

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

People's medicines were not managed appropriately. We identified concerns relating to the administration of medicines prescribed to be given 'as and when required' (PRN medicines).

Very few people had medication care plans in place for staff to refer to which meant there was no information available about how people needed their medicines to be administered and any personal preferences met. In addition, the application of topical medicines such as creams and ointments was not robust. We saw that one person who required creams to be applied to maintain their skin integrity did not have a medication care plan, risk assessment, body map or topical medicines administration record in place to instruct staff about the person's needs, where to apply their creams, and how often. The provider had not ensured that people's medication needs were met.

We reviewed eight people's Medicine Administration Record sheets (MARs) and identified concerns that they were not being offered and receiving PRN medicines as they should. In three cases records indicated that people had not received pain relief medication for over four weeks; with no evidence that they had been offered this and declined. In two other cases people received PRN medicine in the morning and evening, but there was no record that this had been offered to them throughout the day, despite them being prescribed medicine to be taken if needed at more regular intervals.

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

The manager told us that there had been staffing shortages in recent months and that both she and the provider had been working care shifts regularly to cover gaps in staffing. Staff told us that they were working

14 hour shifts back to back, three or four days in a row and this was "exhausting". We saw there were enough staff on duty on each of the days that we inspected to meet people's needs, but these numbers included the manager and provider.

There were a number of permanent staff vacancies in key areas; the manager explained that recruitment had been slow, although vacancies were currently being recruited to. There was a high dependency on both the manager and provider covering gaps in staffing rather than sourcing agency staff to cover these shortfalls and as a result they were pulled away from governing and managing the service. The manager told us that agency staff had not been sourced because she did not believe that care workers could be provided through an agency locally. By the end of our inspection the provider had arranged for care workers from an agency to work in the home.

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

Staff recruitment procedures were appropriate and checks had been carried out before staff started working at the home, including obtaining references from previous employers, DBS checks and checking potential staff's identity. DBS checks are carried out by the Disclosure and Barring Service (DBS). They include checking criminal records and a list of individuals who may be barred from working with vulnerable adults and children. DBS checks help employers make safer recruitment decisions to ensure that any potential new staff are of good character.

People told us they felt safe living at the home. One person said, "I feel safe, definitely." Another person told us, "We are well looked after here. I have never felt unsafe." We considered that although all of the people we spoke with told us they felt safe, the findings of our inspection indicated that they were not.

Inadequate

Is the service effective?

Our findings

We reviewed staff training files and found staff had received training in key areas such as moving and handling and fire safety. There was no evidence of how individual staff member's understanding and knowledge had been assessed. Although staff displayed knowledge about safeguarding and dementia care, we found they did not always apply this knowledge in practice. For instance, safeguarding matters were not reported to Northumberland Safeguarding Adults team in line with protocols. Some staff used distraction techniques when supporting people with their dementia and mental health needs, however, this approach was not consistently applied and some people were simply asked or told to sit down.

Staff records showed that they had received supervisions regularly and appraisals annually and medication administration competency testing took place.

Communication between the manager and the staff team was poor and handovers between changing staff teams were very basic and not documented. There was a risk that important information about people's care and treatment may be lost. Staff told us they were not kept informed by the manager about changes in people's care needs or the outcome of any healthcare professionals visits. Staff said that although people's care records were retained within the office, only the manager looked at and reviewed these and staff only accessed them at the end of their shift to document daily notes about how the person had presented that day.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals.

We found the provider had not consistently applied the MCA. The manager told us that she had no examples of where a best interest decision had been made on a person's behalf, although she said she involved service users' families and their care managers where necessary. We found that decision making was not documented and people's capacity to consent to individual care based decisions was not assessed in advance of any decision making. Each member of the inspection team held meaningful conversations with one person who displayed no lack of understanding, however, the provider informed us that this person was "without capacity".

There were no mental capacity assessments undertaken for people who had cognitive impairments or dementia. For example, people with these needs were restricted to the lounge area, but there was no assessment of their ability to make their own choices and understand this practice, to show that controlling their movements and taking away their human rights in this way, was necessary and in their best interests.

During our inspection we were informed of concerns about people without capacity being made to get up at 5.00am. Where we found this was a routine that was in place, we checked people's care records and found they lacked understanding and capacity, but there was no record that their capacity levels in relation to their ability to agree to this care had been assessed. The decision that they should be made to rise early had not been made communally and staff informed us that they were instructed to get people up by the provider. This meant that people did not receive person centred care and the MCA had not been appropriately applied as their capacity to consent to their care and treatment had not been explored.

Routines existed within the home that were restrictive and controlling. People without capacity were contained to the lounge and we regularly saw them being told to sit down or being physically returned to the lounge should they attempt to leave the area.

Only one person had a granted deprivation of liberty safeguard (DoLS) in place and the manager told us that no other applications had been made to the local authority for the other people living at the home who needed them, to ensure that any restrictions placed on them were both necessary and in their best interests. Following our inspection we learned that in February 2015 the provider had been informed by Northumberland Safeguarding team that they needed to make applications for all individuals who were deemed to be lacking in capacity, as they were potentially being deprived of their liberty. The provider has submitted deprivation of liberty safeguard applications to the local authority for assessment in response to the findings at our inspection. These applications had not been submitted prior to our visit however, and as a result people were being deprived of their liberty unlawfully.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Need for Consent.

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

We found that people's nutritional and hydration needs were not being met. Seven people had lost weight steadily and three people had reached a very low body weight. Despite people being weighed regularly, there was no evidence that input into these people's care from dieticians had been sought by the manager or provider to reduce their risk of malnutrition and promote their health and wellbeing. For example, there were no care plans in their care records regarding fortification of their food to stabilise or increase their weight. Nutritional assessments and score charts were held within people's care records, but these were not always completed. Where they were completed, this was only done on an annual basis. People's 'Nutritional needs' care plans had been reviewed monthly in almost all cases up to September 2015, but not since that time.

People and staff told us that there was only one food choice at each meal and people were not informed of what would be served. The provider told us they knew people well and if they didn't like a meal, an alternative such as a sandwich would be offered. Some people had food preference records within their care files but these were not always completed meaning the provider had not explored people's preferred food choices to ensure their needs were satisfied. One person said, "Food is fixed, nobody comes around and asks me what I want". A member of staff told us, "People have no choices around food, there is just one meal prepared and no choice offered". We observed the meals served on two days and our observations confirmed what people and staff had told us. We also saw that routines within the home meant people were only offered drinks with their meals and at set times outside of mealtimes. Jugs of cold drinks were not available for people to access of their own accord within communal areas.

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

This is also a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Person-centred care.

People received support to meet their general healthcare needs such as receiving regular check-ups of their eyes and their teeth. However, we identified serious concerns regarding the timeliness of medical interventions when people presented as unwell. One person told us they were unwell and were having breathing difficulties for which no medial attention had been sought. We requested the manager sought medical attention for this person and subsequently this person was admitted to hospital. This had not been identified by the manager or provider despite the manager providing care to that person that same day. In other cases people were at risk of falling as interventions into their care had not been sought from healthcare professionals and neither had help from occupational therapists where people's mobility needs had changed, and they needed reassessment to reduce the risk of them being moved and handled unsafely.

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

Following our inspection, and in response to our findings and prompts, a number of referrals were made to health and social care professionals so that people received the appropriate support, and staff the appropriate instruction, on how to meet people's changing needs.

The environment within the home did not reflect best practice guidance about how to appropriately support people living with dementia. There were heavily patterned carpets in the lounge and dining room which can cause difficulty to some people with dementia and there was no signage around the home or contrasting coloured walls to orientate people.

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

Inadequate

Is the service caring?

Our findings

Staff interactions with people were polite and respectful and we saw some caring interactions between people and staff sharing a joke. Some interactions between staff and people were based on the routines that existed within the home. For example, we saw that people were regularly told to sit down when they stood up, albeit politely.

Staff told us they did not like delivering care in line with the routines that had been drawn up by the provider and manager, but they had no choice and could not deviate from these set routines. One staff member asked another what the routine for the rest of the day was – for example meal times, activities planned. They responded that they would see if any of "them" need the toilet before lunch. "Them" was a reference to the people who lived at the service. This was not respectful.

When in the dining room we noted four people were sat at tables alone facing the wall and not facing into the room. Staff informed us, "(The manager) decides who sits where in here. People have no choice and we sit people where we are told to". One member of staff explained why one person was seated alone facing the wall. Staff had no explanation as to why the other three people were seated alone facing the wall. They said, "No people argue and there are no issues so I don't know why people are sat separately. I would be annoyed if I came in and found my relative facing the wall". We noted that there were empty seats on the tables where other people were sitting communally. One of the inspection team sat with a person who had been seated alone facing the wall. They engaged and smiled with the inspector throughout the time that they sat next to them.

We shared our concerns about seating practices during mealtimes, with the manager and provider. In response to our concerns the manager said, "One lady gets distracted and others try and take food off other people's plates. X (person) has sat there for years – she is very happy there". We checked people's care records and could find no information in any of their care records to indicate their seating preferences, or that this had been appropriately assessed as the last possible option. People were not supported with their behaviours at mealtimes and instead the provider adopted practices referred to above which meant people were treated with a lack of dignity and respect.

On the late afternoon of one of the days that we visited the home, we observed that one person still had their clothes protector on four hours after their meal had been served. This was undignified for the person. We heard staff refer to clothes protectors as "bibs" and we saw that this upset one person who said, "Me?, wear a bib?". At times the manager pointed out errors which people had made when talking with us and although this was said in a light hearted fashion and with no intent to cause offence, it went against best practice guidance about avoiding drawing attention to mistakes or deficits.

Staff told us, and our observations confirmed that bundles of clean clothing were placed on people's chairs in their bedrooms. One member of staff told us, "They are put out by staff as X (the manager) wants this to be done. It is people's clothing for the next day. They have no choice about what they wear". All staff told us that this had always been the practice in the home, particularly for those people who could not verbalise

their choices. We discussed our findings in respect of people's clothing with the manager and provider. The manager said, "In the mornings people are too tired to choose their clothes". This meant people were not afforded the respect and dignity of choosing their own clothing, no matter what their level of capacity.

People were clean and well presented on each of our visits to the home. We reviewed the "Bath/Bowels" chart in use to monitor the care delivered. These recorded that people were not always supported to bathe regularly and some people had not received a bath for two to three weeks. When people had refused to be bathed, no record was kept of alternatives offered. Staff did confirm however, that people were offered body washes at various times. One person displayed a strong desire to be bathed and although full water immersion was complicated for them due to their medical conditions, the provider had not advocated on their behalf to ensure that all potential options had been explored to meet their wishes and to promote their dignity.

People were supported to maintain their independence in some ways but this was not consistent. For example, at mealtimes people were provided with plate guards so that they could eat independently and with dignity. Other people were equipped with walking aids designed to support their mobility, but they were prevented from walking around the home freely by the restrictive practices which staff followed. One person asked frequently to go home. The standard and accepted reply from all staff was "You are at home, you live here now." This behaviour represented invalidation, where the reality or feelings of the person were not acknowledged or respected. It did not respect the person's dignity.

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

There was a lack of evidence to demonstrate that people or their representatives were involved in people's care, especially where people had cognitive impairments or were living with dementia. People told us that staff were "friendly" and "helpful". One person said, "The girls are very nice" and a visiting relative told us, "They look after X (person) excellently".

Inadequate

Is the service responsive?

Our findings

We identified serious shortfalls in recording and records. People did not always have care plans and risk assessments in place related to all of their needs and where they did, these lacked detail. Records were incomplete with areas of preadmission assessments, care planning, re-assessments and personal preferences unanswered. This meant that pertinent information was not available to staff to ensure they delivered person-centred care appropriately and safely. For example, some people with behavioural needs had care plans in place but these consisted of only one or two sentences and did not give staff the detail they needed to support the person appropriately. One person who had recently moved into the home had no care plans at all and they had a number of complex health needs. When asked about this lack of information the manager told us, "We usually try and get to know the resident first". This person had been living at the home for over two weeks when we visited. This meant that staff did not have plans in place to follow when they delivered care to this individual, leading to the possibility that their needs may not be met.

People's care plans were inaccurate and out of date. They did not reflect their current needs. Most care plans had not been reviewed since September 2015 other than those where people had joined the service after this date. Where people's care plans had been reviewed, changes had not been applied to their relevant care plan to ensure it contained the most current and up to date information. For example, one person's care plan related to their nutritional needs was dated December 2014 and recorded that they required thickener to be added to all of their drinks. A review of this care plan dated March 2015 stated, "no thickening powder in drinks, has done really well". There was no information about who had made the decision and no evidence in this person's care records of an assessment for this, for example, carried out by the Speech and Language Therapy team. As part of our inspection we contacted this team and they confirmed that they had reviewed this person's needs and issued the instruction to reduce the thickener used in the person's drinks to zero. There was no record of this in the person's care records.

Another example of inaccurate records was that one person's fluid consumption had previously been restricted due to a health issue but this had ceased, and their current care plan continued to record they had a fluid restriction in place. Another person's mobility care plan stated they could walk short distances with a walking frame, but we observed at our inspection they could not weight bear and they were transported around the home in a wheelchair by staff. This meant care plans were out of date and there was a risk that people may receive inappropriate and unsafe care as a result.

Staff told us the manager retained ownership of people's care records and they were not involved in any care planning, risk assessing, reviews of people's care or healthcare professionals visits to the home. One member of staff said, "We are not updated on anything". Staff said that information was not relayed to them effectively. We observed a staff handover which was carried out verbally by a care worker, from memory. There were limited records in place for the transfer of information between changing staff teams and the management and staff. Consequently there was a risk that vital information about people's health and wellbeing, and changes in their needs could be overlooked. There was a risk that people could receive inconsistent or unsafe care and treatment.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, entitled Safe care and treatment.

This is also a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, entitled Good governance.

The culture of care within the service was not person centred and institutionalised practices and routines were embedded in care delivery. People, especially those people living with dementia or some form of cognitive impairment, had very little choice around their activities of daily living. For example, people, particularly those without capacity, were woken from their sleep and made to rise from their beds as early as 5.00am. We observed a number of these people asleep in the lounge within an hour of being made to get up and dressed, and two of them commented to each other that they could "just go back to bed". There was a practice of choosing people's clothes for them in the home, rather than supporting them to choose their own clothes. Food was served not to people's choice but in line with what the provider decided and there was only one meal served at each mealtime. People were directed by staff as to where they spent their time and ate their meals. Their movements were controlled and there were timings and restrictions relating to, for example, what time people received morning and afternoon drinks and when their personal care was attended to. One person said, "There are no choices around drinks. I get brought the same drink each day". The care and treatment of service users was not appropriate, it did not always meet their needs, or reflect their preferences.

The provider informed us at the end of our inspection that the routines and schedules that had been in place prior to and during our visit had been removed, and people were no longer being made to rise at an early hour.

People's care records showed little evidence that they were involved in their care. Only a very small number of records had been signed by people to indicate their involvement in care planning and/or an assessment of their needs and preferences. Where this was the case, these individuals were people who had displayed they had capacity. Where people did not have the capacity to understand the care and choices available to them, there was no evidence that attempts had been made to include them in their care and that capacity assessments had been carried out in line with the MCA.

Activities provided by the service to stimulate and occupy people were limited. There were activities such as games and books stored in the dining room but we did not see these in use. People enjoyed reading a book or magazine in the lounge area and the television was on in the background. We observed a religious service being delivered one day and an activity orchestrated by a staff member on another occasion. One person said to us, "I'm very bored it is a long day and I do nothing but sleep all day". Another person commented, "It's a bit boring sometimes, we just sit around. More could be arranged for us to do. We have got a minibus but it is not used enough". People told us they were rarely supported to sit outside and staff said that on odd occasions, some individuals were taken for a walk around the grounds of the home.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Person-Centred Care.

There was no evidence to show that the provider proactively sought the views of people and their relatives about the service delivered. The last questionnaire was sent out in July 2014 to people's relatives. The analysis of this information showed that people's relatives were happy with the care provided to their relations and they made positive comments about the service. The manager had noted in the service's quality assurance file that people could give feedback at any time and they regularly spoke with people. Two

people commented at this inspection that they were unhappy with some aspects of their care, but this had either not been effectively explored by management, or where it had, it was not formally recorded and plans had not been drafted to address areas of concern raised.

There was a complaints book in place which showed that only one complaint had been received in the 12 months prior to our inspection. Records of how the complaint was handled were limited and this meant that it was difficult to conclude whether or not the provider handled complaints appropriately.

Inadequate

Is the service well-led?

Our findings

The manager and provider were present on each of the days that we inspected and they assisted us with our enquiries. We found a lack of oversight and governance of the service which had led to the serious concerns identified and referred to in this report. We fed back our findings of multiple non-compliance with regulations and our most serious concerns to the provider and manager during and following our inspection.

Staff told us the provider and manager did not act on any concerns they raised and if they wanted to raise any issues about the manager, the provider did not address these. The provider and manager had embedded and promoted routines within the service which have resulted in restraining and controlling people's movements, removing their human rights, a lack of choice, a lack of dignity and respect, and a culture of care that is not person-centred. In addition, they have not appropriately applied the Mental Capacity Act 2005, or followed their legal obligations under this Act.

The provider and manager, as responsible persons, have failed to ensure that the service was safe, that the premises were secure, well maintained and environmental risks assessed. Where people needed input into their care from external healthcare professionals this was not always obtained and therefore their health and wellbeing was put at risk. The service was not governed effectively and the quality of care delivered was not monitored appropriately.

The findings of this inspection have led the Commission to question the skills and competence of both the nominated individual and registered manager to operate and manage the service. The Commission cannot be assured that the nominated individual and registered manager are suitable responsible persons to provide and oversee the management of the carrying on of the regulated activity.

This is a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Fit and proper persons: directors.

This is also a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Requirements relating to registered managers.

We looked at auditing and other elements of quality assurance that were carried out within the service to assess and monitor the quality of the care and services delivered. Auditing was limited and audits that were in place were basic in nature and lacked detail. The audits had not been completed since either July or September 2015. None of the audits provided by the manager had associated action plans to demonstrate what actions had been put in place to improve the service or any issues found.

Accident and incident records were maintained and the provider did an analysis of these annually. A review of each individual accident or incident was also carried out at the time it occurred and any actions taken in response to each specific incident recorded. This meant an overall analysis of the accidents and incidents was not done regularly. Actions that had been taken in response to the most recent analysis stated that care

plans and risk assessments were updated, however, we found people's care plans and risk assessments had not actually been updated. Therefore this system and analysis process was not effective at ensuring that people remained safe and their health and wellbeing was protected.

Records showed that prior to September 2015 the manager had carried out a "Quality Management Visit Report" monthly. These reports looked at different aspects of the service at each visit, such as the appearance of the interior and exterior of the home in terms of cleanliness. They were not extensive and did not consider standards of care delivery, care planning and risk assessments, staff competencies, the maintenance of records and all elements of safety within the premises. There was no action plan associated with any of these visits as no areas for improvement were identified in any of the visit reports for the period May 2015 to September 2015. Therefore, although there was a system in place to monitor some aspects of the service, this was not extensive and did not identify some of the key issues that we identified during our inspection. In addition, the "Quality Management Visit Report" visits had not been carried out after September 2015, so for the four months prior to this inspection, this system was not followed by the manager and there was a lack of oversight.

Staff informed us staff meetings, supervisions and appraisals were held but these were not two-way conversations. They said they did not feel staff meetings were an open forum in which they could raise points, feedback ideas, or highlight their concerns. One member of staff commented, "We have a meeting at various times but it doesn't address things". Another member of staff commented, "It is very rare that anything is done about what is said". This meant that although staff meetings took place they were not effective as staff were not comfortable and confident enough to raise concerns and where they did, they did not feel appropriate action was taken. Staff said that communication from the manager and provider was limited and they did not feel they could speak openly with management about the service or the needs of any of the individual people that they supported. One member of staff said, "We don't get to find out anything here, we just don't get told". This meant staff were not supported to deliver good care.

The "Quality Assurance" file held within the service contained information dated October 2014, January 2015 and April 2015 which indicated that attempts had been made to hold 'Residents meetings' but recorded there was a lack of interest from people and their relatives. However, there was no other evidence of how the provider had adapted their approach to obtaining feedback from people and their relatives, which could then be used to inform service delivery, planning and to drive through improvements.

There were serious shortfalls in the maintenance of records across all areas of the service. For example, people's care records lacked detail, some people did not have care plans or risk assessments in place at all and there was a lack of documentary evidence that investigations into people's conditions had taken place. Recording around safeguarding incidents was poor as was information held about the handling of complaints.

The provider failed to ensure that there was adequate governance and oversight to prevent the systematic failings and shortfalls in a wide variety of aspects of the service that we identified at our inspection. Systems and processes were not in place, or established and operated effectively, to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Good Governance.

The provider had not notified us of several incidents including safeguarding concerns, in 2015. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue

any specific matters with the provider.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 entitled, Notification of other incidents.

We used our regulatory powers to request an urgent action plan from the provider about what actions they planned to take to improve. When we visited the home on 3 February 2016 this was following receipt of the provider's action plan and we assessed what action had been taken. We found that sufficient improvements had been made to ensure people's immediate health, safety and wellbeing at that time. We will continue to monitor the provider's progress against their action plan and will revisit the service to ensure that people's health, safety and wellbeing is protected and promoted.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of other incidents such as safeguarding incidents. Regulation 18 (1)(2).

The enforcement action we took:

We issued a fixed penalty notice in respect of this breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 HSCA RA Regulations 2014 Fit and proper persons: directors The provider did not display the skills and competencies necessary for the effective carrying on of the regulated activity and there were doubts about their character. Regulation 5 (1)(2)(3).

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care and they were not supported to understand the choices available to them. Care did not always meet their needs or reflect their preferences. Regulation 9 (1)(2)(3)(a)(b)(c)(d)(e)(f)(i)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect and

their dignity was not promoted. Regulation 10(1)(2)(b)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider, manager and staff employed at the service did not adhere to their legal responsibilities under the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)(5).

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with unsafe care and treatment because the manager and provider did not appropriately assess or recognise risks and they did not mitigate against them. Medicines were not managed safely and environmental risks were not always assessed. Regulation 12 (1)(2)(a)(b)(c)(d)(g)(i).

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not safeguarded or protected from the risk of abuse or improper treatment. Regulation 13 (1)(2)(3)(4)(b)(c)(d)(5)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have appropriate arrangements in place for people to receive suitable nutrition and hydration. Regulation 14 (1)(2)(a)(b)(4)(a)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who used the service and others were not protected from the risks associated with the premises as environmental risks had not been appropriately assessed and mitigated against and the premises was not secure. Regulation 15 (1)(a)(c)(e).

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place. Records were not accurately maintained and governance of the service was inadequate. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(e)(f)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not display the skills and competencies necessary for managing the carrying on of the regulated activity and there were doubts about their character. Regulation 7 (1)(2)(3).

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who used the service and others were not protected against the risks of inappropriate or unsafe care because the provider failed to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed and deployed. Staff vacancies existed in key roles. Regulation 18 (1)(2)

The enforcement action we took:

Whilst we considered our enforcement options in respect of these breaches, the registered provider decided to cease operation of the home, which is now de –registered