Silverdale Care Homes Limited

Silverdale Nursing Home

Inspection report

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15 July 2016

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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 13 and 15 July 2016 and was unannounced. At our previous inspection in February 2016 we found that people who used the service were not always safeguarded from abuse as staff were unsure of what to do if they suspected someone had been abused. People's privacy and dignity was compromised. There were insufficient staff to keep people safe and the service was not well led. We told the provider that improvements were needed and we rated the service as 'Inadequate' and placed it into special measures.

At this inspection we found that some improvements had been made to respecting people's privacy and dignity, and safeguarding people from abuse but further improvements were needed. We continued to find insufficient suitably trained staff to keep people safe and the systems the provider had in place to monitor the quality of the service were ineffective. There were also concerns with gaining people's consent, the safe care and treatment of people and the recruitment processes.
The overall rating for this service is Inadequate which means it will remain 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.

Silverdale Nursing home provides support and care for up to 27 people, some of whom may be living with dementia. At the time of this inspection 25 people used the service.

The service does not have a registered manager. A person had been recruited into the manager's position but they were not registered with us. 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.

Staff we spoke with all knew what constituted abuse and told us they would report it if they suspected abuse had taken place. However allegations of neglect were not always investigated.

Risks to people were not always minimised through the effective use of risk assessments. There were insufficient suitably trained staff to keep people safe and meet people's care needs in a timely manner.

Staff did not always have the knowledge and skills required to meet people's individual care and support needs. The provider did not have robust recruitment and vetting procedures. Staff did not always have the induction, training and supervision they needed.

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

The principles of the Mental Capacity Act 2005 were not followed to ensure that people were consenting or being supported to consent to their care and support.

Care was not always personalised and did not meet people's individual needs. Advice was not always sought from other professionals to ensure everything possible had been done to mitigate the risks of people coming to harm.

People's medicines were not managed or stored safely.

Some leisure and social activities were provided, but not all people got the support they needed to engage in any meaningful activity. People's right to privacy and dignity was compromised.

People knew how to complain but complaints were not always managed appropriately.

Systems in place to monitor the quality of the service were ineffective. No improvements had been made since the last inspection.

The provider was not notifying us routinely of safety incidents that occurred at the 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. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. There were not always enough nurses or care staff to keep people safe and meet people's care needs. Recruitment procedures were ineffective. Staff did not receive suitable adequate training, induction or supervision. People's medicines were not stored safely or securely. More improvements were needed to ensure concerns with people's safety were referred and raised consistently with the local authority.

Is the service effective?

Inadequate

The service was not effective. The requirements of the MCA 2005 were not always followed. Care staff said they received training however this did not always reflect in their care practices. People's nursing care needs were not met due to the lack of training for the nurses. Records were not consistently completed to ensure people who were nutritionally at risk had sufficient each day. People were not always referred to specialist professionals in a timely manner.

Is the service caring?

Inadequate

The service was not caring. The low staffing levels impacted on the quality of the care and support provided. Institutional routines did not afford people the person centred care they required. People's privacy and dignity continued to be compromised.

Is the service responsive?

Inadequate

The service was not responsive, People did not always receive care that reflected their needs and respected their preferences. People knew how to make a complaint but action was not taken to rectify the concerns.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. Effective systems were not in place to monitor

safety incidents, so action was not always taken to reduce the risk of further harm from occurring. The manager did not ensure there was sufficient staff to meet people's needs. The provider was not notifying us of safety incidents that occurred at the service.

Silverdale Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 13 and 15 July 2016 and was unannounced.

The inspection team consisted of two inspectors 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.

We looked at the information we held about the service. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners. A large scale investigation (LSI) was on-going with the provider and the local authority safeguarding team because of the number of concerns and allegations of abuse that had been reported. The commissioning department at the local authority had placed a suspension of all new admissions into the service until the service had improved and the restriction is lifted.

We spoke with five people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We spoke with seven relatives of people who used the service to gain feedback about the quality of care. We spoke with the operations manager, the provider, one registered nurse, two agency nurses, four care staff, the activity coordinator, the cook, a visiting GP and an independent advocate. We looked at six people's care records, staff rosters, two staff recruitment files and some quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Inadequate

Is the service safe?

Our findings

At the last inspection in February 2016 we had major concerns that people who used the service were not always safeguarded from abuse as staff were unsure of what to do if they suspected someone had been abused. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that improvements had to be made in relation to the safety of people.

At this inspection staff told us they had received training in safeguarding people from abuse. We saw this had also been discussed with staff at a recent staff meeting. We saw safeguarding information was displayed in various areas around the service so that people were aware of where they could refer their concerns. Carers told us they would report any concerns they had to the senior nurse or the manager. Staff were also aware of other agencies they could contact if they felt their concerns were not dealt with appropriately. A nurse told us they would refer any concerns directly to the safeguarding teams if this was needed.

We received two action plans from the provider regarding the action they planned to take: 'All staff to receive supervision on safeguarding vulnerable adults, including how to identify abuse, who to report to and documentation in residents notes. All staff to undertake course for safeguarding vulnerable adults'. With a target date for completion April 2016. No action had been taken to ensure the training provided to staff was sufficient for them to be able to recognise abuse. We saw in May 2016 the social workers had reviewed people's care and support needs and had identified concerns with people's dietary needs and unexplained injuries. Neither the manager, nursing staff, care staff or the provider had recognised these concerns as potential abuse until they had been identified by and discussed with the social workers. Safeguarding referrals in relation to the safety concerns with nine people had not been made until the manager was advised to do so by the social workers. The management of the service had not recognised the need to refer concerns regarding people's safety. This meant that not all staff were able to identify and report abuse so people remained at risk of harm and their safety compromised.

This is a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they felt their loved ones were safe at the service. One person told us: "She's been here that long and I know the staff and I've got every respect for them, and the doctor too, he's an excellent doctor more the old fashioned sort . I can't praise him enough . There is a good combination and you feel you can approach them and ask them". Another relative said: "Yes [my relative] is safe, she's got her own room and there are always people around". Staff told us the information on keeping people safe was in the care plans, and when asked how risks were assessed and managed responded: "If they're at high risk and by getting them assessed". However we saw some staff working practices were not safe, for example the moving and handling techniques used and the lack of updating and reviewing risk assessment and care plans when people's level of need had changed.

Risks to people were assessed and plans were put in place when risks were identified, but these did not

always identify people's current levels of need and support and were not reviewed in a timely way. Some people were at risk of falling due to mobility or cognitive problems. A relative of one person who used the service told us: "My partner has a walking frame but they forget to use it at times. We always remind them and it is always close by but they tend to forget and try to walk without it". The risk assessment for support with this person's mobility included the use of the walking frame and for it to always be in reach. The risk assessment had concluded the person was at very high risk of falls. However we saw that there were occasions when the person had fallen and sustained serious injuries. A falls analysis had been completed but a referral to the falls specialists had not been made for additional guidance as to what actions may be needed to reduce the risk for this person. There were no monitoring or checks made to ascertain if there were any reasons or triggers for the person to continue to experience these falls. The operations manager and the provider were unable to offer an explanation regarding the lack of action in relation to the person's continued risk of falling. This person remained at risk of harm because no action had been taken to identify actions that would mitigate the risks.

We saw a person in their bedroom, they did not have access to a call bell should they require help from staff. We saw that a call bell had not been provided in this bedroom for the person to use. In other bedrooms we saw that call bells had not been provided. This person was at risk of harm due to their poor mobility and reliance on staff to support them with daily living. They told us they would call out for help and then wait for staff to arrive. This meant this person was at risk due to not being able to call for assistance if and when they required it.

Staff told us they had been trained in the safe use of the hoist this included theory and practical sessions. However we saw two staff used an unsafe technique when transferring a person from an arm chair into a wheelchair. We looked at the moving and handling risk assessment which assessed the person as 'able to weight bear', the equipment to be used was recorded as both the standaid and the full hoist. We saw the standaid being used. The standaid equipment must only be used when people were able to weight bear and stand. The person clearly could not weight bear; they had great difficulty with holding onto the arms of the standaid. Their safety was compromised by the use of the standaid and the sling. The sling was pulling the person's arm into the upright position, we intervened because we had concerns for the person and spoke with the two care staff. One of the staff told us this manoeuvre and the standaid were wrong as the person was unable to weight bear. They told us they would report the changes to the nurse who would then review the plan. On the second day of our inspection we saw that the risk assessment and care plan had not been reviewed, the person remained at risk because of the unsafe moving and handling techniques.

Some people were at risk of developing sore skin. Staff told us that some people were at risk of developing sore skin and they reported any concerns with people's skin conditions to the nursing staff for them to take the necessary action. Risk assessments and care plans had been completed with the action needed to reduce the risk of people developing sore skin. Specialist equipment had been provided for some people, for example, air flow mattresses and pressure relieving cushions. These were used to support people with reducing the risk of them developing sore skin. We saw information in one care plan that the mattress pressure should be adjusted to the person's weight. Not all care plans or monitoring documents recorded the information of the most appropriate setting of the mattress to offer the most effective support for each individual. NICE guidelines state that air flow mattress pressure should be set for each individual person according to the manufacturer's guidelines and take account of the person's weight. The settings used and the individual's weight should be recorded in their record. Monitoring systems were not in place for the management or senior staff to ensure the correct use of the equipment.The provider was not consistently following the guidance which meant for some people the equipment in use would not be as effective as it should be.

We looked at the way the service managed medicines. We saw some people had been prescribed cream and lotions for the treatment and prevention of sore skin. These were not stored safely and securely as we saw numerous tubes and tubs of these external preparations deposited on open trollies and in the corridors of the service. People who used the service accessed these areas and could easily remove or take the medicines that did not belong to them. Systems were not in place for the proper and safe management of medicines.

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

We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment of staff. We saw an instance where a person had been recruited with an unfavourable reference. The provider told us interviews were carried out with a manager from another home within the company. The provider confirmed they had not seen this unfavourable reference but recalled a conversation with the manager of the suitability of the applicant. There was no record of this conversation or decision to recruit this person. This lack of scrutiny did not ensure that suitable people were employed to provide care and support to people.

We saw another person was working in a senior position. The provider was unable to show us this person's personnel file and confirmed they had not seen any character or professional references for them. The person told us they had a disclosure and barring check that had been completed for a previous employment. This meant the provider's recruitment procedures were ineffective and did not ensure staff were suitable to work with people who used the service.

The provider supplemented the staffing levels and staff vacancies with the use of agency staff, carers and nurses. We asked the provider how they ensured the agency staff were safe and suitable to work at the service. We were shown some staff profiles provided by the supplying agency, however these did not include when staff had received training or there suitability to work. There were no profiles available for the two agency nurses working at the service during this two day inspection. This meant the provider compromised the safety of people who used the service by not ensuring staff were of good character, had the skills, competence and experience to provide the necessary care and support.

These issues constitute a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager told us that levels of staff were constant with a specified number of personnel rostered on each shift. The number of care staff decreased during the afternoon and again at night. We saw there were five care staff during the morning with an additional care staff to support a person who required one to one support during the day. Staff said that the majority of people who used the service required two staff to support people with their daily care needs. We saw that some people were not supported to have breakfast until 11.00am, their care plans did not record their preferred rising times and they were unable to tell us their preferences.
One member of staff told us at times the staffing levels were 'tight', especially when staff were on annual leave or had called in sick. Care staff reported they were always very busy and had little time to spend quality time with people and we saw most interactions were task based. People's individual needs had not been considered when setting the staffing levels.

One person was at high risk of falls and we saw they had a falls sensor mat in place to alert staff to them moving. Staff explained that they could not always get to the person in a timely manner as they may be

supporting other people who they could not leave. We saw this person had recently fallen when unsupervised and had sustained serious injuries. This meant people were at risk of harm because staff were not available in sufficient numbers to support people in a timely way.

On the first day of the inspection we saw there were two nurses, one nurse was supporting a doctor with their weekly round. The other nurse was from an agency, this was the first time they had been at the service. The permanent nurse left the premises when the doctor's round had finished. This meant that the agency nurse who did not know the service or the support needs of people was left alone and without clinical support. This put people at risk of receiving inconsistent care and support.

On the second day there was a different agency nurse on duty, this was also their first time at the service. Both agency nurses told us they had received a handover from the night staff and we saw the handover sheet contained brief details of all the people who used the service. Both the agency nurses administered the medication to people; we saw they consulted with the care staff to ensure they administered medicines to the correct person. The provider told us that all 25 people who used the service had been assessed as requiring nursing care; there were insufficient nursing staff on the premises to ensure people received the nursing care needs they had been assessed as requiring. The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe and effective care to people who used the service.

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

Inadequate

Is the service effective?

Our findings

At the last inspection in February 2016 we found the provider did not ensure persons employed by the service received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice to ensure the provider made the necessary improvements. At this inspection we saw that the provider had not made the improvements required.

We received an action plan in May 2016 informing us that action had been taken for all staff to have face to face and on line training in numerous courses. This included moving and handling. The compliance officer who completed the action plan wrote, 'by attending manual handling courses the staff can transfer residents that require aid for transfer, to be done so with safely, with dignity, privacy and modesty'. The operations manager was unable to tell us or show us records of any competency assessments completed following the staff training. We saw two staff used an unsafe method of moving and handling and placed a person at risk of harm. There was no clear leadership and direction offered to staff whilst completing their duties which led to some poor practice being observed.

We spoke with a new member of staff they told us they had not received an induction to the service, had not received supervision or competency checks on their work performance. They told us: "I was just left to get on with it". This meant that staff were not adequately supervised or checked to ensure they provided support to people safely and effectively.

We saw that the district nurses had been called to provide a person who used the service with a specific nursing need because the nurses employed at the service had not been trained, were not skilful or competent to perform this nursing task. The nurse confirmed they had not received training and was not competent in providing this nursing task. This meant the person was at risk of not receiving the care they required in a timely way because the nurse was not sufficiently trained to perform this nursing task.The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times.

There was no evidence of improvement in this area and the provider remains in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw restrictions were in place, for example constant monitoring and observation, people unable to leave the premises because of safety concerns and the use of

pieces of equipment. Referrals had been sent to the local authority but we were unable to determine if authorisations had been legally agreed because the record of the referrals was incomplete.

Staff told us and we saw one person's medicine was administered in a 'covert' manner. This meant their medicines were hidden in their food and the person's right to refuse their medicines had been removed. Staff confirmed and the person's care records showed the person's doctor had agreed this course of action because the person needed this medicine for health reasons. We did not see a capacity assessment had been completed to determine and assess the person's own decision making abilities or that their representative had been involved in this decision.

We saw one person had a decision made on their behalf about their end of life care by a doctor and a nurse. There was no indication of the person's physical health status or why this decision was needed. There was no capacity assessment to determine the decision making abilities of the person, their involvement in the discussion or that of their representative. The MCA had not been followed to ensure that this decision was in the person's best interests.

We saw general capacity assessments had been completed for most people; they were not decision specific, the reason for the assessment was 'daily living'. Most had not been fully completed. One assessment for daily living had been discussed with a person's Lasting Power of Attorney (LPA). An LPA has the legal authority to make decisions on a person's behalf if they lack mental capacity at some time in the future or no longer wish to make decisions for themselves. The LPA had authorisations to make decisions in regard to the person's finances but we saw they had been involved with decision making regarding the person's daily living. The provider and the operations manager were unable to tell us if this person had the authorisation to make the care and welfare decisions on the person's behalf. The MCA had not been followed to ensure that this decision was in the person's best interests.

This was a breach of Regulation 11 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff told us that people were offered porridge and a hot drink when they first woke and then were offered a cooked breakfast when they had been helped with their preparations for the day. We saw people had their cooked breakfast in the dining room. One person said that it was 'very nice'. A visitor told us: 'To my knowledge it's pretty good but I'm not here at meal times. When mum came here she was 6 stone or something and very soon she was up to the normal weight again and has been ever since. Yes I think she has enough to eat". Another visitor told us they liked to visit at mealtimes so they could help their relative with their meal. They told us: "They [the meals] seem good; there is always plenty to eat. I do tend to come at dinner time so can see what is on offer". We saw that mealtimes were at set times during the day, people had limited choices and most people needed some level of support from the staff.

We saw that refreshments were offered at regular intervals throughout the day. Staff told us of recent change to the main meal being served during the evening 'people usually have late cooked breakfast so would not be ready for a big meal at lunchtime'. They told us that only very recently had the catering staffs hours been amended to support the preparation, serving and clearing away of this evening meal.

People considered to be nutritionally at risk were provided with fortified diets and food supplements to support them with adequate daily nutrition. Some people had fluid and diet charts to monitor their daily intake. We saw not all of the charts had been sufficiently completed so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs. Staff were aware of the need to complete the food and fluid charts but told us there were times when they were rushed and they forgot to

complete them.

People who used the service had regular consultations with their doctor. We saw that each week the doctor visited the service and completed a 'ward round', this was a check on several nominated people's health. The doctor said this worked really well so that any issues with people's health was identified quickly. We saw that a person recently had a consultation with a community psychiatric nurse when they experienced some distress and anxiety. Some people had input from health professionals when they required it. However some people would have benefitted from the support from other health care agencies. For example people were not referred to the falls specialists when they were at high risk of falls. This meant that people's health care needs were not always met.

Inadequate

Is the service caring?

Our findings

At the last inspection in February 2016 we found the provider did not ensure people's right to be treated with dignity, privacy and respect was consistently promoted. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice to ensure the provider made the necessary improvements.

We saw some improvements had been made but people's dignity and privacy could be compromised because of the lack of suitable signage on bathroom and toilet doors. We saw some communal toilets had pieces of paper taped onto doors saying vacant or occupied but these could easily be removed or not changed when the toilet was being used. People's dignity and privacy could be compromised when using facilities.

A visitor told us at times they felt people were disrespectful to their relative and said: "I don't like the way they refer to people, they might as well say number four, makes her just down to a number! I feel a bit militant about it and always say that this is my mum's home!" We saw some institutional practices, set routines were the norm, and very little consideration given to individuals support needs and wishes. We saw the use of disrespectful terminology recorded in some care documents. This was not conducive to providing care and support to people in caring, compassionate way.

Some visitors told us that the staff were caring towards their relatives. One visitor said: "I've got confidence in the staff if there's any problems they'll speak to me about it". Another visitor told us how staff communicated with their relative and said: [My relative] is deaf and they shout in her ear ... but it's very difficult". Another visitor told us they liked to visit the service each day so they could help their relative with their breakfast. They said: "I like to do this as it helps the staff and I know then that my relative has had something to eat". Staff were aware of people's likes and dislikes, and told us how they involved people in their care. One staff member said: "We ask those who are capable, but still ask anyway". The care and support plans contained very little information about people's preferences or social and life histories.

One relative told us the care provided was 'wonderful' and their relative's health had improved since they started using the service. They told us they had regular discussions with the nursing staff regarding their relative's continuing care and support needs. There was no record that the person or their family member had been involved with discussing the plan of care. We saw documents in this person's care plan that were incomplete, were not signed or dated so it was unable to determine when the assessments had been carried out.

Some people who used the service were unable to tell us about their care due to their needs so we observed their care in the communal areas. We saw one person who used the service was wearing their overcoat, they told us they were 'okay' but feeling very cold. This person was not offered a hot drink or any other support to lessen them with feeling cold. We saw another person sat at the dining table in a wheelchair for over two hours before an offer was made for them to move to more comfortable seating. People sat in easy chairs with the sling around their arms and shoulders after they had been supported to transfer with the use of the

hoist from the wheelchairs. There was a lack of concern for the comfort and well-being of people.

We saw some positive interactions between carers and people who used the service. Visitors reported staff were kind and caring. One visitor told us they were very satisfied with the care and support provided to their relative and said: "Yes, it gives me relief, the staff are very sympathetic". Another visitor said the staff treated their relative well and said: "They [care staff] will sit and hold her hands sometimes like I do". Carers established eye contact when speaking with some people and gave people time to respond. However low staffing levels impacted on people's welfare, we saw people had to wait for assistance and not all people experienced such prompt positive actions from staff.

This constituted a continued breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service responsive?

Our findings

People did not always receive care that was personalised and responsive to their needs. We saw a person needed a certain amount of fluids each day for them to remain well hydrated and for support with maintaining good continence. We saw monitoring documents had been completed which recorded a low fluid intake. No action was taken to improve or support the person with consuming additional fluids. The nursing staff, provider or manager had not recognised the low fluid intake may be a contributing factor for the person experiencing discomfort and then requiring medical intervention.

Staff were aware of people's individual care needs and explained the support they offered to different people. One staff member told us: "We have been here a long time and we get to know people and what their needs are". The care and support plans were not person centred and did not consistently record the preferences of people. The care and support plans did not accurately reflect the support provided by care staff. For example, we saw one person being supported by male and female carers. It was recorded in the person's support plan they did not wish to receive care and support from male carers. This meant this person's preferences were not respected.

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

People knew how to complain. A visitor told us they had recently spoken with the manager regarding their concerns and said: "It got to a stage where I had to say something about the laundry and that sort of thing. I took the manager to my mum's room and pointed things out and said would your mum wear that. I told them if they didn't do something I would do something about it". They went on to tell us about the response they received: "The manager told me everything had to be washed at the same temperature and woollens were boiled the same as everything else to remove infections". Another visitor told us they had made a complaint on the behalf of their relative and said: "I found out my relative was having a shower and I know that she didn't like the shower. The response I got was they said they couldn't give her a bath because the water system wasn't up to it". These complaints were not dealt with in an objective way or any action taken to rectify the situation. The lack of action did not minimise the risk of the complaint arising again, there was no opportunity for learning from the complaints or making any improvements to the service provided.

This constitutes a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people who used the service had an individual plan of care based on an initial assessment of their needs. The plans were not person centred and did not have sufficient information on people's individual preferences and requirements. We saw social profiles were not completed so no information was available to ascertain the person's likes and dislikes. Some people but not all had relatives and families who could provide this information. A visitor told us they were involved with their relatives care assessments and said; "Yes, people come sometimes and ask you". Some people had difficulty with verbal communication so would be unable to tell staff how they wanted their care to be delivered. Staff told us about people's likes

and dislikes but we were unable to ascertain if these were to the preferences of people as no information had been gathered and recorded. This meant important information about preferred lifestyles would be lost as people's ability to recall diminished.

There was routine and structure in place which meant that care was not being delivered in a way that met people's preferences. People had set days for when they were supported to have a bath or a shower. Meals and drinks were provided at set times of the day, there was no provision for people to help themselves to drinks or snacks. Staff told us that people could go to bed and get up in the morning when they wished to do so. People were unable to tell us if they got up a time of their choosing. One person said: " The staff come in and help me I suppose it's okay, I can't dress myself so need help". Nothing about people's personal preferences were recorded in care plans, this meant the service was not responsive or receptive to people's individual requirements.

Recreational activities were arranged but the activity coordinator explained the difficulties in engaging people due to them living with dementia. One person was enjoying doll therapy. We spoke with their independent advocate who was visiting, they told us: "The doll therapy is new; I haven't seen this on my previous visits but it seems to be working, she is so much better and so much calmer something seems to be happening she is much improved". A visitor told us there were no activities that interested his relative. We did see some staff attempted to engage with people, for example offering a game of dominoes, painting and providing people with magazines. However some people remained disengaged and either sat quietly, were asleep or wandered round the building.

A sensory room was available and equipped with sensory equipment that may have supported people when they felt anxious or distressed. However the room was used to store other items of equipment such as wheelchairs. Staff told us that the room was underused due to staff availability, time and workload constraints.

Inadequate

Is the service well-led?

Our findings

At the last inspection in February 2016 we found the provider did not have quality monitoring systems in place to ensure they provide a safe and effective service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that improvements were needed. At this inspection we saw that the provider had not made the improvements required.

There was no registered manager in post. The service was being managed by a manager, who was absent on the day of the inspection, a recently appointed operations manager, the provider and a nurse.

Very little improvements had been made to the care and support provided to people since our inspection in February 2016. We had received three action plans from the provider which told us the plans for improving the service. We were requested by the provider to disregard the second action plan as this was not in sufficient details to inform us how the improvements were to be made. We saw the third action plan had been drawn up but again was not in sufficient detail or correlated to the breaches of the regulations. We continue to have concerns with the management and leadership of the service and the lack of improvements to provide people with a safe service.

The provider was unable to show us any details of the quality and assurance systems in place to ensure a safe, effective and well led service was provided. The provider explained the difficulties with the management arrangements since the last inspection. However this does not vindicate the responsibilities held by the provider in ensuring people who used the service were safe and their wellbeing was paramount. The provider had responsibility for the service, but did not make sure improvements were made immediately and action plans were comprehensive. Action plans were incorrect and not clear about how, why and when the improvements would be made. This lack of action meant that people who used the service continued to be at risk of harm from an inconsistent and inadequate service.

We saw conflicting information in care and support plans which meant people were at risk of inconsistent and unsafe care and support. For example, the level of risk and the level of need differed for people at high risk of falls. Information was not available in regard to the current or people's changing levels of support. Equipment provided to reduce the risk of people developing sore skin was not used correctly or to current good practice guidelines. Staff were not adhering to the instructions recorded in care plans and risk assessments, incorrect equipment and unsafe manual handling techniques placed people and staff at risk of harm and injury. This meant some people were at risk of harm to their safety and wellbeing because their support needs were not being effectively monitored by the managers, nursing staff or the provider.

People had been recruited without the necessary checks made as to their suitability, good character or competencies. Agency staff worked at the home each week to supplement the vacancies of nurses and care staff. No checks were made as to the suitability, good character, skills, competences or experiences of these agency staff to provide the necessary care and support. The recruitment and vetting procedures were not sufficiently robust to ensure suitable people were employed to provide care and support to people.

Staffing levels had not been assessed based on the individual needs of people who used the service and we saw that people did not receive the care they required in a timely manner. Agency staff who did not know the service or the support and care needs of people were left to work alone without any clinical support or guidance. People were at risk of harm and injury due to the current staffing arrangements.

Care staff told us they received training both on line and face to face. They confirmed they had received theory and practical training in moving and handling and the use of the hoist. However staff's competency was not routinely checked and we saw staff supported a person with an unsafe technique leaving them and the person at risk of harm. Nursing staff did not receive the necessary training to deliver the care and support to people who had been assessed as requiring nursing care. There was no clear leadership and direction offered to staff whilst completing their duties which led to some poor practice being observed.

The provider had not followed the principles of the MCA and DoLS to ensure decisions were made in people's best interests. Important decisions were being made on behalf of people who used the service; they were excluded from the discussions. People were being restricted of their liberty and freedom without the legal authorisation to do so. There was a lack of understanding of the legislation to ensure all legal requirements were met.

We saw that social workers had reviewed people's care and support needs and had concerns with people's dietary needs and unexplained injuries. The manager had not identified these concerns as potential abuse until they had been identified and discussed with the social workers. They had not raised any safeguardings in relation to the safety concerns with nine people until advised to do so by the social workers. The manager or the provider had not recognised the need to refer concerns regarding people's safety, so people remained at risk of harm.

Some people were at risk of malnutrition, dehydration, falls or developing sore skin and monitoring documents had been put into use. We saw some but not all monitoring documents were completed following interventions by care staff. There was no evidence to suggest that any necessary action had been taken when concerns were noted. This meant that the provider did not have effective systems in place to monitor adequately people's care and support needs effectively.

People were aware of how to complain about the service. However the complaints procedure was ineffective to adequately deal with complaints and to determine a satisfactory solution.

Systems and processes were not in place to effectively monitor and improve the quality and safety service or to mitigate any risks relating to the health, welfare and safety of people who used your service.

These issues constituted a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from records that people had been assessed as being at risk of falls. We saw that one person had fallen on at least two occasions and suffered broken bones. We had not received any notification regarding these incidents. It is a legal requirement of the registered person's registration that they must notify the Commission without delay of any incidents which affect the health and well-being of people who used the service.

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