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Dunedin Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive ratings inspection took place on the 25th October 2016 in response to safeguarding concerns and a quality assurance inspection undertaken by the local council, which raised concerns about other aspects of care provided at Dunedin residential home. We found significant concerns during this inspection and took immediate action to address these concerns.

However, we received additional information on the 10th November and returned to the service unannounced. At which time we found additional evidence about the lack of managerial oversight at the service and the safety of people living there. On the 16th of November 2016, an inspector and inspection manager met with the providers at the service to discuss on-going concerns.

Dunedin residential home is registered to take up to 23 people requiring accommodation and personal care. At the time of inspection there were 16 people residing at the home. On the day of inspection, the local authority had placed restrictions on the service admitting local authority funded people to the service.

On the 26 October 2016 the registered manager was absent and an acting manager was in place to ensure the continued running of the home. During the duration of the inspection period the registered manager was removed from the service. 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.' In the absence of the registered manage the provider had promoted a senior carer into the role of manager.

We found a number of significant concerns relating the safety and managerial oversight at the service. The environment and equipment at the home was not safely maintained and there was a lack of good infection control practices.

Cleaners found it difficult to maintain the cleanliness of the environment due to its age and run down state. We had to request environmental health inspectors to come to the home to check the safety of the kitchen area due to the lack of cleanliness in the storage of food. Whilst no risk to people was found, it was agreed that the home needed to improve its cleanliness and rotation of food, some that had passed the best before dates.

When incidents of behaviour that challenged occurred, staff did not appropriately record and investigate to discover the cause of the behaviour, and whether they could have prevented the incident. Consequently, there was a culture of not learning from incidents. External professionals did not always receive referrals from the home to support people with complex needs, for example the speech and language therapists and falls team. There were no systems in place to chase up referrals when these were made, such as repair of people's hearing aids, without which left people unnecessary isolated from the environment.

Staff had received training, which appeared to be in date; however, training certificate dates did not match management audits of training undertaken. Only one member of staff had in date manual handling training. Witness statements of staff written following the management of behaviours that challenged demonstrated a lack of knowledge in how to engage with people who were confused and de-escalate potentially unsafe behaviours during incidents of distress.

The dining experience was poor and few people were moved from their seats to enjoy a meal together, often not moving for very extensive periods of time.

Staff demonstrated kindness in their interactions with people and people told us that staff were very kind to them. However, staff used old stained and misshapen bedding for people that they would not use for themselves and supported people to use a toilet / shower area that was dirty. Staff told us when questioned that they would not be prepared to use these themselves.

People who had capacity and were able to vocalise were observed to have positive interactions with staff. People with cognitive impairment, and more difficulty in communication were left for long periods without any interaction or engagement. There was a lack of stimulating activities on offer at the home.

Care plans were not person centred. As a result, people who presented with high-risk behaviours or physical health needs did not have in place interventions that would instruct staff how to be response to their needs, preferences, and wishes.

There was a significant lack of leadership and management across the service, with little effective governance systems in place to monitor the quality and safety of the service provided. The providers had trusted all the running and oversight of the home to a manager who was now absent. They had not assured themselves that the registered manager had been running the service safely. In the place of the registered manager was a senior carer acting up into the role without being given any guidance on how to run the service and what their roles and responsibilities were. This lack of oversight had resulted in significant failings at the service, which had previously been rated as "good" in January 2014.

Consequently, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review. If we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months. You can see what action we told the provider to take at the back of the full version of the report.

The expectation is that providers found to be providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in

special measures.

The 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 no effective systems in place to monitor the safety of the environment and equipment, and act upon potential issues of risk.

The providers did not have proper oversight of the home and had poor systems in place to ensure the appropriateness and quality of staff at the service.

Staff had not always contacted relevant health professionals when people presented with complex health needs and injuries.

Is the service effective?

Inadequate

The service was not effective

There were ineffectual systems in place to monitor staff supervision and training

Diet and fluid charts whilst completed did not always correspond to what people had actually consumed.

Capacity assessments were reviewed every 6 months but evidence of review and actions to take were not demonstrated.

Is the service caring?

Requires Improvement

The service was not always caring.

Communal toilet / shower room and bed linen were dirty. Staff told us they would not use the toilet themselves due to the poor condition, yet were using them for people at the service.

People were not activity encouraged to express their views.

However, we did see that staff spoke to people in a kind way and most people told us they thought staff were kind and caring.

Is the service responsive?

Inadequate

The service was not responsive

Care plans were not person centred and did not reflect people's current needs, preferences, or risks.

When concerns about care plans and risk assessments were highlighted, they were not immediately addressed.

No systems of referrals were in place to external professionals when this would have benefited people at the service in order to meet complex needs.

Is the service well-led?

Inadequate

The service was not responsive

Care plans were not person centred and did not reflect people's current needs, preferences, or risks.

When concerns about care plans and risk assessments were highlighted, they were not immediately addressed.

No systems of referrals were in place to external professionals when this would have benefited people at the service in order to meet complex needs.

Dunedin Residential Home

Detailed findings

Background to this inspection

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

This comprehensive ratings inspection was in response to concerns raised by the local authority Quality Assurance team. The inspection was unannounced and took place on the 25 October 2016.

The inspection team was made up of two inspectors and an expert by experience that had experience for caring for loved ones receiving care at residential homes.
Before the inspection, we examined previous inspection records and notifications we had received about the service. A notification is information about important events, which the service is required to tell us about by law. We reviewed safeguarding concerns raised by the local authority and worked closely with the local authority quality team.

We spoke with six people who used the service, two relatives, three members of care staff, the registered manager, the cook, and one of the service providers. We looked at the care records for five people, including their care plans and risk assessments. We reviewed 10 people's medication charts. We also looked at five staff recruitment files, minutes of meetings and documents relating to the quality monitoring of the service, including complaints and compliments, incident recording and any clinical audits that the service had to monitor the quality and safety of care provided.

In order to gain an understanding of people's experiences of the service we carried out a Short Observational Framework for Inspection (SOFI). This is an observational tool used to collect evidence about the experience of people who use services, especially where people may not be able to fully describe these themselves because of cognitive or other problem.

Inadequate

Is the service safe?

Our findings

The service was not safe. Risk assessments did not reflect people's risks adequately. A safeguarding referral had been raised regarding a person with an identified risk of choking being assisted to eat in a reclined position. Staff had considered that the person might be at risk of choking in that position. No Speech and Language Therapy (SALT) referral could be found to consider the risk, the texture, or thickness of food or even the need for liquid medication. Staff were giving the person a thickening product but we could not find evidence of this being prescribed or how much staff should use. The only thickening product container found in the kitchen had no name on it. There was a very little left in the container and the best before date was June 2016. Staff denied this was in use and the inspector had to ask it be disposed of if it was not in use.

Staff completed witness forms when incidents occurred but only completed incident forms for falls. We saw that one person had been identified as a "Low" risk of aggression, but had, had several incident witness reports detailing episodes of aggression that including; punching staff in the face, kicking staff, placing hands around staff neck, and risks to females living at the service. We saw that staff were telling the person that their behaviour was "not acceptable." Lack of investigation into incidents meant staff and management did not identify triggers to the behaviour that challenged, including staff's responses to people. Risk assessments and care plan interventions did not identify the risk or how staff could support the person. This placed the person, staff, and others at the service at risk.

We saw incident forms detailing past falls for one person. The incident document and subsequent body map detailed that the person had on two occasions hurt their head. This included black eye, cut to cheek with swelling, head cut, skin tears. The intervention was to apply a cold compress and there was no evidence that a medical practitioner reviewed the person, or that further medical advice was sought or physical investigations completed. There was no falls analysis and although there was evidence of a number of falls for the person over a period of time, the service had not accessed support from other professionals such as the falls prevention team or occupational therapy department.

All staff at the service had undertaken current and up to date safeguarding training and were able to explain to us signs of safeguarding concerns and how they would report it to the manager and senior care staff. However, there were no effective systems to safeguard peoples belongs and finances. Staff did not keep an inventory of people's belongings when they entered the service. One relative told a social worker that they could not find some of their jewellery and when they had reported this the registered manager had dismissed this it.

Referrals were made for authorisations to deprive people of their liberty who did not have mental capacity to agree to stay at the home and who would be at significant risk if they left. However, there were no systems in place to monitor the Deprivation of Liberty Safeguards applications, for example alerting the registered and acting manager of when these would be needed to be updated or chased up. People, who lacked capacity and used bedrails at night to keep prevent them from falling from bed, had not had a deprivation of liberty safeguarding (DoLs) referral made. For people who are deprived of their liberty in some way, such as restrictions to keep them in bed for their safety, DoLS applications must be made.

All staff had received training in DoLS, however, most had a poor understanding of what this meant. Staff also told inspectors that even when a person had had not been placed on a DoLS, they probably would not let them leave the home alone as they would be worried for their safety. One person was due to return from a stay in hospital after sustaining injuries from a fall from bed. Despite the lack of assessment prior to the return of that person's needs, discussion with that person, and the person previously having capacity to make decisions, the manager was completing a deprivation of liberty referral to place bedrails on the persons bed. They had not considered carrying out a new risk assessment, or looked at less restrictive methods of reducing the potential risks of falls.

Each external door and floor of the home was locked, accessible by the use of a key code access. The provider had not considered this was a restriction on people's liberty and whether people had capacity to make decisions. The number to use to open the doors or lift were not displayed so people who had capacity, could open the doors. Staff told us that people would ring their room buzzers if they needed to get out and saw that staff responded very quickly to room buzzers. However, two people with capacity were restricted to a hall area with two rooms and a toilet by a key code entrance system. Staff told us that the person did not like to use their buzzer and had unplugged it. However, this was not true. We plugged the buzzer in and found that it did not work.

There was no evidence of checking buzzers were working. Staff told us the person without a buzzer would wake up another person in the next room if they needed to use the buzzer and summon staff. However, this would be unsettling for that person during the night for example, when they were asleep, and staff had not considered the risk of the person without the buzzer falling, and injuring them and being unable to get assistance from the other person. Staff told us at night this risk was mitigated by staff carrying our hourly walk rounds to check on people. There were no systems in place for the manager to assure that these nightly checks took place. Both the local authority and CQC raised concerns and requested this be addressed immediately, however, it was not and consequently the service had continued to deprive the people of their liberty.

At the time of inspection the provider was not recruiting staff and had a full staff complement. However, some staff had multiple roles within the service. For example, the maintenance person was also a carer, and part time cook. The acting manager was also a part time cook and a member of care staff. Other staff providing care also undertook cleaning duties. The service did not use any agency staff and covered shifts amongst themselves. On the day of inspection, a member of staff had phoned in sick and they had been able to cover the shift.

Medicines management was poor. Whilst medicine recording sheets (MARS) were easy for staff to understand and read, and included photos of some of the medications to support staff, the registered manager and acting manager had not any audits to monitor for medication errors. We found that there were missed signatures on medicine charts so staff could not be certain that medicines had been always given.

Medicines were stored in a locked cupboard in the manager's office. However, the medicines room as very warm and there was no temperature monitoring where medicines were kept. This is essential to preserve medicines safety.

There was no PRN (as required) medicines policy, and staff working permanent night duties did not have training to administer medication. Therefore, if a person prescribed pain relief as required needed this at night, staff would not be able to administer it. However, staff working during the day did receive medicine management training and were observed by senior staff at regular intervals to ensure that they were safe and whether they required additional training. This was good practice and in line with the service medicines

policy.

People did not have personal emergency evacuation plan (PEEP) in place. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

Poor infection control systems were in place. We found that the service cleaned all commode pots in bleach in a communal bath. A carer informed us that this bathroom was not used for people at the service, however there had been no consideration about cross infection and health and hygiene.

The lack of processes in place to safeguard people's best interests at the home constituted a breach in Regulation 12, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

There were no effective systems in place to monitor the cleanliness and maintenance of the environment. We observed a number of safety issues when inspecting the home. These included a nail sticking out of the floor causing a potential risk hazard, old tape peeling from a stair lift with potential to catch on people's clothing, carpets coming away from joins causing a trip hazard, a bedroom door which slammed shut due to lack of door restraint (potentially causing risk of pushing someone over, or trapping someone trying to leave the room, or trapping someone's fingers).

We spoke to the manager about this, and they have now repaired this door. We also saw broken towel rails, broken clinical waste bin, wardrobes not secured to walls and being of flimsy quality with backs coming away, some with large items kept on top which presented risk of falling on people and endangering lives and bedrail covers that were old and worn, and could present as an infection control risk.

We inspected the kitchen and found that it was not maintained to a clean standard. For example, a hot plate used to warm people's plates had a centimetre of old grime and food directly under the plate racks. We found out of date yogurts that had been received with short shelf life but still placed in the fridge for consumption. The food store cupboard had a dirty floor, with food and grime debris and shelves that stored tins were heavily soiled with grime. Fridges were dirty, inside and out, and staff did not label food. All of these things were contrary to the provider's food and safety hygiene policy.

A cleaning rota for the kitchen was stuck to a cupboard door, but there were no checks or audits in place to evidence that these had been carried out, and by whom, to ensure that individual staff members were held accountable. Inspectors requested that staff immediately address the cleanliness of the kitchen and due to concerns regarding the poor state and cleanliness of the kitchen; inspectors had to request that environmental health officers attend to ascertain if there were any immediate concerns for safety of people at the service. Whilst immediate concerns for people's health were not identified, environmental health inspectors advised the service that they needed to have a proper rotation of foods and cleaning of the kitchen.

We could not find regular Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) checks for the lift, the stair lift and other lifting equipment. The a full body lifting hoist check was out of date, and PAT tests on all electrical equipment were out of date. There were no audits in place to inform staff when the checks would need to be carried out, by whom and when they were coming. This meant that people were potential at risk of using equipment that was not quality assured to be safe. We spoke to one of the providers during the second day of inspection and they arranged for these checks to be carried out the flowing day.

There was a lift at the service used to support people unable to use the stairs or stair lift to their bedrooms. Staff told us this had broken down in the past but they could access support to get it fixed within a short space of time and in the meantime, they would use stair lifts to manage people's needs. The acting manager told us these checks had been done and were up to date and there was paperwork to evidence this, however this evidence was not provided.

We carried out a further unannounced visit on the 10 November neither the provider nor acting manager could demonstrate these essential checks had been undertaken and could not tell us who carried out these checks. We found old LOLER checks dating back to 2014 but these were significantly out of date. We requested the checks were completed immediately and professionals were booked in to come and carry out the checks. We informed the acting manager that they should send us evidence that these had been completed, but we did not receive this information. We received an action plan on the 16 November detailing that the checks had been completed, however, on meeting with the provider also on the 16 November, we found that there had been a delay in carrying out some of the checks, which had been misreported in the action plan.

People did not have fire escape plans in their risk assessments that might include use of the lift during a potential fire. This lack of foresight placed people at potential risk. Fire extinguishers were available throughout the building and we saw that these had regularly been checked.

The lack of oversight of the cleanliness and maintenance of the environment and equipment was a breach in Regulation 15, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014, Premises and Equipment.

Recruitment processes were not always robust. For example, a staff member who had been identified as having a criminal history through safety checks carried out at the disbarring service, did not have appropriate risk management plans in place to ensure that people were safe. The providers did not assure themselves that people were appropriately safeguarded. Following the inspection the local authority held a strategy meeting with the provider, the local authority, CQC and other professionals to discuss how the service would safely move forward.

The providers had not adequately considered the potential suitability of candidate's they proposed to put in place to improve the running of the home. They gave assurances that the acting manager, who was also working as a cook at the service, would be focusing on the manager role and driving improvements. However, on return to the service two weeks later, we found that the acting manager had been cooking for half of their time spent at the service.

The provider had informed us that a consultant had been retained to support the manager to drive up standards at the home. However, the consultant did not attend the home until two weeks later, having contact only by phone and email before this time. The provider told us they were employing other people to the service, however, we discovered that at least one of these people was already suspended from a management role at another service pending investigation.

Disciplinary procedures were not robust. The provider had suspended a member of staff pending an investigation being carried out following a safeguarding concern. However there had been a lack of firm instruction to the member of staff in relation to their suspension, this meant the staff member was still contacting the home and receiving mail related to the home. This was highlighted to the provider by the local authority who only then took action to ensure this member of staff had no input into the home until the investigation was completed.

When staff were acting up into managerial roles, they were not given appropriate guidance and support to meet requirements of the role. Staff did not have support or risk assessments to manage and support them with on-going health needs that might affect their ability to carry out their duties.

The providers did not have procedures for on-going monitoring of staff to make sure they remain able to meet the requirements, and arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.

This was a breach of Regulation 19 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014; Fit and Proper Persons Employed.

Inadequate

Is the service effective?

Our findings

We found that the service was not effective. Supervision records in staff files demonstrated that staff received regular training and supervision. The manager carried out supervision every two to three months and staff received a yearly appraisal to ascertain their training needs for the following year. We could see that the supervisions asked staff how they felt within their role and the responses were positive. However, they were not robust.

They did not use evidence of staff performance to highlight staff could improve or new policy and procedures and staffs role within these. One of the providers carried out the supervision of the manager and the deputy manager, but we could not be confident that these supervisions were affective, due to the significant deterioration of the service since January 2014. The provider told us the registered manager was excellent and they relied on them heavily for the running of the service. The lack of quality assurance checks and lack of provider oversight meant that concerns about the management of the service had not been picked up.

Staff received regular training from external companies that in addition to mandatory training included basic first aid skills. Staff told us that training was good and one member of staff said, "The place is very good with training, they do a lot. It is organised into two sessions AM and PM so all staff can attend." However, certificates in staff files did not correspond to the training matrix available that recorded when staff had received training. Certificates did however demonstrate that in staff files reviewed most of the staff training was in date.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was not always following the MCA code of practice.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that the management team carried out MCA assessments to consider people's ability to make day-to-day decisions. The registered manager demonstrated that they understood the processes to be followed to assess people's capacity.

Mental capacity assessments covered a whole range of questions, whereas they should be used for just one decision. When capacity was lacking the responses of how to support the person within an activity they lacked capacity for, (such as taking medication or receiving personal care), did not transfer into care plan interventions for staff to action. However, we did observe staff asking people if they needed to the toilet, and whether they need support to eat their meals. Capacity assessments were reviewed every six months but evidence of review and actions to take were not demonstrated.

People residing at the service varied in their ability to be able to consent to care provided. Some people had dementia type conditions and consequently for some activities lacked mental capacity to consent. All staff had received training in the Mental Capacity Act, however, there was little written evidence that consent was gained from people appropriately. We reviewed care records and found staff were recording "Consent gained" as a stand-alone statement in people's daily records. This statement did not specify what the person had consented to or whether they had the ability to consent.

People that lived at the service varied in their ability to consent to care as some people lived with dementia. We observed a person with a chest infection had requested a cigarette. Staff wanted to refuse this; however, they had previously considered this person to have full capacity to make decisions themselves. When they did eventually sit and talk to the person, they found that they were hallucinating and at that time did not have capacity, however they did not consider why that person was hallucinating. Although the person had been seen on two occasions by their GP and was on a second course of antibiotic's, staff had not taken the persons temperature or monitored their physical health within care notes, even when they had been unwell and kept to their bedroom for over two weeks.

We saw that when people lacked capacity to manage their finances, the service did not always demonstrate that the person was supported in their best interests, for example, the service had not requested support from external advocacy services when a person did not have a next of kin or power of attorney in place.

Diet and fluid charts whilst completed did not always correspond to what people had actually consumed. The overall dining experience was poor. Few people used the dining room on the day of inspection. It housed a hoist and chair scales, along with boxes stacked up on top of each other with puzzles and games. Equipment was dusty and dirty. Plastic flowers were present in the room, and where they might have once been attractive, and bright, these were caked in dust. People were not encouraged to use the dining room so instead remained in their lounge seats where they had sat all day, with small tables in front of them. These tables were observed to be dirty with old food.

There was no choice of food on display and people told us, "We get what we are given," "I never get offered a choice but the food is okay," and, "No, I never know what is for lunch and tea." There was no information in care plans or the kitchen detailing what people really liked to eat, so for those that were unable to verbally communicate their choice of food and drink, staff made decisions for them.

On our return the provider had sourced a small blackboard for the lounge area for staff to write the meal options, but we observed that there was only one option available during lunch and that the writing was so small people would have trouble seeing it. All people at the service had received a large English breakfast for their lunch. One person was in their bedroom unwell and was heard being chastised by staff for not eating. However, they had not considered that this person might require an alternative choice due to feeling unwell. There was no care plan intervention to support them whilst unwell.

Evidence in one person's care records demonstrated that a dietician referral had been made as they had lost weight, but this was not always the case. For one person we found that along with a rapid decline in mobility, they had also lost nine pounds in the space of one month. The acting manager told us they had tried to access GP services but this had proved difficult due to a new triage system. They told us that the practice nurse had been to see the person in the home, care plans and risk assessments did not reflect the changes in needs.

On the first day of inspection we observed that throughout the day people were offered drinks at regular occasions, and people told us that they were never short of food and drink and could ask for snacks when

they liked. Jugs of juice were available on tables. One person said, "I'm a big eater and the porridge is lovely. We have a big lunch and a nice dinner, then in the evening, you have tea and then later they make you a sandwich if you want one. We don't go short of grub here!" However, on the second day of an unannounced lunchtime inspection, we found no jugs available in communal areas. People in their rooms did not have jugs placed near them. Fluid charts that should have been with people in their bedrooms for staff to complete were also not there. We could not be confident that people were receiving enough fluid throughout the day.

Lack of effective monitoring of people's needs, visible and enabling choice, and involvement of health professionals to managing people with high risk of choking and malnutrition was a breach in Regulation 14 (1) of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014, Fluid and Nutrition.

External professionals did not always receive referrals from the home to support people with complex needs. We reviewed care files that demonstrated that people had repeatedly fallen, but there had been no referrals to the falls prevention team. There were no systems in place to chase up referrals when these were made such as repair of people's hearing aids, without which left people unnecessary isolated from the environment.

A communication book, which also acted as a handover book, contained no information about people and how they had presented during the day, or whether referrals needed to be made or chased up. We did see that some people would have hospital appointments for various existing health problems, but there was lack of referral for problems that developed whilst in the home.

Requires Improvement

Is the service caring?

Our findings

We found that the service was not always caring. Communal linen, duvets, and towels were in places stained and in poor condition. Staff told us they would not be happy to use these themselves but they were used for people at the service. There were no systems in place to rotate and replace linen that was in poor condition. This demonstrated a lack of dignity and respect for people at the service.

The downstairs communal toilet / shower room was in a poor state of cleanliness and repair. A commode seat was over the toilet to provide people with an armrest. It was covered in old dust build up and talcum powder and staff told us that people would have a wash on the toilet in the room. We saw from the clinical waste bin that people used the toilet frequently, and staff confirmed this. Staff agreed that the toilet was in a poor state of cleanliness and that they themselves would not use it.

Beds looked well made up on initial inspection, however on removing bed sheets we found that bottom sheets were dirty, looked heavily used, had debris, dried skin. We found faeces on one person's bedrails. Staff told us people's bed sheets were changed once a week on their shower day, unless a person had been incontinent.

In the last two years we found evidence of only three community meetings were people at the service had been invited to discuss the service. There had been a recent meeting at the time of the first inspection visit. One person said, "I found out afterwards that they had had a meeting, they didn't ask as I say what I think." There was no evidence that these meetings led to improvements at the service, or that actions arising from the meetings were taken seriously.

Some people did sign their care plans, but the plans did not reflect people's needs and people we spoke to did not know what was in their plan of care. If people lacked the ability to discuss their care needs, or sign their care plan to say it had been explained, then staff simply wrote 'unable to sign'. There was no evidence that staff would seek out relative views on the plan of care and match this to the person's preferences and individual needs. There was no advocacy involvement or information available for people to know what their rights were and what support they could access.

One person at the service told us that they wanted to take part in a variety of things, from accessing the local community to making decisions about their care needs, such as when to have a shower. However, staff were unable to facilitate this. They told us that whilst staff were not unkind, they did not offer choice and variety to meet people's preference's.

For those people who were less able to communicate we observed that they had very limited interaction with staff and who spent much of their day sitting in a chair in the lounge without any engagement other than support to eat or drink. There was no information for staff about what people had liked to do in the past so they could engage with them. The lack of information resulted in interactions being task oriented rather than person centred and consequently interaction lacked the proper respect for individuals.

This lack of thought and attention to basic care and use of toilets and linen that staff would not like to use themselves was a breach in Regulation 10, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014Dignity and respect.

We observed some caring interactions between staff and people at the service. We observed a staff member supporting the member of staff administering medication to a person who did not seem to want to take their medicines. The carer was kind, thoughtful and informed the person of their right to refuse. However, as the person was at risk of choking and on a pureed diet, staff had not considered whether the person had refused their tablets because it was too uncomfortable to swallow or investigated alternatives such as dissolvable or liquid medicines.

People told us that staff were caring. For example, one person said, "The staff here are the nicest people, and they are very helpful." Another told us, "I've never heard the staff arguing at all they seem to get along with each other really well they're very busy." Staff were able to tell us the background history of people at the service and we did observe that staff engaged people in conversations.

We carried out a Short Observational Framework for Inspection (SOFI) which is an observational tool used to collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. We found that all interactions from staff were caring however, there was little meaningful engagement for people who were less able to vocalise their needs and interactions were mainly around offering people drinks.

When people were unable to drink fluid independently, we observed staff speaking softly to them, explaining what they were doing. For those people more able to engage in conversations interactions were more meaningful. In this situation, engagement was positive, warm, funny, respectful, and adult-to-adult. However, we did observe some people who were less able to communicate going without human contact for lengthy periods.

Inadequate

Is the service responsive?

Our findings

Care plans reviewed did not reflect people's actually needs and risks, or personal preferences. We did see that some people had signed their care plan, but there was no record of how they had been involved or if family had been involved. Most interventions were the same in all care plans with an adaptation of each person's name. Due to the lack of individuality in these plans, we were not confident that people had been appropriately involved in devising a care plan that would support them appropriately. People with physical difficulties did not always have their needs appropriately assessed and met. One person had had to obtain their own equipment, as staff had not noticed what they could do to improve the quality of that person's life. One person told us, "The problem here is that they're not set up to look after disabled people."

The lack of person centred care planning and interventions identified on the first visit was also found on the return visit. For example, for those whose risks and needs had changed, for example when their mobility had decreased or physical and mental health had deteriorated. We requested this be immediately addressed and raised a safeguarding alert for two people at the service. However, on returning to meet with the providers on the 16 November, we found that changes had still not been made.

The provider had wanted to develop a robust and comprehensive care plan in response to the CQC concerns; however they had not considered the potential impact of this wait on people who were currently at risk at the service. The provider had begun to access agency staff to support people, without the correct information it would be difficult for them to know how to support people appropriately. During the second visit to the service, we found that that staff were moving people inappropriate using a bed sheet instead the correct manual handling equipment. This placed people at risk. Consequently, a lack of updated manual handling assessment and intervention's meant that people who needed this support would continue to be at risk. We have told the provider they must update those care plans of people that are at immediate risk.

Handover systems were inadequate and did not demonstrate that staff received appropriate information about people and their needs. The handover book was also the communication book, and did not inform staff about information that needed following up. One example was a person whose hearing aid had been broken for some months. As a consequence, the person was unable to fully participate in conversations and risked social isolation. The acting manager told us that they thought the issue had been in hand with the registered manager. However, this manager had been absent from duty one month prior to the inspection. There were no systems in place to make and chase up referrals. Staff had not considered the impact on the person wellbeing of not being able to hear.

Daily activity charts demonstrated poor levels of activity offered. For example, we observed that over a two month period one person's, activity was that they dozed in their chair in the lounge, sat in a chair in the lounge watching a film, had a shower, sat in a chair listening to music, visited by relatives. When we compared this to other activity plans for people, we found that lack of meaningful activity or opportunities for activity was a common theme. One person, who had capacity, told us, "What's wrong here is that they don't tell you about everyday things – we don't know what's going on with the world."

People told us they were bored. One person said," I don't like sitting around here, there's nothing to do; we all just sit here all day." Whilst another said, "I have to sit this side of the lounge, as I don't like to go over that side, as those people can't talk with you. It's a bit boring here really." We did observe some caring interactions between staff and people, but we also observed that many people did not have any engagement, interaction, or activity for long periods. Sometimes the only engagement people had, particularly those with dementia, was to be offered a drink.

The environment was not dementia friendly. We found two dementia friendly signs in the building on two toilets but no other signage. Bedroom doors and cupboard doors were all painted white and looked the same. Some bedrooms did not have numbers on, and when they were numbered these were not always correct. The member of staff showing us around became confused about the numbers of rooms. This potentially made it difficult if staff needed to respond to a person ringing their buzzer for assistance. Staff immediately rectified the lack of room numbers during the inspection. Only one bedroom door had a photo of a person to help guide them to their room. Staff told us other than this door, photos were not used to protect people's confidentiality. There had been no discussion with people or loved ones if they would find this helpful.

Staff told us that all 16 people living at the service preferred a shower once a week on a specific day. However, records kept demonstrated that people sometimes had a shower only once a month and were "strip washed" otherwise, even when "doubly incontinent" In some records, a shower had been recorded by crossing out the "strip wash "and we could not be sure of the accuracy of this record. We saw no evidence of people being given a choice in care records, even when care plans documented that people preferred a bath or shower. One person told us "I really want a shower every morning but I'm not allowed unless it's my allocated day." Staff told us, "People can have a shower everyday but it would have to be done by night staff." With two staff on duty at night, it would be unsafe as removing a member of staff to support with the shower would leave one member of staff supporting the remaining people at the service, some who required two people to mobilise to the toilet for example or to go to bed.

This lack of person centred care and lack of understanding of person-centred care meant that the service had breached Regulation 9, of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014Person centred care.

We did see some thank you cards and compliments displayed in the foyer at the home, but those that were dated were sometimes as old as 2009, others were not dated and we could not be certain of which time period people had been happy with their care.

There was no information about how to make complaints on display at the home, although people told us, "Yes, I will tell staff if I am unhappy with something." A relative told us, "I know that [relative] is safe here. I would know who to complain too."

A PAT (Pet as therapy) dog visited the home with his owner weekly and on the day of inspection, to the obvious delight of people at the service. There was little other external visitors or visiting professionals regularly visiting the home.

Inadequate

Is the service well-led?

Our findings

The registered provider of this service is a partnership consisting of three members. There is a registered manager of this service who is currently unable to fulfil her role and an acting manager is in place. Any registered person must comply with the requirements of all relevant legal requirements in the carrying on of the regulated activity, and so in these circumstances the registered provider must ensure the effective day to day management of the regulated activity they are registered to provide.

However, The acting manager had not been given guidance and support regarding their managerial responsibly under the regulations made under the Health and Social Care Act, 2008. Although there are three members of the registered partnership, only one partner is routinely available and we understand the other two members do not live locally. We interviewed the partners who usually take responsibility for the service about the day to day arrangements, and asked what the relevant legal requirements were and who was responsible for discharging them on a day to day basis. He had a poor understanding of these responsibilities. No other member of the partnership was available to comment on these matters, and we were told that the other partners do not take an active part in the running of the service. Consequently, there was no adequate managerial oversight of the service being delivered, and no system in place for ensuring the compliance and safety of the service being delivered.

We looked at the Governance systems in place at the service and found that there were no systems in place to identify environmental and equipment issues at the service. We observed as a result, incidents of poor maintenance of premises and equipment, disrepair of premises and equipment, trip hazards and poor cleanliness, and saw that these had not been formally identified. No action plans were in place to make improvements. Staff told us of environmental issues within the service, but also told us that they had not acted upon these concerns.

Audits to monitor the quality and accuracy of care plans, risk assessments, medicines management, and care records were not in place. Reviews of every care plan and risk assessment reviewed stated, "No changes." Had appropriate systems been in place the service would have identified that these plans did not represent people's current needs and that they were not person centred. The lack of quality monitoring meant that reviews of people's care had become a documentation exercise of just insuring the right date was recorded rather than the right care provided.

Lack of monitoring of falls, urinary tract infections, incidents and accidents, and pressure ulcers meant that the manager and provider had not identified areas of improvements. Consequently, due to the lack of other robust procedures in place, the failings found in other areas of the service, we could not be confident that there was sufficient processes in place including external scrutiny to ensure openness and transparency at the service about mistakes made. There was no appropriate processes to ascertain people's views and acting upon these. The provider could not demonstrate that they learned from incidents and complaints to continually review the service provided.

Lack of robust governance systems in place, meant that people were potentially placed at risk. This was a

breach in Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance.

We identified during the second visit to the service that we had not received an appropriate notification of someone who had fallen and sustained an injury and stay in hospital. We had previously highlighted what we needed to be notified for this during the first visit to the service on the 25th October. We had also not received a death notification of someone who had been receiving end of life care.

The poor knowledge of and lack of notifications was a breach in regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notifications.

Staff reported that they had enjoyed working under the registered manager who was supportive to them. They could not understand why the manager was absent from duty, but were confident they would return. Staff told us, "The manager is really supportive; we are like a happy family here." Staff said they got on well with the acting manager who had previously been a senior carer and activity coordinator at the home and they were doing a good job in running the service.

However, the acting manager had not been given any training or information about their role and responsibility to notify the Care Quality Commission of certain reportable events, such as granted DoLS, unexpected and expected deaths, injuries, and safeguarding incidents. When we looked back at previous notifications we found that the previous registered manager had only notified us of expected deaths at the service, but incidents and granted DoLS had taken place during a two-year period from the previous inspection, which had not been alerted, to CQC. The inspector provided the acting manager with information of how to report these appropriately.

Staff knew whistle blowing procedures but reported that they would sort out any concerns amongst themselves to ensure the safety of people. Staff had close friendships and some were related to each other. This potentially raised conflict of interest and could prevent staff from speaking out if they had concerns. The provider had not recognised this and consequently had not put in place systems to manage this risk.

Residents' meetings did take place, but one person who did not lack capacity told us, "I say what I think but I didn't know about the last residents' meeting, nobody told me, so I didn't go." There was no evidence that concerns from meetings and action points were fed back to people at the service.

The service had carried out satisfaction surveys but had not done anything with the information. No actions plans were in place and people had not had any feedback from service about the results.

The provider had no oversight of how the service was being run and did not identify risks to people living at the service. This lack of oversight is a breach in Regulation 4 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014, which requires that when the registered provider is a partnership, as is the case here, each member of that partnership must be of good character and able to perform their particular function in the way the regulated activity is delivered. This means that the partnership as a whole must be able to ensure that the service is effectively managed

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans and risk assessments were not person centred and did not reflect changes in people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not reflect on the suitability of their care interventions and equipment used in regards to people's privacy and dignity. Staff told us they would not use some of the facilities due to them being dirty and soiled, yet continued to use them for people at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no systems in place to effectively monitor the safety of care provided. The service did not utilise other health professionals and advice in a way that would support people to be cared for safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always have a choice of food, and those with special dietary requirements did not have their needs assessed by appropriate

health and social professionals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were no systems in place quality assure the service offered to people. No one at the service had proper management oversight of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place quality assure the service offered to people. No one at the service had proper management oversight of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems in place to ensure the suitability of staff were not robust. When risks were identified risk plans were not in place to safeguard people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider had no oversight of how the service was being run and did not identify risks to people living at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no systems in place to effectively monitor the safety of care provided. The service did not utilise other health professionals and advice in a way that would support people to be cared for safely.

The enforcement action we took:

Restriction on admissions to the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not safely monitored and maintained. There were no systems in place to monitor and assess the safety of the environment and identify when improvements needed to be made.

The enforcement action we took:

Restrictions on admissions to the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider had no oversight of the service and heavily relied on a registered manager.There were no governance systems in place to assure the providers that people at the service were being cared for safely. The registered manager had previous criminal convictions which were highlighted to the providers, however they had not taken action to mitigate potential risks. A care worker was placed in the role of acting manager without appropriate support and guidance.

The enforcement action we took:

Issued a section 64 letter requesitng additional information.