Bupa Care Homes (CFHCare) Limited

Chilton Meadows Residential and Nursing Home

Inspection report

Union Road
Onehouse
Stowmarket
Suffolk
IP14 1HL

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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

Chilton Meadows Residential and Nursing Home provides care and support to a maximum of 120 older people, some of whom were living with dementia and/or had complex nursing needs. People were accommodated across four 'houses' called Beech House, Munning's House, Gainsborough House and Constable House. At the time of our visit there were 109 people using the service.

The inspection was unannounced and took place over two days, on the 4th and 5th May 2016.

The home had a registered manager in place. 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 requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

We identified significant shortfalls in the care provided to people across all four houses at the service. This was linked to a lack of oversight from the registered manager and provider.

Relatives and people using the service raised concerns with us about their safety. People were put at the risk of significant harm in the absence of clear records and assessments which reflected all current areas of risk and how these should be managed to protect the person from harm. We observed that staff were not proactive in reducing the risks to people. , The service did not support people to have input from other health professionals such as GP's or dieticians where this would have been appropriate.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). All staff were unable to demonstrate that people were appropriately supported when they were unable to make choices about their lives. Potential restrictions on people's freedom and movement were not assessed and formal best interest processes were not followed.

People were not supported to eat and drink sufficient amounts to maintain good hydration and nutrition.

People were not supported to live full, active lives and to engage in meaningful activity within the service. We observed that people were socially isolated and disengaged from their surroundings. People told us there was little to occupy them, that they were bored, and that the activity that was offered by staff was not always appropriate to their needs. This had not been independently identified by the service so no action had been taken by the registered manager to address this.

People's care plans and assessments were generic and not person centred. Care planning did not include enough information about people's past lives and experiences for staff to understand them. People and their representatives were not consistently involved in the planning of their care, and their views were not reflected in their care records.

People told us and we observed that there were not enough suitably trained and experienced staff available to meet people's social, emotional and physical needs. Staff told us they struggled to meet people's requests for support. Staffing levels were not calculated by the management based on the needs of people using the service and there was no system in place to monitor the effectiveness of the staffing numbers.

People told us staff did not always behave in an appropriate way when supporting them. Staff were not consistently supported to develop their skills within the caring role. There was no system in place to assess staff competency and performance. Supervision of staff was not carried out consistently. Where areas for improvement had been identified, there were no plans in place to support the staff member to improve or to monitor their performance to ensure people received safe and appropriate care.

Staff recruitment was not always conducted in such a way that ensured prospective staff had the skills, background, experience and knowledge for the role.

Systems in place to monitor the quality of the service were ineffective in identifying shortfalls and areas for improvement. Audits and inspections carried out by senior staff did not identify the serious shortfalls we identified during our visit. There was not an open culture within the service. Staff told us they did not feel listened to by the registered manager and there was confusion among staff as to whom they should report concerns about people to.

People told us they knew how to make complaints but they felt it would not be taken seriously. One person said they had made negative comments about the food on several occasions but said the staff laughed and nothing was done.

Throughout the two inspection visits we identified such serious concerns that we fed these back to the registered manager so action could be taken to protect people from harm. In addition, we shared information about the concerns we identified with the local council's safeguarding team and local commissioners. Following the inspection, we wrote to the provider to request information about how they intended to make the urgent improvements required to protect people from the risk of coming to significant harm. We also took urgent action to stop this service from admitting anyone new by amending their conditions of registration. In addition, we placed further conditions on the registration of this service to ensure that immediate improvements were made to safeguard people.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not identified, planned for and managed appropriately. Staff were not proactive in protecting people from risks.

There were not enough staff available to meet people's needs.

Staff recruitment practices did not always ensure that the staff employed were suitable for the role.

Is the service effective?

Inadequate

The service was not effective.

The service was not complying with legislation around the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People were not supported to maintain healthy nutrition and hydration.

Staff received training to carry out their role, but action was not taken where competency issues or required improvements were identified.

Care staff and nurses did not consistently receive appropriate supervision and appraisal in their role.

People were not supported to have input from other health professionals where this would have been appropriate.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always treat people in a caring and compassionate manner.

Staff were observed to ignore people's requests for their attention, so positive relationships were not always formed

between people using the service and the staff supporting them.

Staff did not always uphold the dignity and respect of people using the service.

A culture of kindness and compassion was not promoted by the service. Poor practice was not addressed by unit managers.

Is the service responsive?

Inadequate

The service was not responsive.

People were disengaged, bored and did not have access to appropriate stimulation and activity.

People and their representatives were not involved in the planning of their care.

People's care records were not person centred, and did not reflect people's preferences, interests or past experiences.

People had the opportunity to feed back their views at meetings and knew how to complain about the service. However, people told us that their views were not always acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance system in place was ineffective in identifying serious shortfalls which led to people receiving poor care.

There was not an open, transparent and inclusive culture in the service.

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

This inspection took place on over two days on the 4th and 5th May 2016 and was unannounced. The inspection team was made up of three inspectors, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with 24 people who used the service, 11 members of care staff, the registered manager, the deputy manager, the unit managers and the area director. We looked at the care records for 23 people, including their care plans and risk assessments. We looked at staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they did not always feel safe in the service. One person said, "Sometimes I feel safe but sometimes I call and no one comes and I get a bit fearful." A relative for one person told us, "I'm forever waiting for a phone call saying something has happened to [relative]. I can never relax, I don't trust them to keep [relative] safe." A relative for another person said, "I wish [relative] didn't have to be here. They've fallen a few times and I'm just waiting for the day when something serious happens. I don't know what the staff are doing."

There were ineffective plans in place to reduce risks which had been identified by the service and this put people at risk of harm. In the months prior to our inspection we identified that several people across all four houses had fallen repeatedly but little or no action had been taken to minimise these risks. In Gainsborough House, 110 falls had been recorded between November 2015 and March 2016. No action had been taken to consider how these falls could be minimised or to engage the support of the falls intervention team to assess whether there was any practical action that could be taken to reduce the frequency of falls. We identified that one person had fallen 13 times in eight weeks. These falls had been identified by the service and plans had been put in place to minimise the risk of falls. However, no action was taken to reconsider these plans when the person continued to have falls and these measures proved to be ineffective in reducing the risk. The person was not protected from the risks associated with falls and incurred a potentially avoidable serious injury that required hospitalisation as a result of their last fall. Staff told us that they had raised concerns with the management about the measures in place to minimise the risk to this person being ineffective. They said that they had shared with the management team that they felt they were unable to meet the person's needs, but said that this was not acted on. The registered manager told us that following the person's admission to hospital, they were considering whether the person's needs could be better met in one of the other houses.

We identified that another person that had fallen repeatedly was on two medicines which can have adverse effects which may lead to an increase in falls. One of these medicines was prescribed as a 'when required' (PRN) medicine, but we noted that staff were administering this to the person on an almost daily basis. No action had been taken by the service to have the person's medicines reviewed by their GP with regard to reducing their potential impact on the person's risk of falling. We fed this back to the registered manager during our inspection. Following the inspection the manager informed us that the person's medicines had been reviewed and reduced by their GP.

We found that some mobility aids had not had the appropriate maintenance to ensure they were safe for use. For example, the rubber feet (ferrules) on some zimmer frames were heavily worn which meant there was a risk of the frame slipping and potential for the user to fall as a result. The registered manager told us they didn't have a system in place to check these and was not sure whose responsibility this was.

Our observations confirmed that staff were not proactive in reducing the risk to people. For example, we observed that there was a volatile relationship between two people using the service. Despite this, we observed staff seating these people next to each other on several occasions. On one of these occasions, an

altercation occurred between the two people which resulted in one of them being assaulted and becoming distressed. On this occasion, staff did not take action to move the people away from each other after the altercation, which meant there was a risk of it reoccurring. We spoke to staff who said that these people often had altercations, but they could not explain how they were managing this. Records confirmed that previous incidents had resulted in one of the people being harmed, but there were no recorded plans in place to protect this person from harm or manage the behaviours of these people.

Records confirmed that action was not taken by staff to carry out neurological observations of people who had fallen and hit their head. Staff told us they did not carry out these observations and did not have an understanding of why this was necessary. This meant that people were not monitored by staff to ensure there were no serious adverse effects arising from their fall which may require medical intervention. Action was not always taken by staff to promptly identify where people had incurred other physical injuries which required medical intervention. For example, following one person's fall appropriate action was not taken by staff which resulted in the person not receiving treatment for a fracture for seven days.

Records confirmed that people's levels of pain were not being assessed by the service to identify the pain relief the person required. One person told us they had been in pain for several days but staff had not responded to their needs. They told us, "I rang my buzzer last night because I was in so much pain. They wouldn't give me anymore pain relief. I asked that they call the out of hours GP but they wouldn't. They said they weren't going to call him just because I was in pain and that I would have to wait for the next medication round in four hours. I was literally banging my fists against the wall." Staff had noted in the person's records that they had repeatedly been complaining of pain, however, they had not escalated this to senior staff or requested medical input from a doctor. This person was dependent on staff to relieve their pain and distress. The inaction of staff led to this person remaining in pain for an extended period of time which reduced their quality of life. We were so concerned about this person's welfare that we raised concerns about them with the registered manager. Following the inspection the registered manager confirmed a pain assessment had been implemented for this person but had not contacted the person's GP to review the effectiveness of their prescribed pain medicines.

People were placed at serious risk of skin breakdown because this risk was not planned for and clear management plans to minimise the risk were not in place. For example, we reviewed 13 care plans across all four houses where the person had been assessed as at 'very high risk' of developing a pressure ulcer. For these 13 people there was no clear, concise management plan in place to instruct staff on how to maintain the person's skin integrity. These people were dependent on staff to support them to minimise this risk. Where care planning did state people required repositioning, all these care plans stated this needed to be once every three hours, and the differing repositioning needs of individuals was not calculated based on their risk. There was confusion among staff about who needed repositioning and who didn't. Some staff referred us to a document with a list of people on it who needed repositioning, but this did not include all the people whose care plan stated they required this.

The unit manager in one house told us one person was not at risk of developing a pressure ulcer, despite their assessment stating they had been at 'very high risk' since July 2015. Some people identified as at risk did not have pressure relieving equipment such as mattresses in place to reduce the risk. There was a lack of oversight of these risks which put people at risk of skin breakdown and of not having their needs met in a way which ensured their health, safety and welfare. We fed these concerns back to the management of the service and following our inspection we were informed that they had ordered eight new pressure relieving mattresses for people who required them.

We identified that the care records in Beech House were illegible. We asked staff to read several care plans

to us, and they were unable to, telling us "We can't read [staff member's] handwriting." Four people had been admitted to the service in the month prior to our inspection, but their care records remained incomplete and inconsistent. This meant that staff did not have access to the information they required to provide people with safe, effective care that met their needs and protected them from harm.

People's medicines were administered safely. However, prescribed medicines such as topical creams or pain relieving gels were not stored securely in people's bedrooms. We observed other toiletries such as denture cleansing tablets and nail polish remover unsecured in people's bedrooms. These substances can pose a potential risk to people living with dementia if ingested in error.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

We were so concerned in relation to the staff, manager and provider's lack of recognition of matters that affected the safety and wellbeing of people using the service that we made several safeguarding alerts to Suffolk County Council's safeguarding team. They subsequently investigated and have taken action to work with the provider to improve. The showed that there was a systematic failing within the service to understand and action procedures to safeguard people using the service from abuse or risk of abuse.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2010 (Regulated Activities) regulations 2014.

People living in all four houses were put at risk of harm because there were not enough staff to meet their needs safely and to provide support when they needed it.
People and their relatives told us there were not enough staff available to meet their needs. One person told us, "Sometimes I have to go to the toilet and I have waited quite a while." Several people complained that staff did not help them to get up until late morning and said that this was not their preference. We observed one person being brought into the living area at 10:45am in Beech House. We asked the person if they had a lie in and they said, "Well I did, but I didn't ask for one." The person said they liked to get up early, about 8am. They told us, "I have to wait for them to get me up. I never get up when I want to. They come for me when they're ready. Trouble is, I'll have my breakfast now and then at 12 they will bring my lunch and I won't be hungry. On Sunday they didn't get me up until 11:15 and then I didn't eat my lunch." We spoke to another person who we observed to be in bed at 11am and calling out wanting to get up. When we asked what time they liked to get up, they told us, "7am, but no one comes for me."

We observed that there were many people in bed all day in Beech House. We spoke with the unit manager about this who confirmed two people needed to be cared for in bed but could not tell us why other people were in bed. We spoke with a staff member who commented, "One side [of the house] we get up Monday, Wednesday and Friday. The other side we get up Tuesday, Thursday, Saturday." This was confirmed by our observations and meant that people did not have their right of choice upheld. Similarly, in Constable and Munning's House we observed that many people remained in bed all day with no rationale for this. Staff we spoke with told us they were not able to get everyone out of bed each day due to the low staffing numbers. The nurse in charge of one house told us they had to rely on the care staff to provide the care to people that they should be delivering, because they did not have time to provide direct care. We approached a member of care staff to inform them one person was shouting that they wished to get up, the member of staff said, "Yes I know, so does everyone else. I can't do no more, I'm trying my best but there's only so much time."

Relatives raised concerns about the staffing numbers, one said, "You barely see any staff. You ring the call bell and they turn it off without actually coming to see if you need help. They're meant to check on them

every hour but I've been here several hours and seen no one." Another commented, "The staffing level here is disgusting." Another relative told us, "I worry endlessly about what happens when I'm not here. I doubt [relative] gets much attention or help from staff. Sometimes I come in and the sheets are dirty so I change them myself, or they need a wash so I do that too. It's supposed to be their job isn't it?" Another relative commented, "There are never enough staff around."

We observed that as a result of the low staffing level, care provided to people was task focused and interaction people was only initiated when they needed support with a task. For example, they needed to visit the toilet or support with their meal. One person told us, "They can't stop long, they haven't got time." In between these times, we observed that people were disengaged and under stimulated. Whilst there was a member of activities staff in each house, they were unable to support everyone to engage in activity and other staff could not support them with this because they were busy completing basic care tasks. When we spoke with care staff about the time they have to interact with people or engage them in activity they said, "We don't have time for that. We barely have time for getting people to the toilet or changing their incontinence pads, let alone anything else." One person said, "No they don't really have time for [chat], they are short staffed here anyway."

We observed that there were not enough staff to ensure timely and appropriate help was given to support people during meal times. For example, the number of people remaining in bed meant that these people needed to be supported to eat in their bedroom which took staff away from the main dining area. We observed that this meant people who needed support to eat did not receive this support when they needed it. People in their bedrooms waited an extended period of time for their meals, and we noted several people who had been left with their meals but were unable to eat the meal independently. We observed staff remove these meals once they had gone cold without trying to prompt the person to eat. When we spoke with staff, one said "We can't get to everyone. Sometimes we are lucky and relatives come in and help. There is so many people who need help."

We spoke with the registered manager about how the staffing level was calculated for each house. They told us the staffing level was determined by the number of people living in each house, rather than being calculated according to the dependency of those people. Most of the people in three of the houses had a high dependency level and were dependent on staff to meet their basic needs but this had not been taken into account. Staff told us they had raised concerns about the staffing level but felt this had not been acted upon. We fed back our concerns to the registered manager at the end of our inspection, who had since told us they had put in place an extra member of care staff in each house. However, it is still unclear how the service is monitoring the effectiveness of the staffing level or reviewing how the staff are deployed.

Records confirmed that staff recruitment was not always done in a way which ensured prospective staff had the skills, character and knowledge for the role. For example, we reviewed the interview responses of several staff members employed by the service. We found that no response had been recorded for a question asked about their understanding of quality care. These staff members had been employed in the absence of a response to their question, which does not assure us that the service ensures staff are sufficiently experienced and qualified. This puts people at the potential risk of receiving inappropriate or unsafe care.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA.

People were put at risk of having their rights and liberties restricted unlawfully because the service was not following legislation around the MCA and DoLS. People told us, and we observed, that staff did not always ask for their consent before providing them with support. For example, we observed a staff member place a clothing protector over one person's head before their meal without first asking them. In addition, we observed people being moved in their wheelchairs without staff first speaking to them and asking their permission. At lunch time, we observed staff telling one person to move from the seat they were in and sit somewhere else. The person refused but the staff member insisted and began pulling the chair out whilst the person was still seated on it. The staff member then pointed to another seat and said, "Sit there." This did not promote this person's right to autonomy, independence and choice.

We observed that there were stair gates fitted to the bedroom doors of many people in all four houses. When we asked staff about these, they could not explain why they were in place. The care records for people did not evidence that this was their choice. Where people were assessed as not having capacity to make decisions, there was no evidence that a formal best interest process had been carried out with other appropriate agencies to decide if having a gate in place was in the person's best interests. Similarly, many people had bed rails in place but there was no evidence to support that consideration had been given to whether these constituted a restriction on people's movement. Other people were seated in tilted chairs from which they could not independently get out of, but there were no records to evidence why the person required this type of chair or how it had been assessed.

Many people's care records contained 'best interests care plans' which were inappropriate, because they indicated that it was lawful for staff to make decisions on behalf of the person if they were unable to make decisions themselves. Staff confirmed to us that it was their understanding they could do what they felt was necessary.

We discussed our concerns with the registered manager of the service who has since informed us that most of the stair gates fitted to people's bedroom doors have been removed, except where people had capacity to request them. They informed us that many of the bed rails had also been removed following our findings.

Staff from the Clinical Commissioning Group (CCG) and the Local Authority visited the service after our inspection and raised concerns about further instances of poor practice which did not comply with

legislation under the MCA and DoLS.

This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People were not supported to maintain healthy nutrition and hydration. Meal times were chaotic, and people were served their meals in an ad hoc manner. Meals were served and removed by different staff so there was no oversight of how much people had eaten. People were not given a choice of where they wished to eat, and many people ate in bed without having being given the option to get up for their meal.

We identified that action was not always taken to protect people from the risks of malnutrition or dehydration. Records confirmed that seven people had lost significant amounts of weight since admission to the service. There was no effective management plans in place to reduce the risk of these people continuing to lose weight and becoming malnourished. For three of these people, they had received input from a dietician who had provided advice to the service. However, these people continued to lose weight and the service had not identified that the measures put in place by the dietician were not effective and had not obtained further advice from the dietician. For example, one person's care records stated they had been discharged by the dietician in November 2015 because their weight had stabilised. However, they lost a further 6.4kg between January and May 2016 and this had not been identified by the service. Staff told us the person had been eating less but that a referral had not been made. This person was fully dependent on staff to meet their nutritional needs and ensure they were protected from risks associated with malnutrition.

Where people were identified as at risk of malnutrition, staff were not always recording the nutritional intake for these people. Records confirmed that recording of nutritional intake was inconsistent. When we requested these records for several people, it took the staff a great deal of time to locate the records for the week prior to our inspection. They were unable to provide some records as these could not be found, so it was unclear how these records could be analysed to identify where people were eating less or to identify patterns in people's eating. The unit manager told us that these records were not analysed and they relied on staff to feed back where people had refused their meals. This meant that they would be unable to identify early on where people were eating less and engage the support of other health professionals to protect them from becoming malnourished.

Records and observations confirmed that people were not offered extra food in between meals to boost their nutritional intake and reduce the risk of malnutrition. We observed one person living with dementia who repeatedly asked staff about their lunch. Staff did not offer the person a snack despite it being some time until the lunch time meal service. When the lunch was served, the person stood next to the trolley asking staff about their meal. They were encouraged to sit down by staff, but then waited until last to be served. We noted in this person's records that they were assessed as being at risk of malnutrition. This person could have benefitted from extra foods to boost their nutritional intake and reduce the risk of them becoming malnourished or losing weight.

People were not protected from the risks associated with dehydration. Our observations confirmed that people did not always have access to drinks because they were placed out of their reach or were not offered by staff. We observed that people who were in bed were most at risk, as they did not have drinks they could access independently and they had no access to a call bell to request staff support. These people were reliant on staff checking on them regularly to offer them a drink, but we observed that this did not always happen. People were not having their fluid intake monitored, which meant staff could not identify where someone was becoming dehydrated. When we spoke with staff, they could not tell us all the symptoms of dehydration or the risks associated with dehydration. The records for one person stated the dietician had

advised they required 2000ml fluid per day. The fluid intake for this person was not monitored so the service could not evidence they were receiving this. When we spoke with staff, they told us they were unaware of this requirement. The person had been prescribed subcutaneous fluids (delivered via a drip) to prevent dehydration on an 'as and when' (PRN) basis. There was no information about this in the person's care plan and when we asked staff about when they offered this, they said it was offered at the person's request. This person had been assessed as having no capacity to make decisions in their best interests, so it was unclear whether they would be able to request this independently when required.

People did not receive the support they required from staff to eat their meals. For example, we observed one person struggling to eat their meal independently in their bedroom. Their meal went cold and was removed by staff, and they were not brought any dessert. When we asked staff how much the person had eaten, they said they had eaten most of their meal when we observed they had eaten very little. The care records for this person stated they were at high risk of malnutrition and the lack of support from staff could lead to them becoming malnourished and underweight.

We observed poor practice when a staff member was supporting one person who needed full assistance to eat their meal. The staff member gave the person a few mouthfuls before leaving without saying anything and going to complete other tasks. We observed that the person was distressed during this time and tried to reach for their meal. The staff member returned five minutes later and continued to help the person with their meal.

Relatives raised concerns with us about the portion sizes people were offered. Our observations confirmed that everyone was served a small portion of food, and this was not assessed based on the size of the individual's appetite. A relative told us that due to their relative's dementia, they would not request more food if they were hungry but would accept it if it was offered. We observed that no one was offered more food when they had finished, despite there being a lot of food left over which was then disposed of.

People told us, and we observed, that extra snacks were not offered in between meals. One person said, "Sometimes they come round with something but normally you wait for your three meals." Another person told us, "We don't get anything. They offer us a cup of tea but not even a biscuit." Offering nutritious snacks and extra foods in between meals can help to boost the nutritional intake of people and reduce the risk of malnutrition.

People and their relatives told us there was a choice of meals, but made negative comments about the food provided to them. One person said, "It is god-awful. You do get to choose from a couple of things but they are both so bland. I've said before but the staff just laugh like it's a joke." Another person commented, "Half the time it arrives cold. The vegetables are always soggy, it's always the same thing over and over." A relative commented, "I've tasted it myself and I can say I wouldn't want to live on it." Another relative told us, "The quality is variable according to what it is. Sometimes it's alright, sometimes [relative] says it's tasteless or overdone."

The food and fluid intake of other people using the service was not being consistently monitored where they had been assessed as at risk of malnutrition. This meant that the service could not identify early signs which may indicate the person required more support to eat or input from a professional. Where people were identified as at risk of malnutrition, they were not weighed often enough for the service to quickly identify and put in place any intervention to avoid further deterioration. Staff and the registered manager were not clear what action had been taken where people lost weight. This therefore placed them potentially at further risk of harm.

This was a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Poor staff practice that put people at risk was not addressed to protect people from harm. Staff received regular training in key competencies relating to the caring role. However, where staff performance issues were identified through assessment, action was not taken by the service. For example, we reviewed staff records and identified four staff members who had been assessed as requiring improvement in performance areas related to delivering care. There were no plans in place to improve the knowledge of these staff members to ensure they provided people with safe and effective care. Unit managers told us they were unaware these staff members had been assessed as needing to improve, and told us their performance was not being monitored or supervised. People and their relatives raised concerns about the conduct of staff. One person said, "They mess around with each other when they are supposed to be helping me. One time they were spraying talcum powder around and putting incontinence pads on their heads like it was funny." A relative said, "Some staff are good but others don't seem to want to be here and act like everything is a hassle." Staff, including registered nurses, did not receive regular meaningful supervision or appraisal which focused on their development within their role. Staff said they didn't have supervision often, and some newer staff didn't know what this was. The registered manager told us they were aware that the unit managers were behind with their supervisions. However, no action had been taken prior to our inspection to bring these up to date.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

It was unclear how the service supported people to have appropriate access to external healthcare professionals such as GPs and dieticians. For example, where a referral to the dietician would have been appropriate for someone with unexplained weight loss, staff could not demonstrate that this referral had been made. When a referral had been made, it was unclear what the outcome was, or what advice had been obtained. When people had sustained an injury from an accident such as a fall, staff could not always demonstrate they had obtained advice from healthcare professionals in a timely manner. One person told us that they had requested a GP to visit them but staff had not done this. A relative told us, "I've asked before if they can get someone in and they don't."

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

There were widespread serious shortfalls in the service provided to people which meant that their immediate needs and wellbeing did not benefit from a caring culture. Whilst we saw some positive practice, staff were not supported by the management of the service overall to ensure that people were treated with respect, dignity and kindness. Staff spoke about people in a task focussed manner which did not reflect their individuality and was disrespectful. For example, we observed a staff member tell one person in a communal area loudly that they were going to take them to have their incontinence pad changed. We observed another staff member use a disrespectful term to describe people using the service who required support to eat their meals. There was not an understanding from staff about how to uphold people's dignity and respect, and this placed people at risk of feeling embarrassed. One person said, "I do get embarrassed, they're not always very discreet. They almost leave the door open sometimes and I have to tell them to close it."

Staff did not always respond to people's requests or need for support or show appropriate concern for their wellbeing. We observed one person who was continually calling out for staff throughout both days of our inspection. On the first day the person was in bed and we sought staff support for them on four separate occasions. When staff went to the person, they asked them what was wrong. The person was assessed as not having capacity and had limited communication, when they didn't respond staff left the room without trying to understand why they were calling out. On the second day of our inspection the person was seated in the communal living area. We observed several members of staff repeatedly ignore the person calling out for staff attention, and this led to the person becoming distressed. No one sat with the person and interacted with them to ease their distress, nor did staff try and engage the person in activity to stimulate them. This person's quality of life was significantly reduced as a result of not receiving the attention required from staff to maintain their wellbeing.

We observed other occasions when staff did not respond to people in a caring way. We saw that one person repeatedly said, "Will you sit with me?" to staff but was ignored and they became upset. Another person was repeatedly vocalising loudly but staff did not respond to them. We observed staff become frustrated and short with other people using the service. For example, one person asked about their lunch several times and the staff member sighed and said, "Just go and sit down will you?" Another person requested their bed sheets be changed and the staff member said, "And you think I have time to do that?" These were not caring interactions that made people feel as if they mattered or which maintained their self-worth.

People and their representatives were not consistently involved in the planning of their care. Care records did not reflect people's preferences with regard to how they wanted their care delivered. People and their relatives told us they were not asked for their views or involvement in care planning. One person shook their head and said, "No I don't know anything about that. What are they for?" Another person commented, "I'd better ask about that." Both these people were assessed as having capacity so it was unclear as to why they would not have been directly involved in the planning of their care. The unit manager could not explain the rationale for this. A relative said, "I know there is some plans but I've never seen them. They asked me to fill in a form about life history." Another relative told us, "I got one of those family tree things but I've not seen

anything else."

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care records for people were generic, not centred on the individual and often contained the same information for each person. There was limited information consistently available about the life history and experiences of people living with dementia and relatives raised concerns that staff did not know people very well. One said, "The staff don't seem to know anything about [relative]." Another told us, "If you asked one of them about [relative] I bet they couldn't tell you anything." Whilst some families had been asked to complete a family tree and document about their relative, other families had not been given the opportunity to provide this information. One relative said, "I've not heard about [providing a life history] but it sounds like a good idea." Where other people living with dementia were assessed as currently having capacity, they had not been asked to talk to staff about their past history and experiences so this could be recorded. One person said, "I'm not sure what that is, but if they asked I'd be more than happy to tell them." This information could support staff to understand people's individual needs with regard to how dementia affected them in their daily lives. This information would also allow staff to provide more personalised care or help them to develop better ways to engage or communicate with each individual in a meaningful way. When we spoke to staff about the past lives and experiences of people living with dementia, they could not tell us this information and instead spoke about people's physical needs. This meant that staff were not focused on the person as a whole and were not focused on providing personalised care.

People were not being protected from the risks of social isolation and loneliness because staff did not support people to engage in meaningful activity or stimulation. There was no system to ensure that people who were particularly at risk of under stimulation or isolation were protected from this risk. Staff did not support people to enjoy their individual interests and hobbies. Whilst there was a member of activities staff available in the communal living area during the day, people were not consistently supported to live full and active lives. For example, only group activities such as playing games were available to people. We observed that many people in the communal area were disengaged with their surroundings and no attempt was made by staff to offer them an activity or a source of stimulation. One person living with dementia spent their time walking around the service trying to take items off other people, who sometimes became aggressive with them. Staff made no attempt to distract the person and engage their attention elsewhere which would also reduce the risk of distress to others.

Staff could not tell us about how individuals liked to spend their time and how they supported them with this. Staff displayed little insight into what activities were appropriate to the needs of different individuals. We spoke with one person about living at the service and they told us, "It's terrible, I hate every minute of it. I just sit in this chair all day." They also told us, "We don't get to do anything. Sometimes they come round with a colouring book and that really gets my goat because I'm not a child. I used to do so much, but not anymore. I'd love to do some gardening but nothing like that is allowed here." Another person said, "It's hard to fill the days. Not much going on, I have to rely on people visiting."

Many people remained in bed throughout the day and were left with little or no source of stimulation. We observed one person in bed on both days of our inspection who was persistently rubbing their hand along the cushioned bumper on their bed rails. They had no access to basic stimulation and we observed that staff

interacted with this person very infrequently. No attempt was made to distract the person from this behaviour, and we saw that their hand was visibly red and their bed rails were becoming frayed as a result of the repeated motion. Consideration had not been given to how this could potentially compromise the integrity of their skin. When we asked staff about this, they said, "That's just what that person does." There was no information in this person's records to support that the reasons for the behaviour had been investigated or to evidence that a plan was in place to distract the person from repeating the behaviour. We spoke with another person in bed who told us they got bored and staff didn't speak to them much. They also said, "[Home] is horrible. I wouldn't want to live here." A relative told us, "They never seem to be doing anything when I come in. People are just left to it."

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People and their relatives told us they were invited to resident's meetings where they could feed back their views. However, records and what people told us supported that people's views and suggestions were not always considered and acted on by the registered manager. One person said, "I go to these meetings. I've said a few things about the food once or twice, nothing changed." A relative said, "We try and go to every one to show our faces. They don't seem to listen to what you say." Another relative said, "In my opinion these meetings are a paper exercise. Show me one thing that's changed as a result, I'm sure there's nothing." Meeting minutes did not reflect specific suggestions that people or their relatives had made and staff were unable to tell us how people's views and suggestions were acted on and addressed. Staff confirmed there was no other formal method of obtaining people's views on the service.

People and their relatives told us they knew how to make complaints but didn't feel these would be acted on. One person said, "I complained about the food quite a few times to staff and they laugh like it's a joke. Then nothing changes." Another person said, "I have grumbled so many times to the staff and the unit manager, I've given up now because they don't listen." A relative said, "We have made complaints in the past, there is so many problems with this place and I do think it has got worse." Another relative commented, "Mentioned things to the unit manager loads of times and then you never hear about it again." We looked at the records of complaints that had been made to see how these had been investigated and acted on by the service. The outcomes of these investigations were not clear and we were unable to ascertain how these were used to improve the quality of the service. The registered manager told us there was no current system in place to communicate the outcome of complaints to staff and use them as learning to improve the quality of care provided to people.

This was a breach of Regulation 16: Receiving and acting on complaints of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no effective oversight of the quality of the service from the provider and registered manager. When we commenced our inspection, the registered manager told us they hoped they would achieve a rating of 'good'. However, we found that outcomes for people using the service fell far below the standards required to meet the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we shared the concerns we had identified with the registered manager, they were unaware of these. Quality monitoring processes were ineffective and did not identify poor care which put people's health, safety and welfare at risk. For example, the registered manager told us that a two day internal inspection of the service had been carried out the week prior to our inspection. This inspection included, but was not limited to, an audit of care records, risk assessments, nutrition records and an observation of staff practice. We were told that no significant issues had been identified during this inspection, and a report from this internal inspection confirmed that none of the significant failings we found had been identified independently by the service. The provider's failure to identify these risks exposed people to the continuing risks associated with being delivered with poor and substandard care.

The provider and registered manager had no system in place to monitor the competency and effectiveness of the unit managers who were in charge of running the four houses. This meant that shortfalls in practice could not be identified and resolved to ensure care staff were learning by good example. We observed several instances where unit managers showed little understanding of the people they were in charge of caring for and where they engaged in poor practice in front of other staff. This meant we were not assured that those in direct line management of staff in each house had the skills, experience and knowledge to inspire and drive quality care.

Staff across all four houses told us they did not feel supported by the management of the service, and said they were unclear about who was in charge in the absence of the unit manager. The overall culture across the service was not open and inclusive. One told us they were, "Often dismissed," by the registered manager and unit manager when they asked questions or raised concerns. Another said they received supervision from their line manager, "Very rarely," and did not often have the opportunity to speak with them one on one. Other staff members told us they would not go to the registered manager if they wanted to raise concerns or had a question. One described the registered manager as, "Unapproachable," and said, "They don't want to hear what we have to say." Staff told us that the registered manager did not spend much time in the individual houses or with the staff. Staff were not given an opportunity to be involved in the development and improvement of the service. Meeting minutes didn't demonstrate that staff could use these as an opportunity to discuss worries, performance or changes to the service. This meant we were not assured that staff received consistent support from the management of the service which encouraged a culture of openness and transparency.

Feedback from people using the service and relatives told us definitive actions were not taken to drive improvement or to take on board their comments about the service. Meeting minutes confirmed what people told us. There was no feedback to people and/or their relatives in response to issues that were raised.

Whilst some incidents and accidents such as falls were analysed by the registered manager, learning had not been taken forward as a result of these events to reduce the risk of repeat incidents. Records and speaking to staff confirmed that action was not always taken to reduce risks to people where these had been identified through analysis, and this had led to some people coming to harm that was potentially avoidable. For example, definitive actions had not been in place for several people who had fallen repeatedly. Where people continued to fall, further action had not been taken to protect them from harm.

We shared information with the Clinical Commissioning Group (CCG) and the safeguarding team at the local authority following our visits so that we could work in a joined up way to ensure people were protected from immediate harm. We were so concerned about people's welfare we made the decision to issue an urgent notice to stop the service admitting new people to the service. This was because we considered that the service needs to focus on improving the quality of care provided to people currently using the service and we had concerns they could not safely meet the needs of new admissions.

Following our inspection visits, prompt action was not taken by the management to safeguard people from harm or to rectify shortfalls we raised concerns about. Staff from the Clinical Commissioning Group (CCG) and Local Authority Safeguarding Team visited the service the week after our inspection and found that limited immediate action had been taken and that the registered manager was not being supported to address the widespread immediate concerns. This meant we had serious concerns about the ability of the management to bring about prompt and meaningful improvements to keep people safe. Due to these ongoing concerns, we took the decision to urgently place conditions on the registration of the service. These conditions ensure that the management has to make improvements faster and provide us with regular meaningful information that evidences this.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.