Aadams Residential Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 12 and 19 January 2015. The home is registered for a maximum of 33 people. It is a purpose built property on two levels and is located close to the city centre of Preston. Accommodation is provided in single rooms with en suite toilet facilities. There are 2 lounge areas and a dining room.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. Whilst we were giving feedback on our inspection to the service provider and registered manager, the service provider announced that he had made the decision to close the care home as a result of reviewing the service's financial position, and he believed that a planned closure of the home was in the best interests of the people living at the home. The service provider proceeded to give 30 days notice to all the people living at the home. After liaison with the local authority and clinical commissioning group, all the people living at the home moved to alternative accommodation. The home closed on 16 February 2015.

Summary of findings

Peoples view's about the service they received were mixed. While some people were very happy, others were not. In addition, our observations did not always match the positive descriptions that some of the people living at the home had given us.

The systems and procedures operated at the home were not designed to enable people to live their lives in the way they chose, so they could be as independent as possible. The care and support offered to people at the home was not personalised and had the potential to put people's dignity at risk, as well as increasing the risk of people developing health and social care problems. The care provided was task orientated and did not take account of people's assessed needs, preferences and choices.

The service did not consistently respect and involve people in the care they received. For example, all the care plans viewed did not show the person's choices and personal preferences. The care plans did not involve the person or their relative when they were written and their views were not reflected in the care plans. People told us they had no input into the menus or activities and we saw that the choice of meals was limited.

Staff members did not always follow the Mental Capacity Act (2005) for people who lacked capacity to make decisions. People's mental capacity was not properly assessed and there was no information available in the service for the staff that helped them support a person with fluctuating capacity. We saw inconsistent approaches from staff with some staff explaining to people before they undertook a care process, other staff failed to give the person any information about the care and support they were about to deliver.

Staff were not provided with effective support, induction, supervision, appraisal and training. The service did not have a system to manage and report accidents and incidents. When action plans were needed to monitor people's safety these were not produced. The service did not have any robust quality assurance and, where appropriate, governance systems in place.

There were little or no accountability systems in operation within the home. If care tasks or records were not completed, no action was taken by the Registered Manager or service provider to address the issues and ask people for a clear explanation as to why they had not undertaken their responsibilities properly. There was a registered manager in place at the time of our inspection. 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. We last inspected this service on 19 August 2014 and the home was compliant with the regulations we checked during the inspection.

Summary of findings

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 inappropriate systems in place to identify the possibility of abuse and prevent it before it occurred.

The processes in place to make sure the premises were free from avoidable risks were inappropriate and ineffective.

Reasonable steps had not been taken to assess the risks and prevent, detect and control the potential spread of infection.

Is the service effective?

Inadequate

The service was not effective.

The systems in place to ensure people's dignity, privacy and independence was protected were inappropriate and ineffective. The processes in place to support people to make informed decisions about their own care and support ineffective.

There were inappropriate and ineffective processes in place to make sure people did not experience poor healthcare.

Staff training was non-existent and staff were not engaged in appropriate supervision or appraisal of their practice.

The skills base of the staff team was not appropriate to meet people's assessed needs.

The systems in place to make sure people did not experience poor nutrition and hydration, by way of ongoing assessment, planning and monitoring were inappropriate and ineffective.

Is the service caring?

Inadequate

The service was not caring.

There were inappropriate and ineffective processes in place to make sure people were involved in discussions regarding end of life care. People were not enabled to make choices and decisions about their preferred options.

The systems and procedures operated at the home were not designed to enable people to live their lives in the way they choose, so that they could be as independent as possible.

People were not always treated with dignity and respect.

The relationship between the staff and people living at the home was task orientated.

Is the service responsive?

Inadequate

The service was not responsive.

There were inappropriate and ineffective processes in place to make sure people's health and social care needs were properly assessed and planned for so that they could be effectively met.

Summary of findings

We found people's care needs were not appropriately planned for by the service. The service failed to respond to people's changing needs by ensuring amended plans of care were put in place. We found that care based on people's assessed needs was sometimes not delivered.

Is the service well-led?

Inadequate 

The service was not well led.

There were inappropriate processes in place to make sure that the quality of service delivery was effectively assessed and monitored to ensure people received safe and appropriate care and support.

There were inappropriate systems in place to make sure that information about people's health and social care needs was shared in a timely way to the most appropriate agency.

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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 checked 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.The inspection was carried out by the lead adult social care inspector for the service and a fellow adult social care inspector on 12 January and 19 January 2015.

Prior to this inspection visit, we received a number of safeguarding alerts from the district nursing team and local authority. We also had discussions with a family member of a person living at the home regarding what they believed was poor quality care. The issues they raised related to a lack of support when being help to eat, poor mouth care, and inadequate support with personal care.

During the inspection visit we spoke with a range of people about the service. This included Registered Manager, five staff members, the service provider, six people who used the service and two visiting family members. We also spoke with a visiting district nurse and a social worker. Prior to this inspection we contacted the local authority in order to ascertain if there were any issues from their perspective. They had major concerns regarding the nature and number of safeguarding alerts they had received. We spent time looking at records, which included the care records of seven people, five of the staff training records and a number of management and audit records relating to the running of the home.

Inadequate

Is the service safe?

Our findings

The people who lived at the home said that they felt safe. One person said, "I like it here, they look after me really well."

Despite positive comments from people who lived at the home, people who used the service were not protected from potential abuse or avoidable harm because the registered manager and service provider had not taken reasonable steps to minimise the risks associated with the care of vulnerable people.

Accidents and incidents were not documented, and if action was needed to be taken to address issues or change practice, this was not completed by the staff. A staff member told us that a person had recently had a fall in their bedroom. We could not find any written records relating to this incident. Risk assessments and care plans had not been updated following this incident. We found that people's needs had changed over time due to deteriorations in their health, however, the risk assessments and care plans did not reflect these changes. One person who had suspected epilepsy did not have a risk assessment in place and another person who had pressure area care needs did not have a care plan or risk assessment in place. People at risk of losing weight not did have risk assessments in place for the staff to follow in order to reduce, minimise or eliminate the possibility of weight lost.

We found records to show that people who lived at the home smoked, and that there was evidence to show that one person had been smoking in their bedroom. Cigarette ends and burn marks were found on the sheets and pillows in one person's bedroom. Although the registered manager was aware of this, we did not find any written records to show that action had been taken to monitor this issue, or put control or safety measures in place to prevent further smoking or tackle a potential fire.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not appropriately assessed the needs of the people living at the home, and planned for the safe delivery of their care and support.

The service had a policy and procedure in place that gave details as to how people living at the home should be protected against alleged or suspected abuse, however, staff were unable to describe what constituted abuse and the action they would take to escalate concerns. We spoke to three staff members about their understanding of the policy and procedure and found that their understanding of this policy and procedure was limited. One person said, "If we were to see someone being abused or shouted at then we would report it to the manager, and they would pass it on". Another staff member said, "If we have concerns then we get the senior to write them in the handover book, and they pass the concerns onto the manager." We asked the staff if they could describe the types of concerns they may report. One said "If someone had a bruise then I would report it, and if I saw someone hitting a resident then I would tell the manager straightaway." When we asked if there were other types of abuse that could occur in a care setting, the person said, "There probably is, but I can't remember what they are. "We asked one staff member if they had read the home's safeguarding policy and procedure and they said they had not. When we asked about training in this subject the staff member said, "I had training in my previous job, but I haven't had any training since starting work here over 12 months ago." The staff on duty were unfamiliar with the home's whistleblowing policy and were unsure how to access it if they needed to raise concerns about poor practice.

Information supplied to us prior to the inspection by the local authority safeguarding team showed that they had received six safeguarding alerts. The alerts had been made by visiting district nurses and related to concerns about people's healthcare needs and their general welfare. When the local authority had completed their investigation into these concerns five out of the six alerts were upheld, which meant that the local authority had found evidence of neglect.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not taken reasonable steps to put appropriate systems in place to identify the possibility of abuse and prevent it before it occurred.

Staffing levels were not always found to be appropriate to meet the assessed needs of the people at the home. We discussed with the registered manager how rotas were set out and he told us that this was done against the assessed needs of each individual. However, we found that the staffing levels frequently dropped below the accepted minimum due to staff sickness. The registered manager explained that he would frequently cover these shifts as the

Inadequate

Is the service safe?

use of agency staff was restricted by the home owner. We spoke to the home owner regarding this and he confirmed that agency usage was limited due to the financial costs involved, adding that staff at the home usually covered the extra shifts. One four occasions in the previous month we found that when staff had called in sick, none of the home's staff had covered the shifts, and this had left people living at the home in a very vulnerable and unsafe situation.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not taken reasonable steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

The service had recruitment policies and procedures in place. Pre-employment checks had been carried out, and application forms completed, Disclosure and Barring Service (DBS) clearances, references and identification checks were in place. Staff we spoke with confirmed that they had attended a formal interview and did not begin work until references and appropriate clearances were obtained.

We looked at the systems for medicines management and saw that the records relating to medicines held at the home were found to be up to date. People were found to receive the correct medicines at the right time. However, staff working at the home had not received appropriate training in the area of medicines administration. Risk assessments and care plans relating to people's needs in relation to medicines were not in place for each person at the home.

We looked to see what steps had been taken in the home to protect residents and staff from the spread of infection. Information held within the home's training records showed that the staff had not received training in this area. One staff member said, "We have not had any training, and sometimes the home looks like it needs a proper deep clean. We try and keep equipment clean, we make sure we wash our hands, but sometimes there isn't enough soap for people to use, and sometimes there isn't any washing powder to clean people's clothes and bedding." We spoke to the registered manager about infection control measures and he confirmed that he had not undertaken an infection control audit for over 12 months. He said that washing powder was always available but locked away for safe keeping. He conceded that the home needed a deep clean but said that the pressures on the staff rota did not always allow for this.

On touring the home we found some of the carpet in one bedroom were stained and were in need of either cleaning or replacing. We suspected that some residents did not have access to their own toiletries as these were not evident in people's rooms. However, we were informed that if people did not have toiletries could and would be provided by the home. Although the home had two washing machines in the laundry room, the registered manager explained that only one worked, and that this frequently added delays to the time taken to wash soiled clothing. As a result, soiled clothing was found to be left for long periods of time in the laundry room area. Rather than using papers towels in communal toilets, fabric towels were found to be in use. We explained that this practice was a potential infection control risk. During the inspection we referred the service onto the local Clinical Commissioning Group (CCG) infection control department as a result of the concerns we had for people who lived at the home.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not taken reasonable steps to assess the risks and prevent, detect and control the potential spread of infection.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We found that action had not been taken by the service to assess people's capacity to make decisions. We did not find any written records to that any considerations had been made to assess and plan for people's needs in relation to mental capacity. The registered manager only had a very basic understanding of MCA and DoLS.The training records showed that the registered manager was the only staff member who had received "training" in this area, however, this training was not satisfactory. He explained that he had watched a video on the subject, and had received some basic training on the subject in 2011. We found that one person had been subjected to potentially restrictive practice. Information held within their records showed that a chair had been placed next to their bed in order to prevent them from getting out of bed. The records showed no efforts had been taken by the registered manager to assess this person's mobility needs since they moved to the home and no efforts had been made by the registered manager to assess their capacity to make decisions about getting out of bed, or put appropriate measures in place following a risk assessment.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person could not demonstrate that they were obtaining and acting in accordance with the consent of the person or a person lawfully able to consent for them, in relation to their care.

The service provider had installed CCTV in all communal areas of the home. Although its usage was not found to be problematic, we found no consideration to meet the guiding principles of the Information Commissioner's Code of Practice on the use of CCTV had taken place. We did not find any written record that a privacy impact assessment had taken place; there was no signage to show that CCTV was in operation, there was no clear policy and procedure for its usage or storage, or details of when or by whom it could be accessed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not made suitable arrangements to ensure people's dignity, privacy and independence was protected.

We spoke to three staff regarding the training offered to them by the service. One said, "I have not received any training since starting work here over 12 months ago." We looked at the training records for five staff members and found that they had gaps in their refresher training linked to health and safety, personalised care, fire safety, infection control and moving and handling. One person had not received any training despite working at the home for over 18 months. None of the staff working for the service at the time of our visit had received training in First Aid, or held an up to date and valid First Aid certificate, despite the fact that the service's own health and safety policy stated that they should be a trained First Aider on duty at all times. The registered manager explained that staff were meant to receive an annual appraisal and regular supervision meetings. However, he admitted that this had not been taking place. Information held with the personnel records confirmed this. One care worker said "I do not feel supported. I am not sure if I can raise issues with the management as I am not confident I will be listened to." Another said, "I don't get supervisions even though I'd like to".

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not made suitable arrangements to ensure staff were appropriately trained, supervised and their practice appraised.

Information within the care files showed very little effort had been taken to record details of people's dietary needs and preferences. The kitchen and care staff were unsure about people's dietary requirements and when we asked two care workers about this topic, they could only state who they thought was a diabetic. When we asked how information was gathered about people's dietary preferences, one staff member said, "People just eat whatever is on the menu and don't complain."

Inadequate

Is the service effective?

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make sure people did not experience poor nutrition and hydration, by way of ongoing assessment, planning and monitoring.

The Registered Manager explained that many of the people living at the home had significant healthcare needs and that these were monitored via the District Nursing team. He said, "Although the staff are involved in supporting people in their healthcare, I'm not sure that they all have the right skills or in depth knowledge to fully deal with some of the healthcare concerns that people have." We found information to show that some people had been assessed as being at risk of losing weight and of dehydration. Despite this, the systems in place to monitor and manage these risks were disorganised or non-existent. Record keeping was either inaccurate or out of date. We asked two care workers, "Who is most at risk of weight loss, and what plans are in place to help this person?" The care workers were unable to clearly identify any service user and were unsure of the plans in place to support them. One person who had significant healthcare needs was meant to be following a diet that restricted their fluid intake. However, we found that they had been given a considerable amount of fluids over a 24 hour period which had resulted in them being admitted to hospital for treatment. The Registered Manager was unable to explain how this situation had arisen. One staff member said that they were unaware of the need to restrict this person's fluid intake.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make sure people did not experience poor healthcare.

On touring the building, and after reviewing the records relating to its up keep and the safety procedures linked to it, we found the Registered Manager and service provider had not fully taken into account of the safety needs of people who used the building. None of the staff and residents had taken part in a fire evacuation procedure for over 18 months; there were no clear procedures in place for how to deal with a fire and no clear fire evacuation plan. Safety precautions that should have been in place in relation to designated smoking areas were not. The arrangements in place to meet the Control of Substances Hazardous to Health guidelines were poor as we found cleaning liquids left unattended, and these could have been consumed by people at the home. There were no clear procedures or records in place to show how the identification, assessment, management and review of risks within the building had been undertaken. In between our two inspection visits, the Fire Officer inspected the home and found significant breaches in fire safety regulations and issued the home with an enforcement notice.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make the premises were free from avoidable risks.

Inadequate

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about the care provided by staff. Comments included, "They are great staff", "Most of them are lovely and you can have a laugh with them". One person told us, "It all depends on which staff are on duty: some are better than others." We spoke with one person about how involved they were in their own care and in the running of the home. They said, "I don't really feel I am consulted, empowered and listened to. I asked for a change in the menu a year ago and nothing has been done about. Some of the staff talk to me about how I am feeling, but a lot of them just come to work and do their job without even talking to the people who live here. To be honest, I don't feel very valued, and it's like the staff are not really interested in me. Most of them are just interested in getting the job done as quickly as possible." Other people that we spoke with said that they though the staff did a good job, but sometimes in a rush. One person said, "They do an ok job, but are always very busy and sometimes rush me along."

We saw some positive interactions between people living in the service and staff. On one occasion, a person was being supported to go to the bathroom and the staff helping the person did this in a discreet and sensitive manner. They were seen to consult with the person and gave the person time to make decisions.

Some interactions appeared task-focused and inconsistent. On one occasion, staff gave no information about what was happening and did not engage people in conversation when using a hoist to transfer a person from their chair to a wheelchair. They did not speak to the person as they put them into the sling. They did not offer any reassurance or commentary whilst the person was in the hoist waiting to be lowered into the wheelchair, despite the fact that they appeared to be a little upset. However, on another occasion, we observed staff move another person using a hoist and they engaged in a very animated conversation with the person which included reassurance when the person became upset.

The registered manager said that the staff on duty were some of the best. He explained that if we had visited on a different day we would see a different picture. When we asked what this meant, the registered manager said that other staff needed a lot of motivation to undertake their work. When asked what action he had taken to tackle to this, the registered manager said he had repeatedly spoken to staff about the way they should conduct themselves to no effect. He added that he was about to introduce a new supervision regime and this would be used to identified poor staff practice, training needs and potential disciplinary action if improvements did not take place.

When asked we asked the registered manager if he had spent time observing the staff and monitoring their practice, he said he did not, as he did not feel he had the time.

We asked people whether they felt that the staff listened to them. Most told us they did. We asked had they been involved in any "residents and relatives meetings", two people were unsure if they had done so. Four other people could not remember attending a meeting. One relative told us no one in the home has asked them their opinion as to how the home was run.

We observed staff practice to see how they promoted people's privacy, dignity and independence. We noted that a number of people moved freely around the home. One person said, "I can come and go as I please. I go to my room to watch TV and come downstairs to eat my meals. I feel quite independent to be honest." Access to toilets, baths and showers was not to be restricted and this enabled people to maintain their privacy and dignity. One staff member said, "We realise that people sometimes want to be alone and we respect this, and when we talk to people about personal issues, then we make sure that others don't overhear our conversation." We saw this take place in practice when a staff member discreetly spoke to a person prior to them using the bathroom. We noted that some people living at the home looked unkempt. We spoke to the staff about this. One said "People can make decisions about what they want to wear and what they want to look like." Another said, "We have real problems with some people who live here. They don't let us help them when we try and get them dressed." We spoke to the registered manager about this and he said that some people lacked capacity when it came to dressing appropriately. When we suggested that the staff had a role in supporting people more effectively in this area, he said that some staff would try to support people by making numerous requests for

Inadequate

Is the service caring?

them to either change their clothes, or engage in personal care. However, he added "There are some staff who will not bother, and will just go onto the next task that needs to be completed."

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to support people to make informed decisions about their own care and support.

The Registered Manager explained that he would be looking into training for staff in relation to how care and support was offered to people with advanced or progressive illnesses. Although he added, "At the moment, the service does not provide services to people in this position, and the priority would be to cover other areas of care and support through appropriate training." We looked at five care files and found that no records had been made regarding any discussions that staff had had with people regarding their thoughts and wishes if they were to find themselves living with an advanced or progressive illness. One staff member told us, "If we needed help in this area we would look to get support from another agency, and they could offer guidance and support in relation to subjects such as the management of pain and other symptoms."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make sure people were involved in discussions regarding end of life care and were enabled to make choices and decisions about their preferred options.

Inadequate

Is the service responsive?

Our findings

We spoke to three people living at the home about how to make a complaint. One said that, "I'm confident that we can speak to the staff and make a complaint. The registered manager is usually very approachable." Other comments included, "I just tell the staff if I've got a problem. They usually deal with things quite well" and "To be honest, I'm just happy I have somewhere to live so I try not to rock the boat. I'm ok really". The home had a suitable complaints policy and procedure that was publicised within the home.

We found that people's care files did not contain up to date and accurate information relating to risk assessments for pressure area care, falls, personal safety, behaviours that challenge, mobility or nutrition. All the care plans we viewed did not have life histories. In discussion with staff they told us that as most of them had worked at the home for over 12 months, they felt that they were familiar with people's needs and personal histories. We asked a staff member who had worked at the home for only 6 months about people's life histories. They were unaware about this and said that they had not been given any information about people's life histories and were unsure as to where they could obtain this information. The daily records for one person showed that they repeatedly refused to engage in personal care and could be very "difficult to work with". We could not find any written records to show that action had been taken by the registered manager and staff to seek any external support, guidance or advice when dealing with this people's care needs.

There were no care plans or risk assessments in place to show how the home would support and work with people in a proactive or person centred manner. When care plans did state that the staff should take action to support people in a particular area e.g. monitor weight, provide fluids, turn someone every two hours, we found there were no records to show that this action had taken place. The registered manager said that he was sure that the staff would have undertaken these tasks, but had failed to record the details. We saw very little evidence in people's care files that people's preferences regarding activities were recorded.

We noted that the registered manager did not demonstrate a clear understanding of the importance of person centred care. We asked the staff to tell us about, and give us documentary evidence to help demonstrate that the home had systems in place for gathering, recording and evaluating information about the quality and safety of the care and treatment provided by the home. Staff told us that they were not directly involved in this aspect of the service. One said that they believed that the registered manager and service provider spoke with people about their care and support; however, we did not find any recorded evidence of this. We spoke to one person living at the home about their care, and they were very clear on their views on the home. When we looked at their file, we found this had not been recorded and issues they raised about their dietary requirements had not been dealt with.

The staff we spoke with said there was very little time to engage in social activities with people. One person said, "There is a lady who comes into the home and she does chair bound exercise with people, but apart for that there is nothing for people to do. People either spend time in their rooms, or watch TV in the lounge." The registered manager explained that there was an activity co-ordinator who worked at the home, and they spent time with people undertaking activities such as pamper sessions and general discussion. We spoke with this staff member and they said that they did help people with their nails but added, "I spend a lot of time working as a carer, and so don't have a lot of time to do individual activities with people."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make sure people's health and social care needs were properly assessed and planned for so that they could be effectively met.

Information held within people's personal care records showed that limited liaison had taken place with other health professionals regarding people's care and support. However, this seemed to only take place following the involvement of visiting professionals such as district nurses and social workers. We found that there were frequently delays in the time taken to respond to healthcare issues. We found a number of entries to show that two people at the home had unexplained bruising. There was no written evidence to show that this issue had been either monitored or responded to.

This is a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the

Inadequate

Is the service responsive?

registered person had not ensured there were appropriate processes in place to make sure that information about people's health and social care needs was shared in a timely way to the most appropriate agency.

Inadequate

Is the service well-led?

Our findings

Inadequate systems were in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included dignity and respect, nutrition, care and welfare, managing risks to people and staffing levels. These issues had not been identified by the provider prior to our visit, which showed there was a lack of robust quality assurance systems in

place. We did not find any written documentation to show that the registered manager or service provider had properly established any robust monitoring systems. There were no audit systems in place for issues such as medicines, health and safety, risk assessments, care plan, staff absence or the quality of food. The registered manager and service provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was no evidence of recent quality monitoring of care documents at the home. We found that care plans lacked detail and others did not contain appropriate advice for staff to follow. Other care plans were missing information about people's preferences, life histories and mental capacity assessments.

We found a number of daily records to show that various people at the home had visited the accident and emergency department at the local hospital in recent months. We explained to the registered manager that these visits required a notification to the Commission; however, no notifications had been made by the home. We found written evidence to show that that the registered manager had notified the local Safeguarding Team of various issues. Again, these referrals required a notification to the Commission; however, no notifications had been made by registered manager. We found written records to show that police had recently visited the home after they were notified of an incident relating to a person living at the home, again CQC had not been notified of this incident

We observed a poor atmosphere in the home, with most of the communal areas populated by people and staff who seldom interacted with each other. We did not observe many examples of staff trying to engage with people who used the service or lift the atmosphere. There was no evidence of good leadership by senior staff to improve the experiences for the people who lived there.

None of the care and support systems in the home were based on current best practice. The home was disorganised and we found that there were no clear lines of responsibility. If tasks or care work did not take place then there were no systems in place to monitor this or for the registered manager to take appropriate action to tackle the issue. Partnership working with other agencies was not planned, but was seen to be a last resort if issues or emergencies arose.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the registered person had not ensured there were appropriate processes in place to make sure that the quality of service delivery was effectively assessed and monitored to ensure people received safe and appropriate care and support.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not appropriately assessed the needs of the people living at the home, and planned for the safe delivery of their care and support. The registered person had not ensured there were appropriate processes in place to make sure people did not experience poor healthcare. The registered person had not ensured there were appropriate processes in place to make sure people involved in discussions regarding end of life care and were enabled to make choices and decisions about their preferred options. The registered person had not ensured there were appropriate processes in place to make sure people's health and social care needs were properly assessed and planned for so that they could be effectively met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not ensured there were appropriate processes in place to make sure that the quality of service delivery was effectively assessed and monitored to ensure people received safe and appropriate care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not taken reasonable steps to put appropriate systems in place to identify the possibility of abuse and prevent it before it occurred. The registered person had not ensured there were

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appropriate processes in place to make sure that information about people's health and social care needs was shared in a timely way to the most appropriate agency.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not taken reasonable steps to assess the risks and prevent, detect and control the potential spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person had not ensured there were appropriate processes in place to make sure people did not experience poor nutrition and hydration, by way of ongoing assessment, planning and monitoring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not ensured there were appropriate processes in place to make the premises were free from avoidable risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to ensure people's dignity, privacy and

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Action we have told the provider to take

independence was protected. The registered person had not ensured there were appropriate processes in place to support people to make informed decisions about their own care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person could not demonstrate that they were obtaining and acting in accordance with the consent of the person or a person lawfully able to consent for them, in relation to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person had not made suitable arrangements to ensure staff were appropriately trained, supervised and their practice appraised.