Angel Care Agency Ltd

# Fernleigh House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

The inspection took place on 6, 7 and 13 August and was unannounced.

Following the last inspection, the Commission considered its enforcement policy, and took enforcement action, which was to impose a condition on the provider's registration. This meant on a monthly basis, the provider was requested to submit a report detailing action they had taken to improve medicines management, the assessment and management of people's health and safety needs, infection control, the cleanliness and maintenance of the environment, governance systems, their recruitment process and ensuring staff employed were suitable for the work and to ensure staff received the training and supervision necessary to meet people's needs. We also met with the provider.

The Commission had been receiving and reviewing the provider's monthly returns, which had demonstrated ongoing improvement at the service. The findings of this inspection found the information which had been provided had not always been fully accurate and did not always reflect the current regulatory position within the service.

Fernleigh House accommodates up to 11 people in one adapted building. It is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection 9 people were living at the service.

Fernleigh House also provides a domiciliary service from the same location, providing personal care to people living in their own homes in the community. Not everyone using the domiciliary service received regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection 15 people were receiving personal care from the service.

There was no registered manager employed to run the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider told us they were in the process of recruiting a new manager. A staff member, who described themselves as the deputy manager had taken on some managerial responsibilities but had also been providing care to people using the domiciliary service due to lack of staffing. This had reduced the number of hours they had been available to provide management support to the service.

People were not safe living at the service. People were supported by staff who had not all been recruited safely; for example some staff did not have appropriate references in place or had not provided information about their previous job roles. Staff had received safeguarding training but when staff had raised allegations of abuse, the provider had not ensured people were protected until a proper investigation had been

completed. Staff did not always have up to date information to keep people safe. Risks that might affect people, relating to their needs or to the environment, had not all been assessed, recorded or updated effectively.

People's health needs were not always monitored properly and staff did not always have the skills or knowledge to support people safely with their health care needs. Staff had not received training related to people's individual needs, such as diabetes or skin care. People were not always supported in line with the principles of the Mental Capacity Act 2005.

People were not supported by sufficient numbers of staff to ensure their safety. Due to staff shortages, staff were working long hours to cover shifts and staff who had not been trained to provide care, were being used to support people's care needs.

Medicines were not always managed safely. During the week of the inspection, there was not always a staff member trained to administer medicines, working in the home. People told us their medicines were often late and when people had run out of medicines, these had not been re ordered.

People's preferences had not always been sought or recorded. People were not enabled to fulfil any aspirations they had. They had not been consulted about what food they would like to eat, how they liked to spend their time, or how they wanted to be cared for at the end of their life. People's records did not always reflect their current needs. Staff knew how to communicate with each person but this information had not been recorded to ensure consistency between staff.

People's confidential information was not always protected and people were not always treated with dignity and respect. The home had not been maintained or upgraded in a way that met people's needs. People's needs had not always been considered in relation to the design of the environment. People using the domiciliary service told us staff were kind.

The provider had not taken sufficient action to ensure the service improved. People's views about the service had not been sought and information provided by other organisations relating to gaps in the quality of the service had not been acted upon.

The provider had not monitored the service effectively to identify areas for improvement. Where changes had been made, they had not checked to ensure staff had implemented these. The monitoring they had completed had not identified all the concerns identified during the inspection. Where work had been delegated to members of staff they had not ensured staff had the skills and knowledge to complete the work and had not checked it had been done to the correct standard.
People using the domiciliary service told us staff were caring and did not miss visits.

During the second day of the inspection, the local authority reviewed the needs of the people living in the home and decided they would no longer commission with the service. By the final day of the inspection, everyone living in the residential home had been found alternative accommodation by the local authority. Following the inspection, the provider decided to apply to cancel their registration of the care home and the domiciliary care agency. This is being processed. No one is now receiving a service from this provider at this location.

We found breaches of regulation. 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

People were not protected from abuse.

People were not protected from risks relating to their needs or the environment.

People's medicines were not always managed in a safe way.

People were not supported by staff who had been recruited safely.

People were not supported by sufficient numbers of staff to keep them safe.

### Is the service effective?

**Inadequate**

The service was not effective

People were not supported by staff who had the right training and knowledge to meet their needs.

People lived in a home that was not always clean or suitable for their needs and that had not been properly maintained.

People were not supported in a way that reduced risks relating to their health or eating and drinking.

People's needs and preferences had not always been sought or met.

People were not always supported in line with the principles of the Mental Capacity Act 2005.

### Is the service caring?

**Inadequate**

The service was not always caring.

People's confidential information was not always protected.

People's care and treatment did not always meet their needs or

reflect their preferences.

People were not always treated with dignity and respect.

People using the domiciliary service told us staff were caring.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People's records were not always up to date and reflective of all their current needs.

People were not supported to remain active.

People's preferences for communication were not sought or recorded.

People's wishes for support at the end of their life were not discussed with them.

## Is the service well-led?

**Inadequate**

The service was not well led.

People did not live in a service which was monitored effectively by the provider to ensure improvements were identified and acted upon.

People's views of the service were not regularly sought to ensure they were involved in the development of the service.

People did not benefit from a service where changes were implemented as a result of information received by the provider.

The service was not led by staff who had the skills and experience to do so.

The provider did not always act in an open and transparent way.

# Fernleigh House

**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.

The inspection took place on 6, 7 and 13 August 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection, we received a concern that despite an allegation of abuse against a staff member, they had been enabled to continue working at the service. We did not investigate this concern but used the information to inform our inspection planning.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with everyone living in the care home, two people using the domiciliary service and two relatives. We also spoke with a community healthcare assistant who was visiting the home. We reviewed four people's records in detail. We also spoke with six staff and looked at four personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the quality and safety of the service was monitored and maintained. This included audits, minutes of meetings and policies and procedures.

Inadequate

# Is the service safe?

## Our findings

The service was not safe. At the last inspection, this domain was rated as inadequate. At this inspection we found improvements were still required and the service continues to be rated Inadequate.

At our last inspection we found there were no records that staff had received safeguarding training. At this inspection, most staff members had received safeguarding training. However, people were not protected from abuse. The PIR stated, "Our service will ensure that all residents are protected from all forms of abuse. In the event that an incident has become of knowledge, all necessary guidelines and procedures will be followed to ensure that the safety of the resident is maintained." However, following an allegation of abuse against a staff member, the deputy manager had not acted to protect the person. They had not followed the provider's or the local authority's policy. They had investigated the allegations themselves and had allowed the staff member to continue working with the person concerned. Staff members who had whistle blown to protect the people living in the service told us they were concerned appropriate action had not been taken by the provider or deputy manager. The deputy manager had not alerted the local authority or CQC.

Following concerns being raised to CQC and the local authority by a staff member, the local authority took action to refer the allegation to the police and to investigate the incident. During this time the provider and deputy manager still did not act to protect people. A staff member told us, "[The deputy manager] said the staff member should remain on the rota until the local authority had completed their investigation." On the night shift prior to the inspection, people had been supported by the staff member against whom the allegation had been made. The second staff member on shift that night had not been recruited safely and had not completed safeguarding or manual handling training. Daily notes showed both staff members had provided care to the person who was the subject of the allegation being investigated. The PIR stated, "Staff assist with ensuring the rights and freedoms of the resident are maintained." However, the provider had not acted to protect the people living in the service or keep them safe from abuse.

The provider did not take action to ensure disciplinary procedures were followed in order to protect people from unsafe care. The PIR stated, "Staff who perform poorly are immediately actioned and steps taken to improve performance. This includes training and being mentored by a senior member of staff." The provider and deputy manager had not acted in relation to allegations made against a member of staff. They told us they felt the allegations were malicious, however they had not taken any action regarding the staff they believed were acting maliciously either.

People were not protected from the risk of financial abuse. The deputy manager had put records in place to record people's personal money. However, it was not clear what each expenditure related to and the deputy manager did not have receipts available of the money that had been spent on people's behalf. They also had decided to keep people's money in their own home rather than at the service. This meant we could not confirm people's money had been spent according to the items on the records and that the balance was still available to people.

The provider had not ensured people were protected from abuse. This is a breach of Regulation 13 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found risks to people were not always assessed or managed safely. At this inspection we found people's records still did not provide up to date information for staff to understand risks relating to people's needs, or what action they needed to take in order to reduce the risks. One person was diabetic and their records said staff needed to familiarise themselves with the signs of hypoglaecemia and hyperglycaemia (when people's blood sugars are too low or too high). However, there was no further information describing what these symptoms looked like for the person concerned or what action staff should take. Staff had not received training in diabetes either. The PIR stated, "Risk assessments are updated whenever there is a change of circumstance and at a minimum are reviewed annually." However, one person was described in a risk assessment as a high risk of falls. Staff members told us that following an operation and change to medicines, they had not fallen. The person walked round the home a lot, chose not to wear well-fitting shoes and often forgot to use their walking frame The risk assessment did not reflect this information.

At our last inspection we found there was no detail or staff knowledge about the correct settings for air mattresses used to protect people from pressure related ulcers. At this inspection, we found this concern had not been acted upon. One person who was cared for in bed had a risk assessment stating they were at risk of pressure ulcers. An air mattress was in place to help reduce the risk however, staff did not know that the setting on the mattress may need to be changed according to the person's weight.

People were not always protected from risks relating to the environment. A risk assessment covering areas such as medicines, fire and infection control had been completed. However, staff did not always follow the actions described in order to mitigate the risks identified. Other risks had not been identified or recorded. For example, people's call bells were accessed via long cords which hung over or near the head of their bed and were long enough for the person to become entangled in them; the cleaner was also seen hoovering a room whilst the cable from the hoover ran across the corridor floor from another room. This was a trip hazard to people and staff. The chairs in one of the lounges were low and made of material that would be easy to slide off and would have caused a risk to people with limited mobility if they tried to sit on them.

At our last inspection the provider had failed to ensure repairs and maintenance were carried out promptly when necessary to prevent accidents or injuries. At this inspection we found this still to be the case. For example, one person told us their room was very warm but they could not open the window. This had been reported but no action taken. This left the person at risk of heat stroke due to the particularly high temperatures for the time of year.

At our last inspection the provider had not ensured medicines were managed safely by staff who were trained and assessed as competent. At this inspection people were still not supported by safe or effective medicines policy and practices. At the beginning of the inspection, we identified that there was no staff member in the service who was trained to administer medicines. The rota showed that for most of the week, there would not be a staff member trained to administer medicines, working in the service. On the first day of the inspection, staff members arranged a member of staff who usually worked in the domiciliary service to attend the service to administer people's medicines. One person had run out of a pain medicine and no action had been taken by staff to re order the medicine. Another person told us, "I am meant to get my tablet at 8am but it can come any time during the day." This meant people received their medicines later than prescribed.

Staff members who administered medicines in the service were not all appropriately trained. The PIR stated, "Staff will be provided with training to administer medication and follow the policy and procedures on the

varied resident. The service will ensure that staff are trained in accurately recording medication administered." We asked the deputy manager to show us evidence that one staff member had been trained to administer medicines and they responded, "They have always done medication, since before I was here." Staff members who administered medicines had not had checks on their competency to do this.

People had medicines profiles in place describing how and where they liked to receive their medicines. These were respected by staff members. However, when people had medicines prescribed to be taken 'as required', clear information was not always in place about what the medicine was for and how staff would know the person needed it.

Staff members did not follow best practice when completing medicines administration records (MARs). This increased the risk of errors occurring. There were some gaps in the MARs where staff had not signed to say they had administered medicines. Where staff had handwritten medicines and the directions for administering on people's MARs, these had not been signed by two staff members. Where people had been given medicines that need extra security, these had not always been signed by two staff members.

Prescribed creams were not always managed safely. Since the last inspection cream charts were in place to record the use of these creams, but these were not always completed accurately by staff. The details describing how to administer them did not always match the prescription details on the MARs. Creams were not all dated on opening to ensure staff knew when they needed discarding.

The deputy manager told us they had completed an audit of medicines but could not find it. They told us they had identified that staff members were not using the correct codes on the MARs and that the re ordering of medicines was not being recorded for staff to action. There was no evidence these areas had then been monitored for improvements.

Medicines storage was not always safe. There was a locked fridge used to store medicines that required refrigerating. There was a sheet to record the temperature of the fridge but this had not been completed since 29 July 2018. When people refused their medicine, these had not been recorded or stored safely. They had all been left in a jar in the medicines cabinet, which meant staff could not account for what should be there and whether any had gone missing.

Medicines were locked away safely, medicines that needed extra security were stored safely and the amount of each medicine in the service recorded accurately. The temperature of the room where most medicines were stored was recorded regularly to ensure it did not get too hot or too cold to store the medicines safely.

Some people using the domiciliary service required assistance from staff to take their medicines. People did not raise any concerns about the way their medicines were managed.

At our last inspection the provider had not ensured people were protected from the spread of infection. At this inspection we found this was still the case. The PIR stated, "Staff will be trained in infection control and food hygiene to understand the importance of this and responsibilities." However, staff had still not all completed infection control training. Dirty washing was left in laundry baskets with no lids in the laundry, below clean washing. Soiled laundry was in an appropriate bag but in a swing top bin, on which the lid didn't close properly. This was also in the same room as clean laundry.

The home was not clean or hygienic. There were stains on walls and radiators and the whole home smelt continually of urine throughout the inspection. Communal and people's en suite toilets did not always have toilet roll available in them. People's en suite bathrooms had wet flannels in them which had been used to

provide personal care. A healthcare professional told us there was rarely liquid soap available in people's rooms. This meant they usually had to walk through the home to wash their hands in the kitchen, after providing care to people. This increased the risk of cross infection. There were cleaning records in the communal bathrooms and toilets but these had not been completed recently. The most recent one completed in the bathrooms downstairs was on 23 July 2018.

People were not protected from the risk of fire. The deputy manager told us there had been a fire drill four months ago but they did not have a record of which staff attended. Staff members had not all completed fire safety training and there was no record that fire alarms had been tested regularly. The deputy manager told us they had not been tested recently. People had personal emergency evacuation plans in place.

We shared this information with the local fire authority who contacted the local authority to gain assurance people were moving to other services and therefore would not be at risk of fire.

Staff were aware they should report incidents however, there was no clear process in place to ensure incidents were reviewed, action was taken and learning was identified. During the inspection staff could not find the current accident book. This meant any accidents could not have been recorded correctly.

The provider had not acted to keep people safe and mitigate risks to people using the service. The provider had not ensured medicines were managed safely. These are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We shared all this information with the local authority who took immediate action to keep people safe.

At our last inspection there were no records of references or Disclosure and Barring Service (DBS) checks for staff. At this inspection we found people were still not supported by staff who had been recruited safely. The PIR stated, "We have now implemented a robust recruitment process." Most staff had recent DBS checks in place, however the DBS check on one staff member's file showed it was from another organisation. Four staff members had no application forms or career history recorded, one staff member had no references on their file and two staff members only had one character reference recorded. At the beginning of the inspection, a new staff member was shadowing staff; however, they did not have a DBS in place. The staff member's shadow shift was terminated when we identified this.

The provider had not ensured people were supported by staff members who had been recruited safely. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection there were insufficient staff on duty in the care home at night to ensure people received safe care at all times. Staffing had been increased at night and there were now two staff working each night in the home. However, there were not always sufficient staff to meet people's needs safely during the day. The PIR stated there would be two staff members on all day with three from 8am to 9am. The rota in place during the inspection showed there were only two care staff working in the service throughout the day. Three people required two staff members to support them when receiving personal care. Staff members told us this could take up to 20 minutes to provide. During this time there were no staff members available to support the needs of other people living at the service. One person had fallen in the past, they didn't like to wear shoes that would reduce the risk of them falling and often forgot to use their walking frame. Whilst staff were providing personal care to other people, no staff members were available to ensure this person's safety. Some staff members told us they were sometimes working 17 hour shifts to ensure the rota was covered.

The provider had not ensured there were sufficient staff available to provide the agreed calls to people using the domiciliary service. The deputy manager told us, "I am working in the community four days a week." This meant they had not been available in the care home to ensure the quality of the service was monitored and action taken to improve it. There was no information available in the service regarding who received care from the domiciliary service and when. This meant when the deputy manager was not present, no-one was overseeing whether the calls had been completed. During the first day of the inspection, a staff member told us they had to visit a person in the community, as their call had been missed. They did not know which staff member should have attended the call and had only found out it had been missed as the person had contacted the service themselves.

The provider had not assessed the needs of the people living in the service to ensure there were sufficient numbers of staff available to meet their needs. The provider had not ensured there were sufficient staff members available to provide the agreed calls to people using the domiciliary service. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people using the domiciliary service told us they were happy with the service and had never had a missed call. The explained they always knew who was visiting them and were always told about any changes. One person confirmed, "They have never let us down".

Inadequate

# Is the service effective?

## Our findings

At our last inspection we rated the service as requiring improvement in this area. At this inspection we found improvements had not been made. In fact, the service had deteriorated and is now rated Inadequate.

At our last inspection training records for staff were unavailable and staff told us training courses were "poor". Staff were also not trained to ensure they had clear information and guidance on how to meet people's needs fully. At this inspection we found people were still supported by staff who did not always have the skills and knowledge to meet their needs. The PIR stated, "Our staff will have the required training to ensure that the care practices carried out are in a safe manner. That includes providing assistance with transferring or using the hoist." Staff were not always up to date with the training the provider had identified as mandatory. The deputy manager had an overview of which staff needed to complete training but told us that, as they were often covering shifts, they were not able to release staff to complete the training. The provider told us staff did not always complete training when requested. They had not taken further action to ensure staff were appropriately trained.

Staff did not have training to meet people's individual needs. For example, some people were living with dementia, one person had diabetes and others were cared for in bed. However, staff had not received training in dementia, diabetes or skin care. Staff members who supported people to move had not always received manual handling training.

New staff members did not always receive a comprehensive induction before supporting people. The PIR stated, "Staff have a two day induction including philosophy, values & principles, confidentiality, equal opportunities, fire routines, dementia, care practices, food hygiene, drug administration, safeguarding, pressure care & manual handling." One staff member who had not been in post for a month told us they had received some training and had the opportunity to read care plans before they started supporting people. However, they had not completed all mandatory training. Another staff member told us they had received some training before being put on the rota. However, they were working with one other staff member during the inspection and told us they were only just getting to know people.

Staff members did not always receive effective support and supervision to fulfil their role. Some staff members had received supervision and the deputy manager had a matrix to identify when staff members were due a supervision. However, due to the amount of time they spent supporting people using the domiciliary service, they had not been able to complete supervisions according to the dates on the matrix. Some staff members told us they had been delegated responsibilities without any information or training about how to fulfil them, for example, managing rotas or auditing records.

The provider had not ensured staff received the training, development and supervision required to carry out their role. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the environment required upgrading and had not always been designed in

line with people's needs. At this inspection, we found people's needs and preferences still had not been considered in relation to the environment. For example, one communal toilet was small and difficult for people with reduced mobility to access; and another person's en suite was difficult for them to access as the door would not open fully.

There was a clear lack of care for the environment. Plaster had been chipped off the walls in areas of people's bedrooms and not repaired, there were areas of the home where paint and wallpaper was peeling off. One person had an unused bed rail leaning up against their wall and another person only had one curtain at their window, which itself had nearly fallen off.

The provider had not ensured the premises and equipment were clean, properly maintained and suitable for the purpose they were being used. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a stair lift for people to use and bath chairs to help people use the bath.

At our last inspection people told us they were not always offered a choice at lunchtimes. At this inspection we found only one option was available at lunch time. There was a menu board but this was left blank until nearly lunch time. People's needs and preferences regarding their diet were not always requested or recorded to ensure these were reflected in the food people were offered. At our last inspection, we found that if food suitable for people with diabetes ran out, those people had to wait until a weekly shop was completed before more suitable food was provided. At this inspection staff members told us the level of food available in the service had improved.

At our last inspection we found poor records relating to people's fluid intake. At this inspection we found this had not improved. Some people's files showed they had risks relating to weight loss; however, staff were not following the guidelines described in people's care plans and risk assessments to reduce the risk. One person's care plan stated staff should monitor their eating, drinking and weight loss. Staff recorded the person's fluid intake but did not provide a total for each day to identify if they had had enough to drink. Staff told us they recorded information about what the person had eaten in the person's daily notes, but no-one monitored this to ensure they were consistently eating enough. Staff told us the person was not weighed as they could not weight bear. No other methods had been employed to allow staff to monitor whether the person might be losing weight.

When risks related to eating had been identified, recommended actions to reduce the risk were not always followed, or the person's care records updated when their needs changed. One person had been assessed by the speech and language team (SALT) as being at risk of choking. Information displayed in the kitchen and in the person's room stated they should have a soft diet. The person was seen eating liver at lunchtime without staff always present to monitor their safety. The deputy manager told us the person was now able to eat a normal diet, but this had not been recorded anywhere and no records from relevant professionals were present.

People's health care needs were not always monitored effectively which meant any changes in their health or well-being may not have been identified. The PIR stated, "Staff are trained in monitoring and observing any issues or change in needs of the resident and report to management." However, one person had a catheter and their records required staff to record amount and type of urine and stools. These had not been completed regularly and there was no further information to inform staff when they would need to refer the person to a healthcare professional.

Staff did not have the skills or information to support people to take risks to retain their independence whilst minimizing any hazards. For example, people who had a risk of falling were encouraged to stay still all day, even though one of them liked to walk about. We heard a staff member say about one person, "I will put her in the dining room now and then I won't have to move her again."

The provider had not ensured that risks relating to people eating, drinking and health needs were properly recorded or that action was taken to mitigate the risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A healthcare professional confirmed the staff contacted them when they had any concerns.

People who were supported by the domiciliary agency had support from staff, when necessary to contact healthcare professionals.

We observed staff asking people for consent before providing care. Some people had also signed to say they consented to receiving care as described in their records. However, the deputy manager told us they were keeping people's personal money at their home and had not asked for people's consent to do this. There were no records that people had consented to have their money looked after by staff or the deputy manager.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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. We found people were placed at risk of their human rights not being respected or up held. Some staff had a basic understanding of the mental capacity act. However, even though they told us some people lacked the capacity to make certain decisions for themselves, MCA assessments had not been completed to evidence why staff were making certain decisions in their best interests.

The provider had not ensured that the principles of the Mental Capacity Act 2005 had been followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). The registered manager had applied for DoLS on behalf of people however, these were awaiting review by the local authority designated officer.

Inadequate

# Is the service caring?

## Our findings

At the last inspection the service was rating as good in this area. However, at this inspection we found the service was not always caring and have rated it as Requires improvement.

People were not always treated with dignity. Signs had been put on people's walls telling them to put their continence pads in their bin. One person, whilst being supported to eat, told a staff member they needed to pass urine. The staff member responded, "That's ok, you have a pad on", and continued with the task in hand.

People's privacy was not always respected. Staff closed people's doors when they were providing personal care but the rest of the time, people's bedroom doors were left open, even when they were sleeping. There was no evidence to show they had consented to this and staff did not routinely ask them if they were happy to have their doors open.

Staff did not always promote people's independence. For example, people were not encouraged by staff to be involved in activities related to their own needs or the daily activities within the home. Care plans did not always detail what a person could do for themselves and what they needed support with.

The provider had not ensured people were treated with dignity and respect or that their independence was supported. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person receiving care in their own home had regained their independence following staff support. Their relative explained, "They have assisted with daily exercises and enabled him to walk again which we were told he would never do".

People's confidential information was not always protected. There were three rooms which held information about people using the service. During the inspection, these were regularly left unlocked.

The PIR stated, "I feel we provide a very caring service." Staff spoke to people in a caring way but were not always knowledgeable about the best way to relieve any distress people felt. There was no guidance in people's care plans about how to support people to maintain their wellbeing or what action to take if they experienced anxiety.

Friends and relatives were able to visit. Information had not been sought that would enable staff to support people to maintain important relationships.

The provider had not always ensured people's confidential information was protected or records provided up to date information to enable staff to meet people's needs and wishes. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the domiciliary service told us staff treated them with respect. They spoke highly of the care staff provided. One person told us, "I know all of them, all caring, dedicated people, we wouldn't swap them for anyone else"

Inadequate

# Is the service responsive?

## Our findings

At the last inspection the service was rated as requires improvement in this area. At this inspection we found the service was not responsive and have rated them as inadequate.

At the last inspection we found changes in people's needs had not always been updated after their needs had been reviewed. At this inspection we found people's care plans still did not always reflect their up to date needs. The PIR stated, "Care plans are updated monthly, or more often if a resident's needs change. Residents are consulted to discuss whether they are happy with the plan or what changes they would like. Residents' interests are identified in the care plan." However, there was no evidence to show people had been involved in the content of their care plan and people's needs were not always reviewed when required.

Conflicting information was present throughout people's care files. For example, one person had decided to be cared for in bed. They had three different instructions regarding how often they needed to be repositioned. The deputy manager advised these were not correct. The person's needs had changed but this had not prompted a review. The records for the domiciliary service had not been reviewed or updated to ensure they were still reflective of people's needs. A staff member told us they knew people's records weren't good but had no time made available to improve them. Staff told us however, that they ensured any changes to people's needs were communicated with the whole team and this was confirmed by people supported by the service.

Staff knew people well, however, people's individual routines and preferences for how they received their care were not included in their care plans. The deputy manager explained, "Three different staff members have been sent to the service to write care plans, staff who don't know the people in the service." A staff member confirmed that they were not consulted when the previous manager had updated care plans, even though the manager did not know people well.

The provider had not ensured accurate, complete and contemporaneous records were maintained in respect of each individual. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection some people told us their social needs were not always met. At this inspection, we found people had little opportunity for support with any interest they had or for interaction with others. The PIR stated, "Staff are to encourage to assist them e.g. to read newspapers, do crosswords, knit, do puzzle books etc. There is an afternoon activities chart detailing activities staff are expected to do with each resident. Staff record daily what has been done. Arrangements are made for links to social clubs, coffee mornings etc to be maintained." One staff member told us, "There are activities a couple of afternoons a week". However, during the inspection most people spent time watching the television or doing nothing. Staff told us they had held a cupcake day and a befriender visited the home regularly. One person's care plan stated, "We offer lots of activities through the week which [...] can take part in." However, although we observed the person colouring for a short time with a staff member during the inspection; the rest of the

time they were sitting in the lounge, alone for most of the time.

Due to lack of staff and lack of opportunities within the home, people's choices were limited. Records of how one person had spent their time in the week prior to the inspection had only been completed on four days. Three of these days stated they had watched TV and one day stated they had listened to music. Another person's 'activities log' listed, "sat in the front room", "wandering in the home" and, "listening to radio." Nothing else was added about how the person spent their time on these three days. Staff confirmed that if people's relatives did not take them out, they did not go out and there was no other involvement in community activities or organisations.

Staff did not have the time, skills or information to ensure people's individual needs were met effectively. People's wishes and interests had not been discussed with them. People's records did not always contain information about their background, life history or what was important to them. People passed their time watching television or lying in bed.

Staff told us they worked well together as a team. However, effective communication systems were not in place to ensure staff remained up to date with any changes to people's needs or related actions that were required. Handover sheets were used but gave very little information about each person.

People's end of life wishes had not been documented as part of their care plan. This meant that if someone was at the end of their life and/or died, staff may not be aware of their preferences at this time.

The service did not reflect best practice relating to the accessible information standard. The accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Assessments to identify any disability related information or communication needs had not been completed.

The provider had not ensured the care and support people received met their needs or reflected their preferences. The provider had not ensured people's wishes for the end of their life had been sought and recorded. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the domiciliary service had copies of the provider's complaints procedures.

There was no log of complaints in the service. However, the PIR stated, "We have not received any formal complaints in the last 12 months we have had few verbal complaints with the mix up in laundry. As a result all new residents have an itemised list completed of what they have brought into the home. We ask that all residents clothes are initialled."

People living in their own homes who received the domiciliary service were happy with the responsiveness of the service. A person told us, "They are amazing."

Inadequate

# Is the service well-led?

## Our findings

At the last inspection well led was rated as Inadequate. Following the last inspection, the provider had been submitting monthly reports to the commission detailing what action they had taken to improve the service. We found the information in these reports were not consistently an accurate reflection of the quality of the service. At this inspection we found improvements had not been made and we have continued to rate the service as Inadequate.

At our last inspection we found that despite problems being highlighted by the provider, actions had not been carried out or maintained to address the issues. At this inspection we found improvements had not been made. The provider did not visit the service regularly or provide appropriate levels of leadership and governance. When they did visit they reviewed some aspects of the service. For example, at a recent visit they had reviewed medicines management and visited some people using the domiciliary service. Some actions had been communicated to staff as a result, however there was no process in place to check staff had made the required changes or that these had been effective. Their reviews had not identified most of the concerns we found during the inspection.

Information had not been used to aid learning and drive improvement across the service. At our last inspection we detailed areas where improvements were required. At this inspection we found the provider had not used this information to ensure they improved the quality of the service received by people. For example, our last inspection identified that people's needs and risks had not always been sought, recorded or met. This was still the case at this inspection. At our last inspection, the provider had not ensured there were sufficient and suitably qualified staff available to meet people's needs. This concern continued at this inspection.

At the last inspection, the registered manager was unable to provide evidence of their monitoring and quality assurance activities. At this inspection the same concern remained. The PIR stated, "We have a quality assurance policy which involves annual reviews of key areas of the service." However, when we requested evidence of the quality assurance activities, none were available. At the last inspection we found medicine administration and management had not been monitored or audited effectively to improve practice. We also found there were no health and safety audits in place to ensure the safe running and cleanliness of the home. At this inspection we were told these audits had been completed but the deputy manager could not find them. We requested these be emailed to us following the inspection but we did not receive them.

The provider had not ensured the deputy manager had the time available to monitor and improve the service. The deputy manager had plans in place to complete staff supervision, update training and staff personnel files; and ensure people's care plans were reflective of their needs; however, they had not had been able to do this due to the time they had spent covering care shifts.

There was no registered manager in post. There had been a variety of different managers in the service and staff told us they did not always know who they were or that they were coming. One staff member told us,

"The inconsistency in management makes it very difficult to know what to do and who to report to." Even though we had raised serious concerns about the service and the level of risk people were exposed to, the provider left the service following the second day of the inspection. They did not live locally. One staff member told us, "They don't care, they have no loyalty."

There was little evidence that staff or the provider sought people's feedback on the quality of the home. Two quality assurance questionnaires were available to view. One suggested, "going out more with residents" and another requested a barbeque. There was no evidence to show that either of these had been acted upon. Staff confirmed to us that people did not go out.

There was not a positive culture in the service. The provider had not ensured there was clear and consistent leadership in the service to ensure staff understood and were held accountable for meeting their roles and responsibilities. The PIR stated, "Our philosophy & values make this a resident centred service where the wishes of the residents are paramount. Staff know that their role is to find out what residents want and to deliver it, giving them choice and allowing them to take risks. Staff are in no doubt that compassion, dignity, independence, respect etc are primary values." The service and the staff working in the service did not reflect this philosophy. The service was not organised around the needs and wishes of people and they were not enabled to make choices and take risks. The provider had not acted to ensure the values of the service were embedded in staff culture. They had not ensured open communication with staff members about the management of the service or any changes being made. This had created uncertainty within the staff team. One staff member explained, "[The provider] is not prepared to pay for decent staff, we have had no support from her, the only time she has come to see the domiciliary care service is when CQC instructed her to".

The provider had policies and procedures in place but none of these were specific to the domiciliary agency. For example, there was no lone worker policy.

The provider had not ensured the quality of the service was assessed, monitored and improved. They had not sought feedback from service users or used information in order to improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not clear who held overall accountability for the day to day running of the service. A staff member told us they were the deputy manager but the provider told us the same staff member was the manager. This staff member spent most of their time fulfilling a caring role, due to lack of staffing. This meant they were unable to manage or monitor the service.

The deputy manager did not live locally and at times had to leave the local area to go home. Staff members told us they were not sure when the deputy manager was leaving and when they would be back. In the deputy manager's absence, staff remaining at the service did not have the time, information or skills to ensure the service continued to run safely and effectively. The PIR stated, "Information where required will be shared with outside agencies to improve the safety and wellbeing of the resident." There were several messages from social services requesting the deputy manager contact them in relation to the service and people's needs but these had not been fulfilled as they had not been in the service for six days prior to the inspection. There was no consistent contact point for external professionals.

The provider had not ensured that staff who were expected to complete work delegated to them by themselves or the deputy manager, had the skills and experience to do so. The deputy manager did not have all the necessary skills and knowledge to manage the day to day running of the service. Decisions made by the deputy manager had not been in line with best practice and had not always protected the people living in the service. When they had delegated responsibilities to other members of staff they had not

ensured they had the skills and knowledge to complete the task. This had resulted in people being put at risk. For example, when a staff member who had been responsible for the day to day running of the domiciliary service had left, they had not been replaced. Existing staff members told us they had been expected to take on this role as well as continuing to provide care to people in their homes. They told us they had not been trained in the computerised rota planning system.

The provider had not ensured that staff employed in the service had the time, skill and experience to complete the duties delegated to them. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always open and transparent. They had not ensured the commission and the local authority were notified of allegations of abuse within the service in line with their legal obligations. During the inspection they told us they had not been aware of the content of the allegation. However, they had previously discussed this and the reason for their lack of action with a different CQC inspector.

The provider had not ensured the commission was notified of allegations of abuse. This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Following the inspection, the provider decided to apply to cancel their registration of the care home and the domiciliary care agency. This is being processed. No one is now receiving a service from this provider at this location.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents |
| Personal care | The provider had not ensured the commission was notified of allegations of abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Personal care | The provider had not ensured the care and treatment people received met their needs or reflected their preferences.<br><br>The provider had not ensured people's wishes for the end of their life had been sought and recorded. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Personal care | The provider had not ensured people were treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Personal care | The provider had not ensured that the principles of the Mental Capacity Act 2005 had been followed. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not acted to keep people safe and mitigate risks to people using the service. The provider had not ensured medicines were managed safely. The provider had not ensured that risks relating to people eating, drinking and health needs were properly recorded or that action was taken to mitigate the risks. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured people were protected from abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had not ensured the premises and equipment were clean, properly maintained and suitable for the purpose they were being used. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not always ensured people's confidential information was protected. The provider had not ensured accurate, complete and contemporaneous records were maintained in respect of each individual.<br><br>The provider had not ensured the quality of the service was assessed, monitored and improved. They had not sought feedback from service users or used information in order to improve the service. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had not ensured people were supported by staff members who had been recruited safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not assessed the needs of the people living in the service to ensure there were sufficient numbers of staff available to meet their needs. The provider had not ensured there were sufficient staff members available to provide the agreed calls to people using the domiciliary service.<br>The provider had not ensured staff received the training, development and supervision required to carry out their role. |