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Benthorn Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 April 2016 and was unannounced.

This was the second comprehensive inspection carried out at Benthorn Lodge since the service was last inspected on 11 December 2015. At this time they were found to be in breach of three regulations.

Prior to this inspection we received concerns from the local authority about a lack of staffing and poor care practices which meant that people were not receiving the best possible care. Concerns were also raised in respect of inadequate training for staff, a lack of activities to stimulate people and poor management and leadership of the service.

Benthorn Lodge provides care and support for up to 20 older people who have physical and mental health needs. Most people living at the service have advanced dementia care needs. There were 15 people using the service when we visited, one of whom was in hospital at the time of our visit. .

The service did not have a registered manager. 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.

At the previous inspection we found that staffing levels were not adequate to meet the needs of people using the service, in a timely manner. During this visit we found that there were still insufficient numbers of suitably qualified, competent, skilled and experienced staff providing care or treatment to people.

At the previous inspection we found that there was a lack of stimulation and interaction between staff and people using the service and the provision of meaningful activities. During this visit we found and records confirmed that few meaningful activities took place and people were at risk of being socially isolated.

At the previous inspection we found that there was a difference in the philosophy and ethos of the management of the service between the registered manager and the provider. This had led to poor management and leadership. At this visit we found the registered manger had left and although the registered provider was at the service everyday they were not providing any direct leadership or management of the service.

These were continued breaches of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014

Although people told us they felt safe at the service the staff we spoke with felt that people were not always safe because of insufficient staffing numbers. They told us they would not feel confident that any concerns they raised with the registered provider would be dealt with effectively. This meant that while people said

they felt safe, safeguarding concerns had not always been reported and escalated appropriately and placed people at risk of harm.

We found that risks to people's safety had been assessed, however for one person new to the service they did not have any risk management plans in pace. This meant that staff were not provided with guidance to provide support safely.

People had not been protected against the risks associated with unsafe or unsuitable premises. Service certificates for the premises and equipment had expired and environmental checks had not been undertaken. This showed that the provider had not taken appropriate action to ensure people were safe through a regular programme of servicing and maintenance of the premises and equipment.

A dependency tool was used to assess the number of staff needed to provide care and support for people. However, this tool did not reflect the current dependency levels of people using the service and as a result we found staffing levels were not sufficient to meet people's needs and this was having an impact on the quality of care received by people using the service.

Robust recruitment policies and procedures had not been consistently followed to ensure that staff were suitable to work with people.

Systems and processes in place for obtaining, administrating, storage and recording of medicines were not always safe. This meant that people's care and treatment was not provided in a safe way and the registered provider had failed to deliver the safe and proper management of medicines. This has subsequently placed people's health and wellbeing at immediate risk.

Staff did not receive appropriate support and training to perform their roles and responsibilities effectively. They told us they had not received practical training in moving and handling. This placed people at risk of receiving unsafe care by staff who were not trained appropriately to carry out their roles.

People's consent to care and treatment was not sought in line with current legislation. People's capacity to make their own specific decisions had not been assessed. There was no evidence that best interest meetings took place when specific decisions needed to be made or evidence that any least restrictive options were explored for any decisions about their care.

People did not always have timely access to health care professionals to meet their specific health care needs. This meant people may be left in pain or discomfort until they were supported to see a healthcare professional. This also placed people at further risk of deterioration of their condition.

People were not always offered choices about their care and were not involved in decisions about their routines. We also found that staff did not always promote people's privacy and dignity, and confidential information was not always stored securely. This meant that staff did not always have due to regard to people's right to dignity, privacy and confidentiality.

People did not receive care that was responsive to their needs or focused on them as individuals. We found one person using the service had not received an initial assessment, and as a result of this there was no care plan or associated risk assessments in place. This placed the person at risk of unsafe and inappropriate care and treatment.

Records showed that people and their relatives were not involved in the care planning and review process.

The registered provider confirmed that reviews of people's care had not been held regularly and were overdue for some people. This showed that changes to people's care and treatment were not consistently reviewed and updated with the involvement of people to whose care they related and their family members.

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The service did not have a complaints procedure in place and we found there was no system for logging and recording complaints. This demonstrated that people's concerns were not listened to and acted upon by the registered provider.

We found the culture at the service was not open and transparent and we found a lack of leadership in the day to day running of the service. Quality assurance, health and safety checks and feedback from people had not been undertaken for a lengthy period and did not therefore effectively check the care and welfare of people using the service. Required notifications had not been sent to the Care Quality Commission. This meant that the management of the service and systems in place were not effective or robust enough to ensure that risks relating to the health, safety and welfare of people using the service were responded to.
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During this inspection we identified a number of areas where the provider was not meeting expectations and where they had breached Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

People were not always protected from avoidable harm. Staffing levels were not sufficient to meet people's needs or safeguard them from potential harm. Incidents of potential abuse were not dealt with effectively by the registered provider.

Risk assessments were not in place for all people using the service to protect them.

People were at risk because the premises had not been adequately maintained and service certificates had expired.

Recruitment practices were not robust and there were gaps in staff employment checks.

Systems for the management of medicines were unsafe and did not protect people using the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not provided with regular training to develop their skills and knowledge to enable them to perform their duties effectively.

The service was not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and people using the service could not be confident that their human rights would be respected and taken into account.

We found that people's care and support was not planned and delivered in a way that consistently ensured people's health and well-being.

People were provided with choices of food and drink to meet their dietary needs.

Is the service caring?

Requires Improvement

The service was not caring.

Care was mainly task focused and did not take account of people's individual preferences and did not always respect their dignity.

People were not supported to express their views and be actively involved in making decisions about their care, treatment and support.

We found that people were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

The service was not flexible and receptive to people's individual needs and preferences.

There was a lack of stimulation and interaction between staff and people using the service. Meaningful activities were not provided which meant that people were not engaged adequately.

People's views were not regularly sought, listened to and used to drive improvement in the service.

Systems were not in place so that people could raise concerns or issues about the service.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager in place and this was having a significant impact on the leadership and direction for people living in the service and staff.

We found that staff were not supported to question practice and we were unable to find how people who raised concerns, including whistle-blowers were protected.

People were put at risk because systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment were not effective.

Benthorn Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 April 2016 and was unannounced. The inspection was carried out by two adult social care inspectors from the Care Quality Commission.

We checked the information we held about the service and the provider, such as notifications and any safeguarding or whistleblowing incidents which may have occurred. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority, who have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant most were not able to talk to us about their experiences.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people who lived at the service and observed the care being provided to a number of other people during key points of the day, including lunch time and when medication was being administered. We also spoke with four relatives of people using the service to determine their views of service delivery on behalf of their family members. In addition we spoke with nine members of staff, including the registered provider, the chef, the administrator, the maintenance person and five care members of staff. We also spoke with one visiting healthcare professional.

We looked at five people's care records to see if their records were accurate and reflected their care and

treatment needs. We also examined other records relating to the running of the service - such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Inadequate

Is the service safe?

Our findings

During our last visit on 11 December 2015 we found that staffing levels were not always sufficient to meet people's care and support needs appropriately.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this visit we checked to see if improvements had been made. We found there were insufficient numbers of staff available to keep people safe.

One person told us, "Sometimes they are short of staff but it's okay." Two relatives we spoke with also commented on the staffing numbers. One told us, "There are never enough staff. Sometimes there are no staff around for ages." The second relative said, "They could definitely do with more staff." We also found that family members had commented on staffing levels when answering the service's satisfaction survey. One comment in a service satisfaction survey that we looked at stated, "We remain concerned with staff levels."

Staff told us that staffing numbers were inadequate. They said there were three staff in the morning and felt this was usually sufficient. However, the number of staff in the afternoon had dropped from three to two and staff told us this was unsafe. One staff member commented, "Staffing numbers are ridiculously low." Another member of staff told us, "Staff are working long hours. Normally the rotas don't come out until the day before the next rota starts." Another staff member confirmed they were working 60 hours that week and the rota we looked at confirmed this.

A visiting healthcare professional told us that the service was often chaotic and there was a lack of staff to meet people's needs.

We requested to look at four weeks of staff rota. The provider was only able to produce two weeks, the current week and the previous week. When we asked to see the others we were told they were in her car and she failed to produce any more. Rotas demonstrated that over a two week period two staff had been on duty in the afternoon on ten occasions. Agency staff were used every night and one night a week two agency staff were used. The provider told us when this happened they would sleep in at the service. The provider also told us they attempted to use the same staff from the agency to ensure some consistency of staff. We saw that the rota finished on the last day of our inspection and there was no new rota in place which meant staff were unaware of what shift they would be working the next day.

We found that in addition to their care duties, staff also had to complete cleaning duties, the laundry and provide meaningful activities to people using the service. We asked the provider how she assessed the staffing numbers against the needs of people using the service. She told us there was a form that had been used previously but she did not know where to find this. The document was produced on the second day of our inspection. It was not dated so we could not be sure when it was last completed. The tool stated that

four people using the service had high needs. However, electronic records we looked at showed that eight people had high needs. This meant the staffing numbers in place were not sufficient to meet people's needs and this was having an impact on the quality of care received by people using the service. .

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received mixed views about whether people were safe at the service. Two people we spoke with told us they felt safe and comfortable in the company of staff. One person told us, "Oh yes I'm safe. I am looked after." The second person smiled, nodded their head and said yes when we asked them if they felt safe. One relative said, "Yes I think [Relative] is safe." However, a second relative expressed doubts about their family member's safety. They said, "They are always short of staff. Sometimes there are no staff around the lounge where everyone sits. There's little observation of people. It worries me."

Most of the staff we spoke with did not feel that people were always safe. One commented, "I don't feel people are safe. We have two people who constantly try to stand up. In the afternoons we usually have two staff so we can't be around all the time. They are at risk of falls." Another member of staff commented, "People don't have a say. It's institutional abuse basically."

All the staff we spoke with could explain how they would recognise abuse. However, most staff said they were not confident that if they reported any concerns about abuse or the conduct of their colleagues, the registered provider would listen and take appropriate action. One said, "I am not confident that it would be dealt with." Another staff member informed us, "I wouldn't hesitate to report any concerns I had. I wouldn't report them to [provider] because I know nothing would be done. I have reported two incidents direct to the safeguarding team before." This meant that safeguarding concerns had the potential to go unreported by staff because they had very little confidence that their concerns would be dealt with effectively.

Staff told us they had received training on safeguarding procedures. Records demonstrated that some staff training had expired and needed to be updated. We also saw that staff who worked in the kitchen and the maintenance staff had not received any safeguarding training. One member of staff told us, "The training is not very good. We have to complete booklets and they go off to be marked, but that's it. I don't feel like I learn much that way."

The registered provider had limited understanding of their responsibility to report incidents that may have the potential to be a safeguarding concern and to notify the Care Quality Commission (CQC) of these. The provider told us, "I'm more used to helping out 'on the floor'." She also said, "Safeguarding have been in twice, as far as I am aware they were quite happy." This meant that while people said they felt safe, safeguarding concerns had not always been reported and escalated appropriately and placed people at risk of harm.

Following this discussion we saw that the local safeguarding team were at the service to follow up on a concern regarding one person who had passed away. They also wanted to follow up on a service wide protection plan which had been introduced following numerous safeguarding concerns. We later spoke with the safeguarding officer, who informed us that no areas of the protection plan had been actioned.

We found that the service had their own safeguarding policy that had been updated in March 2015. The provider was unable to locate a copy of the local authority safeguarding procedure so we could not be assured they were following best practice in line with local policies. .

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were risk management plans in place to protect and promote people's safety. One person told us, "I had to have a risk assessment when I used to go out on my own. I don't go now because of my health."

Staff were able to explain to us how risk assessments were used to promote people's safety. For example, one member of staff told us about one person's pressure area care risk assessment. They said this was in place to prevent the pressure sore becoming worse.

Staff told us that most people were not able to be involved with the development of their risk assessments. One relative informed us, "I have no idea what risk assessments are in place for [relative]. We are not involved and never informed."

We saw that with the exception of one person, there were risk management plans in place for people living at the service. These outlined key areas of risk, such as falls, medication and manual handling as well as any other areas of potential risk specific to each individual. They included information on what action staff should take to promote people's safety. We saw that risk assessments were up to date and reviewed as people's needs changed. One person who regularly visits the service for respite care did not have any risk assessments in place. This meant that vital information about how to provide care and treatment to this person safely was not available for staff. This placed the person at risk of receiving unsafe care and treatment.

During our visit we found that people were not protected against the risks associated with unsafe or unsuitable premises.

We observed areas of damp in several areas of the home. In the office used by staff there was a large area of damp around the window sill. Staff showed us that towels were in place on the window sill and the printer to absorb water. We noted there was electronic equipment in use in this area.

We found that several bedroom carpets were stained, particularly around the sink areas. In the top floor hallway we saw that the main light was not working, resulting in a dark hallway, particularly outside the room of one person who was independently mobile and who had poor eyesight. Also in this area there were signs of damp on the ceiling, missing skirting boards on walls showing exposed plaster and masonry, including holes in wall. In some toilet areas we found no toilet paper in the holders, no hand wash sink in one toilet, no paper towels available and no sanitary waste bins. There were gaps between the skirting and wall making it a potential area for infection. We saw areas where the skirting was broken around the plumbing, exposing holes in walls and masonry.

We spoke with one of the people responsible for the maintenance of the service and asked if we could look at the refurbishment and improvement plan for the service. They told us that most of the jobs needed at the service were, "In my head." He showed us that there was a maintenance book which listed the jobs around the service that needed to be completed. These were not dated, but did give a timeframe for completion. Some jobs had been signed off by the maintenance staff; however there were a number of gaps. The maintenance person stated, "I have been a bit slack with that in the last few months." There was no evidence of managerial review or oversight of the maintenance book, the environment of the maintenance staff.

During our visit we noted that the following certificates were out of date. These were the employer's liability

insurance, emergency lighting, fire alarm systems and Portable Appliance Testing (PAT). We discussed this with the registered provider and the administrator for the home. The administrator told us they had reminded the registered provider about these, but nothing had been done. They made arrangements for the employer's liability insurance to be re-started at the time of our inspection and the registered provider assured us that the service was insured. However, on leaving the service at approx. 17:00pm there had been no email confirmation from the insurer to confirm this. When asked about these certificates, particularly the lack of insurance, the registered provider stated, "Isn't that the manager's job? What if I'd retired abroad?" This showed that the provider had not taken appropriate action to ensure people were safe through a regular programme of servicing and maintenance of the premises and equipment.

In addition, we found further checks of the environment had not been completed when required. For example, the last assessment of the building was undertaken in January 2015. The Gas safety check had expired, and the most recent monthly Infection Control check had been undertaken in April 2015. In addition, the fire risk assessment that stated it was to be reviewed annually had not been updated since July 2014.

This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment procedures were not robust to ensure only suitable staff were employed by the service.

We looked at six recruitment files for staff working at the service. The file for one of the maintenance staff contained a current Disclosure and Barring Scheme (DBS) checks, a holiday form and a moving and handling certificate. There was no evidence of references, an application form, health declaration or that an interview had taken place. Further files demonstrated gaps in staff employment histories that had not been explored, DBS checks from previous employers that had not been renewed by the service and no photographic identification for one staff member.

We asked the registered provider about why the service had accepted DBS checks from previous employers but had not then renewed them. They told us, "I assumed that once you had a DBS, you didn't have to renew them."

Staff files demonstrated that staff members had not always been safely recruited and that appropriate steps had not been carried out, to ensure staff were of suitable character to work with vulnerable people. This meant that people may receive care and treatment from staff who were not suitable to work with vulnerable people.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that systems in place to ensure medicines were administered safely were not consistently followed. A staff member told us, "Trained staff give untrained staff medication to give to people, then tick to say it is administered."

During this visit we looked at the storage of medicines and at records of medication administration. There was an electronic Medication Administration Record (MAR) system in use, which supported staff to administer medicines at the prescribed time and prompted them to make a record. We found that the system stated there were 11 people with missed medication recordings. On investigation, we found that

there were 306 'missing' entries for these 11 people. These were for a mixture of regular and 'as needed' (PRN) medications. Staff explained that this may be because PRN medication had been entered as regular medication on the system. The errors we found dated back to February 2016, and there was no evidence to show that these had been identified by the service or any remedial action taken.

We checked stock levels for five people's medication. We found there were 15 different medications recorded with stock levels that varied from the information recorded on the system. In one case the difference was by 17 tablets.

We found that one person's medication had run out when we checked stock levels on the first day of our visit. Records showed they were due to have one tablet at 8am the following day, however no medication had been ordered. We had observed the registered provider and the administrator for the home sorting through prescriptions in the afternoon on the first day of our visit. The registered provider told us that the surgery had lost their repeat prescription requests, which is why the stock had run out. There was no documentary evidence to support this. We spoke with the registered provider on the second day of our visit who told us that stock had been ordered and that this person would be given the missed medication once it arrived in the evening. They had not sought medical advice as to whether or not they could give this tablet safely give this tablet so far from its prescribed time or whether they could then give the next prescribed dose at 08:00am the following day at a time not and they were unaware that the y needed to report the lack of stock as a safeguarding concern. The registered provider later assured us that they called the pharmacist and would document this in the person's notes. They also stated they would contact the local safeguarding team and raise it as a concern. This placed the health and wellbeing of people using the service at risk because the ordering and administration of medicines was not safe.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

The training and development systems in place were ineffective and failed to ensure that staff received the training they needed to care safely and appropriately for people using the service. There was little evidence to confirm that staff received a comprehensive induction and we found that most had not received or been enabled to keep up to date with the providers mandatory training program. This placed people at risk of receiving unsafe care by staff who were not trained appropriately to carry out their roles.

We received mixed views from relatives about the knowledge and skills of the staff. One relative said the staff knew how to manage their family member's dementia well. They commented, "I know [Name of Person] can present with some difficult behaviours but I have always seen the staff cope with it in a sensitive and patient manner." A second relative raised concerns with us about their family member and how staff appeared unaware of their health needs. They told us their family member was not in good health and appeared to be in pain. They told us that staff they spoke with did not appear to have an understanding of what was wrong with their family member. They said, "The care could be better. The staff need more training so they know how to deal with people's health needs."

A visiting healthcare professional told us that not all staff were knowledgeable about people using the service or their conditions. They said, "Some staff have a very basic knowledge of pressure sores and palliative care." This meant that some people may receive care and treatment that was not in line with best practice and could have an impact on people's specific conditions or end of life care.

There was no recognised national induction training programme for new staff. Not all staff we spoke with were able to confirm they had received an appropriate induction to the service before they commenced work. One staff said, "I shadowed a more experienced member of staff for the first half of my day. Then I had to use the hoist to move someone from the chair to the bed. I was being observed by the previous manager who was on her phone at the time. She didn't give me any guidance and I was expected to start moving people after that." Another member of staff stated," I am concerned that staff are starting work without a proper induction." This meant that people may be cared for by staff who did not have the skills and knowledge to meet their needs effectively.

One staff member commented, "The training is not regular and it's not good quality. We have to fill in paper booklets. I don't learn well that. Staff need more training in hoisting and transferring. New staff are not trained properly, so we are all vulnerable as well as putting the service user at risk."

During our visit to the service the administrator was organising training for all care staff in relation to practical moving and handling techniques. By the end of our inspection she was able to confirm that this had been arranged for July 2016.

Records we looked at demonstrated that no staff members had completed emergency first aid at work training, 10 staff, including the provider had not completed up to date basic food hygiene training and 10 staff had not completed up to date fire safety awareness training. In addition, we also saw gaps in relation to

practical moving and handling, medication training, safeguarding training and basic dementia training. Therefore staff were not adequately supported to acquire and maintain the skills and knowledge to meet people's needs effectively.

Most of the staff we spoke with felt they were not being supported by the provider of the service and one staff member commented, "I don't feel valued at all by [Name of provider]. I go to a team leader for support because there is no one else to go to." Another staff member commented, "I just try to sort out any problems myself. I don't currently have anyone to help me and to give me advice and support."

We were informed by staff that they had not received supervisions or an annual appraisal on a regular basis and records we looked at confirmed this. One staff member commented, "We don't have supervision. I was threatened with it once." A second member of staff commented, "What's supervision?" A third staff member said, "I'm glad we don't have supervision. I suspect it would be used to have a go at us. It wouldn't be a positive experience." Most staff we spoke with felt there was poor communication within the service and with the provider which made them feel unsupported in their roles.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that systems were in place to assess peoples' capacity. Throughout the inspection we observed that staff sought consent from people before undertaking any activity. They encouraged people to make their own choices and decisions, as far as possible. For example, giving them a choice of what drinks to have, what they would like to eat and where they would like to sit. However, staff we spoke with said, "We are told to get everyone up by this time, toileted by this time, meals at the table." Another told us, "People can't eat what and where they want." Our observations showed that staff encouraged people to make choices but were often prevented from doing so by the institutional regime and instructions from the registered provider.

We spoke with staff about MCA and DoLS .One staff member told us, "Care plans have people's consent and agreement. I don't think mental capacity act training is put into place here." Another member of staff told us, "I'm not sure whether or not DoLS are in place." A third staff member commented, "A lot of the time people are not given choice, it's regimented."

One staff member described to us a situation where one person had refused to take their medicines. They said they had been instructed to hide the person's tablets in their sandwich.

The provider demonstrated a very basic knowledge of the MCA and DoLS and was not sure if anyone using the service was subject to a DoLS application. When asked if the MCA or DoLS was used at the service they commented, "I'm not sure. Somebody did when [previous manager] was here. There is no folder; [previous manager] did all this."

The vast majority of people using the service had advanced dementia care needs. Records demonstrated that people's capacity had not been assessed in line with the MCA and we were unable to find any evidence that decisions had been made in people's best interests to ensure they received the right care and support to maintain their health and wellbeing or evidence that any least restrictive options were explored for any decisions about their care. .

Training records demonstrated that most staff, including the provider, had not completed training in relation to MCA and DoLS. This meant that staff did not fully understand what they must do to comply with the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and did not always work within the law.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service did not always support people to maintain good health and to access healthcare services when required. Records demonstrated that people had been seen by their GP, the district nurses, dietician and the Speech and Language Therapist. (SALT). One person said, "I have to go to the hospital a lot. My family take me."

A relative raised concerns with us about their family member. They told us their family member was in need of dental treatment and appeared to be in pain. They had been asked to take them to a dentist but were having difficulties arranging this due to their availability. They said, "I would have thought that if [relative] was in pain the home would have taken her."

The provider confirmed this person had been seen by their GP and had advised that they needed to see a dentist. The registered provider told us they had asked the person's family member to take them and said, "We always ask families to take their relatives to appointments. We would never do it without their permission." They confirmed to the inspectors that this person had been waiting three weeks to be taken to the dentist. When asked why the service had not arranged for them to go they were unable to give a satisfactory response and repeated that they always ask families to take people to their appointments. This meant the person was in need of dental care and in pain for an unacceptable length of time with no action taken to alleviate their pain and discomfort.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they had enough to eat and drink and that they enjoyed the food provided. One person said, "The food is good. The chef is very good and he knows what I like. He always asks us what we would like and we get a choice." Another person commented about the lunchtime meal, "It's really lovely and tasty."

The chef told us that menus were completed on a four weekly programme and took into account people's preferences and choices. When cultural diets or condition specific diets were required we found that systems were in place to ensure these were provided, for example, soft options or diabetic diets. Records showed that people's nutritional needs had been assessed, with any specific requirements such as soft options or assistance with eating.

We observed the chef on both days of our visit asking people what they would like for their meal and if they didn't like what was on offer he offered an alternative. Throughout the day a choice of food and drinks were readily available. We also observed that some people's dining experience was affected by the length of time they were sat at dining tables, before their meal was served. For example, a small number of people were

seen sitting at tables for over 30 minutes, at times with their eyes closed.

We saw that care plans were in place for eating and drinking and there was information about people's dietary preferences. Care files contained information about people's nutritional screening such as a nutritional assessment and a record of their weight. We saw for one person who was being cared for in bed that a food and fluid chart was in place. This was up to date and had been fully completed.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that the staff were kind and caring but had little time to spend with people. One relative said, "They make you feel welcome but don't have time to sit and chat. They are so busy."

Staff told us they worked hard and cared about the people using the service. One staff member commented, "I love my job." A second member of staff told us, "I care about the people who live here." However, staff also informed us that the regime of the home was too disciplined and task focused. One staff member said, "We get told off if we are seen talking to people." A second member of staff commented, "The girls work really, really hard but they are never told it's good." A third staff member of staff told us, "The [provider] is institutional and old school." They also informed us, "The staff here work very hard but get no recognition for it."

We saw that people who lived at the service looked comfortable and relaxed in the company of care staff but that positive meaningful interactions were limited. Care staff were patient and kind when supporting people but were largely task rather than people focused. They provided support as and when required but social interaction with people who lived at the home was reserved primarily for when an activity took place such as meal times. This was because staff were busy undertaking tasks such as the laundry and cleaning, under the instructions of the registered provider. This meant that staff routines and preferences took priority and the registered provider had little understanding of the impact of this approach on the wellbeing and needs of people using the service.

We did observe that when staff did interact with people their interactions and approach was positive and caring. For example, we saw that staff demonstrated an understanding of the needs of the people they were supporting. We observed them gently persuading a person to change their top because they had spilt food on it. We noted staff to be supportive. We saw one member of staff offer gentle encouragement to a person to eat their lunch time meal. We also observed other staff providing people with positive feedback, in a kind and sincere manner. For example a member of staff was looking through a book of cars with one person. When the person recognised a car the staff member said, "Well done. That's brilliant."

We observed the registered provider was the only member of staff in the dining room at one point. They sat with one person to support them to eat their breakfast, however they offered very little interaction or conversation.

People were not able to confirm that they were involved in making decisions about their care and day to day routines. Relatives we spoke with raised concerns about the lack of involvement in their family members care. One relative commented, "My [relative] lost a tooth three months ago which we were not informed about. Also the doctor visited and said [relative] had a particular condition for which they were prescribed antibiotics. We weren't told about that either." A second relative told us, "Communication is not brilliant. I'm not involved with [relative] care or asked for my opinion."

We looked at people's records and saw no evidence to show how people and their family members were

involved in the decision making processes. This meant that the service did not listen to people or understand how to support them to express their views about how they wished their care to be delivered. This placed the people at risk of unsafe and inappropriate care and treatment.

People could not be assured that information about them was treated confidentially and respected by staff. We found a handover book in the lounge that contained personal information about people and their care needs. We found there were occasions and practices that did not ensure people were treated with dignity and respect at all times.

A relative told us, "[Relative) is not wearing her own clothes today. Quite often when I come in she's not wearing her own clothes."

We observed one person in the lounge that was in distress trying to explain to a staff member that they needed to go to the toilet and were uncomfortable. After trying to explain to a staff member why they were upset, the member of staff said they would tell the senior staff member. We saw them arrive and they asked the person again what the matter was. We heard them say "I don't know if you are prescribed anything for constipation but I will have a look." The team leader then proceeded to call the person's GP in the lounge and discuss their personal problem loudly over the phone. This meant that some staff did not have an understanding of how to promote respectful and compassionate behaviour towards people using the service. In addition, people could not be confident that information about them was treated confidentially and respected by staff.

At the time of our inspection there were no suitable private or quiet areas for people to spend time with their families if they wanted to, apart from the main lounge. We saw numerous relatives visiting on the two days of our inspection and observed that there was no privacy for them when talking with their relative.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We did observe some good practices around maintaining people's privacy and dignity. Staff gave us examples' of how they maintained people's dignity and respected their wishes. One staff member said, "We all have to respect the people living here, it's their home and we are in their home." Another staff member commented, "I always knock before entering people's rooms. I always cover people with a towel to stop them feeling embarrassed."

We observed one person receiving insulin administration in the lounge. Portable screens were used to ensure their privacy was maintained. We observed staff knocking on doors before they entered and ensuring personal care was carried out in areas where people's privacy could be maintained.

Inadequate

Is the service responsive?

Our findings

During our previous visit on 11 December 2016 we found that there was a lack of stimulation and interaction between staff and people using the service and the provision of meaningful activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this visit we checked to see if improvements had been made. We found that people were not enabled to participate in activities that met their needs and reflected their preferences.

A relative told us, "I don't see activities going on when I visit. It's a shame." Another relative commented, "They just don't have the time. They are lovely girls but they are so busy they can't provide activities for everyone."

One member of staff said, "There is no activities co-ordinator, the girls do try." Another staff member commented, "Staff do activities with people, they put games out and read books." A third member of staff told us, "We don't have time to do any activities in the morning. We put the TV or some music on." We also found one comment made via the latest service satisfaction survey that raised concerns about the lack of meaningful activities. It stated, "Staff could be more aware of the need to stimulate residents, e.g. with accessible TV or films (suitable for their age)."

We saw people were offered limited opportunities for occupation beyond the television and music. We asked the registered provider how people were provided with opportunities to follow their chosen pastimes and they acknowledged this was an area where the service needed to improve.

We saw that staff were busy undertaking tasks, such as tidying up and the laundry, and had little time to spend with people. One staff member told us, "We had a church service and instead of being able to sit with everyone and provide support we were all sent off to do jobs. I had to mop the laundry floor."

During the second day of our inspection we observed two staff undertaking activities with two people. One staff member was looking through a book and the other member of staff was playing a board game. However, the remaining people using the service sat for long periods with little interactions. There was also one person being cared for in bed and we were unable to find any information about what the staff did to provide this person with this person with stimulation. This meant that people were at risk of becoming socially isolated.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most people using the service were not able to tell us if the care they received was personalised and reflective of their needs. However, one person was able to tell us, "They look after me alright. I get a lot of

help from my family." A relative told us, "I can't count how many times I've come to see [relative] and she's not wearing her glasses. She likes to read her bible but she can't see without her glasses."

Staff told us that care was task focused and not personalised. One staff member told us, "We get told to get everyone up to sit at the table for their meals, whether it's what they want or not." Another member of staff commented, "People here don't have many choices. We have to do what [provider] tells us. It's very institutional and not person centred." Another member of staff commented, "I wouldn't put my [relative] in here." This demonstrated a task centred approach to people's care rather than in response to their individual needs and preferences.

Staff were knowledgeable about the people they cared for. They were all able to tell us about people's needs and how they managed behaviours that may challenge the service.

The registered provider told us that that before people used the service; an assessment of people's needs would be undertaken.

Records we looked at demonstrated that each person had been assessed before admission to the service. We saw that they recorded people's likes, dislikes and preferences. This information was then used to develop a care plan that reflected how each person wanted to receive their care and support. However, we found that from our own observations of peoples' care during our visit the care being provided did not always match what was recorded in people's care plans. We saw that people were not always offered choices on a day to day basis about their care. We found that decisions about people's routines were not always in line with their preferences and many people's daily routines were not person centred but task-led by the staff, under instruction from the registered provider. This meant that people's care records did not sufficiently guide staff on people's current care, treatment and support needs; this puts people at risk of inappropriate care.

We found that one person had a pressure sore and the instructions in their care plan was that they were required to get out of bed for two hours every day. Records demonstrated that over a two week period they had been supported to get out of bed on just five occasions. This placed the person at risk of further deterioration of their pressure wound and did not meet their needs.

A relative told us, "We are never invited to reviews so we can't speak up for [relative]."

We asked the registered provider about reviews and why family members did not attend. The registered provider stated that the local authority organised these. We asked about people who were privately funded and she said, "The private ones, as far as I know, they haven't been done." This showed that changes to people's care and treatment were not consistently reviewed and updated with the involvement of people to whose care they related and their family members.

One relative told us they did not know who to complain to and said they did not have any information about making a complaint. They said, "If I thought it would do any good I would complain. Communication here is poor."

Staff were aware of the complaints procedure and told us, "All complaints are dealt with by [provider]. I don't think she deals with them properly. I know that when staff have raised complaints it's swept under the carpet."

We asked the registered provider where they kept a record of any complaints received by the service. They

told us they didn't know where this was and admitted they had no system in place to investigate and log complaints. This meant that people were not given an opportunity to express their views about the care they receive.

This was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

During the previous focused inspection carried out on 11 December 2015, CQC identified a lack of management oversight and failure to identify the staffing issues and the impact this was having upon service users. We issued requirement notices in respect of Regulation 17. This inspection undertaken on the 14 and 15 April 2016 found that no improvements had been made and there was a continued breach of regulation.

There was no registered manager in place at the time of our inspection. We found there was no direct leadership or management of the service because the registered provider was not delivering this. A staff member told us, "We don't know where we stand. There is no clear instruction or guidance from [provider]. Another staff member confirmed, "We don't have any management here. The [provider] has not kept up to date with practices." A third member of staff commented, "I try to deal with issues myself because there is no one else to go to." A further comment from a staff member was, "We need a manager. Staff's roles need to be defined, more so they know who to go to."

We found the arrangements to ensure staff were appropriately supported to deliver care and treatment to an appropriate standard, by receiving essential training, was lacking. At the time of our visit we found that staff felt unsupported, they were not encouraged to give their views and ideas about the service by way of regular staff meetings and formal supervision. We found the culture at the service was not open and transparent and we found a lack of leadership in the day to day running of the home. One staff member told us, "We have a team meeting tomorrow. Staff are scared that it's going to be a witch hunt." A second member of staff commented, "Team meetings are not a discussion. You get ordered to do things." Records demonstrated that staff did not receive regular supervision and an annual appraisal. In addition we found the training matrix showed gaps in staff training and there was a lack of documentation to demonstrate that staff had undertaken an induction to the service. Roles and responsibilities within the service were not clear, and the staff were unsure who they were accountable to and what they were accountable for.

When we asked the registered provider about the leadership at the service she said, "It's disjointed, I accept that." They also commented, "The management side of it and the paperwork side of it have dropped and I openly admit that."

At this inspection we found that systems to ensure recruitment procedures were robust were not in place. Staff files were not audited or quality checked to ensure the correct process had been followed.

We saw that the service had admitted one person for respite care, despite reassurances from the registered provider in January 2016, stating that they would not admit any more people until staffing levels had improved. We found that this person had no assessment of need, care plan or associated risk assessments in place. We asked the registered provider why they had admitted this person and they told us, "I thought private was alright".

This inspection identified that there was no audit systems in place to identify when equipment and appliances used at the service required a service to ensure they were safe to use. There was no management

oversight of the environment, there were no environmental audits in place and no maintenance plan to ensure areas of risk that may be hazardous to people's safety and health were identified and rectified as soon as possible. This placed people at risk of harm from unsafe premises.

We found that systems in place to assess people's needs and calculate the number of staff needed to meet those needs had not been effectively undertaken. The dependency tool did not accurately reflect the current dependency levels of people using the service and as a result we found staffing levels were not sufficient to meet people's care. This was having an impact on the quality of care received by people.

When the inspectors spoke with the registered provider it became clear that she was not fully aware about all her legal responsibilities. We asked if there had been any CQC notifications submitted regarding a recent death of one person using the service and a grade 4 pressure sore of another person. The registered provider stated, "I don't know where they are. We've had four years of [name of a previous registered manager] and one year of [name of previous manager] doing it. I haven't done it for 5 years." Providers are legally required to send to the Care Quality Commission notifications, which are information about important events at the service. This meant that the management of the service and systems in place were not effective or robust enough to ensure that risks relating to the health, safety and welfare of people using the service were reported to the relevant authorities so they could be responded to appropriately.

The safeguarding policy had been updated in March 2015; however the other policies had not been reviewed since December 2014. There was no evidence that policies had been updated to reflect the latest guidance and regulations. A copy of the local authority safeguarding procedure was not available.

We found that people, relatives and staff were not consulted regularly about the delivery of service. We were unable to find any evidence of recent relative and service user meetings. We did look at a service satisfaction survey that had been undertaken at the start of 2015. Five responses were received and we found that relatives had raised areas of concern. There was no evidence that they had been analysed or used to improve the service. We also found there were no systems in place to encourage people to make a complaint and there was no log of complaints maintained at the service. This demonstrated that the registered provider did not understand the principles of good quality assurance resulting in a service that lacks any drive for improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person failed to ensure that the care and treatment provided to people was appropriate and met their needs and preferences. In addition the registered persons person had not made suitable arrangements to ensure that people were enabled to participate in activities that met their specific diverse needs and reflected their interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person had not made suitable arrangements to ensure that personal and confidential information was stored securely and that people were treated with people 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
Treatment of disease, disorder or injury	The registered person was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Receiving and acting on complaints The registered person had failed to ensure suitable systems were in place so that people could be supported to voice their opinions or raise concerns about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to ensure that robust recruitment practices were carried out to ensure only people suitable to work with vulnerable people were recruited.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not protected people against the risk of unsafe management of medicines. The systems in place to ensure medicines were administered safely were not consistently followed.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to ensure service users were effectively safeguarded against the risk of abuse and harm.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had failed to ensure that people were protected from risks associated from unsafe or unsuitable premises.

The enforcement action we took:

Notice of decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system in place to monitor the quality of care

provided to people or to manage risks of unsafe or inappropriate treatment. There was a lack of management and leadership at the service.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person has failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

The enforcement action we took:

Notice of decision