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Durham Care Homes

Inspection report

99-105
Durham Care Homes
Hull
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Tel: 01482229766

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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

About the service: Durham Care Homes is a residential care home for up to 20 people. At the time of the inspection, it was providing personal care to 14 people aged 65 and over.

People's experience of using this service: The quality of care had deteriorated since the last inspection. People's safety had been placed at risk due to safeguarding policies and procedures not being followed. The provider and manager had not assessed and managed risk, which placed people at risk of harm. Some people had not received their medicines as prescribed. Staff recruitment continued to be poor. There was insufficient staff to meet people's needs. There were concerns with staff practices regarding infection prevention and control.

Some people's nutritional and hydration needs had not been fully assessed and met; the meals provided were repetitive and gave limited choice to people. The meals and snacks for people on soft diets were inadequate. Staff contacted health professionals when required, although during the inspection, staff had to be prompted on two occasions to seek medical assessment for people.

Staff did not have the right skills, experience and knowledge to care for people safely. There was partial understanding from the manager regarding mental capacity legislation, the need for people's deprivation of liberty (DoLS) to be authorised and the need for people to consent to their care. However, some people's DoLS had expired and applications had not been resubmitted. Three people met the criteria for DoLS but applications had not been made to the local authority for authorisation.

We observed episodes of care and staff interaction with people and each other that was poor and required improvement. There were also some interactions between staff and people who used the service that was kind and considerate. There were times when people's privacy and dignity were compromised. There was very little social stimulation provided to people, especially those people who remained in their bedrooms.

People had assessments and plans regarding their care and support needs. However, the care plans lacked important information, were not always kept up to date when changes occurred and had limited direction for staff in how to deliver care in a person-centred way.

The service was not well-led and there continued to be a lack of effective governance and oversight by the provider and manager. The day to day shifts lacked organisation and the culture in the service required significant improvement; there was institutional and unsafe practices, which went unnoticed and unchecked by management. Records were not always accurate and up to date.

More information is in the full report.

Rating at last inspection: Requires improvement; published 19 February 2019.

Why we inspected: We received information from the local authority regarding an escalation of concerns about the service; they had been completing monitoring visits. We completed this inspection based on these concerns. At the time of the inspection, we were aware of incidents being investigated by another agency.

Enforcement: The service met the characteristics of Inadequate in four key questions of safe, effective, responsive and well-led and Requires Improvement in caring. We are taking enforcement action and will report on this when it is completed.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Durham Care Homes

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns raised by the local authority following a series of monitoring visits to the service.

Inspection team: The inspection team consisted of two inspectors on 6 and 7 February 2019 and one inspector on 8 February 2019.

Service and service type: Durham Care Homes is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager in the service but they had not yet registered with CQC. It is important for a manager to be registered with CQC so they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced on the first day. The provider and manager were informed we were to return on 7 and 8 February 2019.

What we did: Before the inspection we spoke with local authority safeguarding, contracts and commissioning teams. We attended a meeting with agencies to listen to and discuss concerns. We reviewed notifications of incidents received since the last inspection in November 2018.

During the inspection, we spoke with four people who used the service and two of their relatives. We spoke with the provider, the manager, two senior care workers, two care workers, the cook, a catering assistant and a visiting health professional. It was difficult to speak with a second cook as their first language was not English.

We looked at care records for nine people who used the service and medication records for 13 people. We looked at a range of other records used for the management of the service. These included three staff recruitment files, audits, the staff rota and training records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely.

- At the last inspection on 28 November 2018, inspectors found people had not received their medicines as prescribed. We found this concern persisted and people had not received their medicines as prescribed.
- There were times when people had not received their medicines due to an error, inadequate directions, stock control issues, and being asleep or refused with no follow up. There were also times when medicines were omitted and coded 0 which meant 'other'. This was not defined so the reason for omission was not known. The manager was unaware of the reason for the omissions.
- Staff were observed giving medicines to people and in two instances they left medicines in a pot on the dining table and returned to sign the medication administration record without witnessing people had taken them. There was information available to guide staff on when medicines that are prescribed to be taken 'when required' should be given. However, the information lacked details regarding the rationale for decisions when variable dose was required such as one or two tablets.
- Medicines were stored in a locked trolley in the dining room. On the second day of the inspection, the remaining store of one person's high strength codeine tablets went missing and a new prescription had to ordered immediately. The provider could not account for how the tablets went missing. Staff recorded the fridge temperature daily, however the minimum and maximum had not been recorded. There were also some gaps in the recording so the records could not give assurance that medicines requiring cold storage were kept at appropriate temperatures.
- The above concerns were brought to the attention of the manager to address.
- The failure to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong.

- At the last inspection on 28 November 2018, inspectors found risk was not managed appropriately, and there were concerns about infection prevention and control. We found these concerns continued.
- There was a lack of thorough assessment and risk management plans for people's moving and handling needs, skin tears, pressure relief, nutritional needs and risk of choking. We observed people were moved and handled in an unsafe way, had sustained skin tears (one of which was being investigated by the local safeguarding team), had inconsistent pressure relief and were given meals and snacks contrary to professional advice.
- Staff were observed carrying metal kettles with boiling water on the tea trolley when giving hot drinks to people. Staff told us they carried boiling water in bowls to people for personal care in a number of bedrooms where the hot water outlets ran cool. This posed a risk to both people who used the service and staff.

● There remained hot pipes in bathrooms and toilets that were not lagged. The staff toilet had very hot water; there was no hot water warning sign. Bedroom doors were wedged open, which meant they could not easily be closed in a fire emergency.
● There had been a failure to learn from previous moving and handling incidents. There were concerns raised about moving and handling in December 2018 and staff supervisions had been completed. Staff had completed moving and handling training. A person had sustained a skin tear due to a moving and handling incident following the supervisions and training. Staff were observed carrying out unsafe moving and handling techniques despite having training.
● Not assessing and managing risk to ensure the safety of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were observed not following good practice guidelines for infection prevention and control and failed to change gloves in between completing different tasks for people. For example, a member of staff completed three different tasks for different people in a short space of time whilst wearing the same gloves. These were administering medicines to people, completing a moving and handling task and assisting a person to eat breakfast.
● Staff left a discarded catheter night bag in the corner of a bedroom all day until 6pm. A person's catheter bag was not anchored to their leg properly and was touching the floor, which posed a risk of infection. There was one full sling and one toileting sling for use between three people. This posed a risk of cross contamination and availability issues when they were in the laundry.
● There were areas of cleanliness in the service that were pointed out to the manager for immediate attention. There were other areas of the service where items would need replacement and refurbishment.
● Not ensuring safe systems to prevent the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
● At the last inspection on 28 November 2018, inspectors found staff had not been recruited safely. We found this concern persisted and full employment checks had not been completed for two staff who started working at the service since the last inspection.
● The shortfalls in recruitment practices included not checking incomplete application forms and the accuracy of references. No record of checking training had been completed as stated and obtaining certificates. No record of interview for the manager's recruitment. No record on induction for the manager and a senior care worker.
● Failure to ensure a thorough and safe recruitment system was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff told us people's needs had increased and more people required two staff to support them. The current staffing levels were insufficient to meet this increase in people's needs. This had impacted on people who used the service as on the first day of inspection, we saw three people who had bed rest in the afternoon, were not supported back to bed. The manager said, "There is not enough staff for the increase in people's needs" and "We need at least another member of staff in the mornings; some people are not getting up until 10am." Care staff said, "We have agency staff but it's not ideal as they don't know people" and "There is just not enough time on the shift to do everything." People told us there were not always sufficient staff around to assist them. A relative said, "There are staff shortages and it means things like their teeth don't get cleaned; I know because their toothpaste is not going down."
● During the inspection, the manager resigned and did not attend for their shift on 8 February 2019. Two other staff also did not attend for their shift on 8 February 2019. This left a new senior, who was still under mentorship and whose first day was 6 February 2019 in charge of the morning shift. The new senior did not

have full knowledge of people who used the service to ensure their needs were met.
● During the inspection, the local authority provided their own staff to work alongside care staff at Durham Care Homes to ensure shifts were adequately covered and to observe staff practice.
● Failure to ensure sufficient numbers of staff were deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse.
● The service used an agreed multiagency policy and procedure to guide staff if they became aware of abuse or had concerns. Since the last inspection, a member of staff had written about concerns to management but procedures had not been followed with regards to referring them to the local safeguarding team for assessment and a decision about investigation. During the inspection, we told the manager to refer three incidents to the local safeguarding team.
● People told us they felt safe in the service and comments included, "I do feel safe", "I'm happy here" and "Yes, everything is alright." A visitor confirmed they felt their relative was safe in the service and another said, "It's clean and there are no odours."
● The provider, manager and staff had not followed safeguarding procedures and not ensured people were safeguarded from the risk of harm and abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience.

- At the last inspection in November 2018, the provider had failed to ensure staff received appropriate training, supervision and appraisals. They also failed to ensure staff were suitably skilled and experienced for their role. At this inspection, we found there had been only limited improvements.
- Since the last inspection, the manager and eight senior care staff had completed medicines management training. However, errors in administration and recording continued and poor administration practices were observed.
- Since the last inspection eight staff had completed a three-hour moving and handling training course and 23 staff completed moving and handling as part of a refresher training day. However, unsafe moving and handling techniques continued to be used by staff.
- Staff had limited knowledge of diabetes and how to recognise the signs of a diabetic emergency and the action they would need to take. One person in the service was an insulin-dependent diabetic and this knowledge was vital for staff.
- Since the last inspection five out of 13 care staff had received supervision, two of these were in response to observed poor moving and handling techniques in December 2018. No staff had received an appraisal of their skills or observation of their practice, apart from hand washing.
- In the recruitment files for two people who started employment since the last inspection, there was no record of induction. When agency staff worked in the service, there was no record they completed any induction. On one of the inspection days, an agency staff arrived for work and was not given a handover of information. They told us they had been to the service once previously.
- Failure to ensure staff were supervised, skilled and implemented training to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such

authorisations were being met.

● People who met the criteria for a DoLS did not have current authorisations in place, which meant they were unlawfully deprived of their liberty. Four people's DoLS had expired in August and December 2018 and re-applications had not been submitted; this was confirmed in discussion with the local authority. One person's DoLS had expired and a re-application had been submitted to the wrong local authority. This was identified by a social worker during the person's review and the manager was requested to submit it to the right local authority; this was completed following the review and confirmed by the social worker.
● During the inspection, we saw three people met the criteria for DoLS but had not had a capacity assessment or application for DoLS completed; this was confirmed in discussion with the local authority.
● In three of the care files we looked at, people had restrictive bedrails. It was stated these were used in their best interest but there was no capacity assessment and to evidence their ability to consent or not. There was only a best interest discussion in one care file regarding who had been consulted in the decision-making.
● Failure to work within the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
● People had assessments of their needs completed and some of these were thorough and covered all their needs. However, other assessments and risk assessments lacked important information.
● People did not have full information about how they were to be moved and transferred safely. People's continence needs had not been assessed. Some people's needs in relation to pressure relief had not been fully assessed. People's nutritional needs in relation to soft options had been assessed by a health professional but not carried out consistently by staff. People's risk of choking and counter measures had not been fully assessed.
● Failure to assess people's needs effectively was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support.
● The one-week menu was repetitive and provided limited choice for people. There were poor options for people who required a soft diet, especially for the evening meal.
● The electronic daily records for people on soft options indicated they had snacks contrary to professional advice such as biscuits and cake. The manager told us the entries could have been made in error.
● One person had information from a health professional which stated they were to cease having food supplements but were to have milk shakes fortified with full fat milk, ice cream and cream. The electronic daily records for this person showed they continued to have food supplements and did not have any milkshakes. The cook told us they didn't make milkshakes.
● One person was a diabetic, which was controlled with tablets and diet. We observed the person was given biscuits, cakes and desserts with a high sugar content and not offered any healthy alternatives. There were three bananas in the fruit bowl near the dining room but these were not ripe enough for people to eat.
● Some people required closer monitoring and support regarding hydration. However, monitoring records were inconsistent, we saw people had not always had sufficient to drink and staff organisation meant people's hot drinks were left to go cold.
● There were mixed comments about meals. Two people told us they liked the meals and one said they hadn't made any complaints about them. A relative said, "The food is monotonous and of poor quality. Some is only fit for kids such as chicken nuggets and burger and chips. [Name] lost weight but is putting it back on again; I make sure they eat lunch every day" and "Sometimes there are strange combinations like jacket potatoes and chips."

● Not ensuring balanced nutrition and adequate hydration was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence staff contacted health professionals and supported people to attend hospital appointments. A GP told us staff contacted them when needed and they completed home visits. A health professional told us communication could be improved as they were not always informed of changes in people's needs.

Staff working with other agencies to provide consistent, effective, timely care.
● A district nurse told us they had not been informed a person had been visited by a GP to assess whether a skin tear was infected. This meant they had not been informed a dressing needed to be reapplied.

Adapting service, design, decoration to meet people's needs.
● At the last inspection in November 2018, it was noted that some areas of the service did not meet the needs of people living with dementia. There had not been sufficient time between inspections for the provider to make large refurbishment changes, although they told us this was planned.
● We saw toilet doors had been painted a different colour to help people living with dementia distinguish them from other doors. There were grab rails in toilets and frames that went over toilet seats to assist people with mobility and balance issues.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence.

- During the inspection, we observed a person was moved with the use of a lifting hoist. There was no consideration to the person's privacy and dignity and the inspector had to intervene to place a cover over their exposed legs. Another person was pulled to a standing position by their arm, which was unsafe and undignified.
- We observed one person had their trouser leg rolled up exposing their lower leg to their knee; staff did not offer the person to have a cover over their legs until a wound was seen by a district nurse.
- People had not been shaved for several days and looked dishevelled.
- One person's catheter bag filled with urine was visible and had not been anchored correctly. A night catheter bag had been removed and left in the corner of their bedroom all day, visible to visitors; these issues did not protect their privacy and dignity.
- Staff were overheard talking about their own relative's health problems to each other. Staff were heard arguing amongst themselves in front of people who used the service and visitors and grumbling about staffing levels.
- People had not had continence assessments and staff selected aids from a communal stock. Staff told us some of these were an incorrect size for people, which at times had impacted on their dignity.
- Care records were held electronically and computers were password protected. There were paper care files for each person, which were held securely in the staff room. There was only one telephone, which was situated in the office so phone conversations with health professionals were completed there. The manager's office was not always locked and some people's personal records were visible on the desk such as appointment letters and post. This was mentioned to the manager to address.
- Failure to ensure people's privacy and dignity were maintained was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; equality and diversity.

- We observed some positive interactions between staff and people who used the service. For example, staff had placed a person's legs on a padded foot stool and another person was resting in a recliner chair and looked comfortable with a blanket over them. Some people had their hair styled by the hairdresser, which looked nice and helped with self-esteem.
- One member of staff and the cook were chatty to people when they arrived for breakfast, smiled at them and assisted one person to cut up their food. The cook supported one person to eat their breakfast and was chatty throughout, telling them what the cereal was. We overheard one member of staff compliment a person on their return from the hairdresser, telling them how nice their hair looked.
- One person told us staff looked after them well, another said staff were good and a third person said staff

were nice to them. One person said, "[Name of staff] is very good and knows what they are doing." A relative said, [Name] likes living here and likes the provider. The staff are good but there is just not enough of them."

● There were other interactions and delivery of care that were poor and required improvement. For example, a member of staff giving medicines to people was observed putting a tablet in someone's mouth whilst they were still chewing their food. A member of staff flitted between assisting someone to eat and back to giving medicines to people so the person received disjointed support and cold food. There was also no interaction when they gave the person their medicine. When staff were assisting people to eat lunch there were some positive and some negative interactions between them and the people they were supporting. Some people's drinks went cold as staff didn't support them to drink them.

● Some people were not attended to in a timely manner. For example, at 12.30, one person had asked staff to reposition them in their chair. At 15.30, the person had not been assisted to move and asked staff again. At 15.50 staff supported the person.

● At 15.30, one person was observed sleeping in an armchair and looked uncomfortable; their head was to one side with no pillow and no blanket to cover them. A member of staff told us this person, and two others, usually went back to bed after lunch to rest but could not account for why this had not happened.

● One person who remained in their bedroom all day had very little interaction with staff and only during personal care tasks. They were observed sitting in a chair in the dark at 6pm with no television or radio on.

Supporting people to express their views and be involved in making decisions about their care.

● There was a lack of interaction between staff and people who used the service when decisions were required. For example, a member of staff turned the television off and put music on without any consultation or consideration to people who may have been watching it. They told the inspector, "We usually put music on." Three quarters of an hour later, a member of staff asked one person if they would like the television putting back on.

● At lunchtime, people were given blackcurrant juice without giving them a choice of other drinks. There were no table cloths or placemats on the tables and one set of condiments for four tables.

● There was limited input from people who used the service regarding menu planning. In one person's care file we looked at the food preferences page was left blank. A relative said, "The previous manager made a list of things they liked such as pasta, fish pie, curry and meat pie but they don't get any of these."

● There were no pictorial menus to help people make choices about the food they would like to eat.

● We found toiletries for communal use in one of the bathrooms; the manager told us the provider purchased toiletries for communal use. This was not good practice and people should be supported to purchase and use their own toiletries in line with their preference and choice.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Assessments and risk assessments lacked important details, which impacted on the care plans developed from them and meant staff had limited care directions.

● Several people had high risks associated with fragile skin and required pressure relief. Although specialised mattresses and cushions were supplied, there was limited direction for staff regarding pressure relief in care plans. For example, one person's care plan indicated their high risk and advised staff to 'introduce a repositioning schedule'; the plan didn't state what this was and we observed the person had excessively long gaps in between pressure relief. There was a similar lack of pressure relief direction in other people's care plans. A health professional told us they had advised staff on pressure relief and monitoring charts for one person but there was a difficulty in locating monitoring charts.

● Care plans were not updated with information following changes in people's needs. For example, one person had sustained a skin tear, which required dressing by a district nurse. The care plan and risk assessments had not been updated to guide staff on measures to take if the dressing came off, what to put in place until the district nurse could redress and how to move and handle the person correctly to prevent a reoccurrence. During the inspection, we found shortfalls with how the person's skin tear protection was managed.

● A second person had a catheter and there was no information to guide staff on how this was managed. For example, on personal hygiene, position of tubing, changing of day and night bags, anchoring of day bag, position of night bag for optimum flow, monitoring urine colour and output and what to look out for to alert them of concerns. During the inspection, we found shortfalls with how the person's catheter was managed.

● There was some personalised information on assessments but this had not been transferred to care plans. Staff did not have any information recorded on people's preferences for bathing, showering, continence aids, the type of toiletries they liked to use or clothes they preferred to wear.

● Some people had a list of their preferred foods, times of rising and retiring and interests but this was not consistent in all the care files we looked at.

● We found staff had not been responsive in referring people for continence assessments and instead used a selection of communal products, which had been found in the loft. The provider, manager and staff had no knowledge of who the continence aids belonged to and none of the boxes they were stored in had any names on them.

● There was limited social stimulation for people. There was no designated activity coordinator. The activities seen on three days of inspection was watching television, listening to music, one person completed some colouring and two people were seen looking at a newspaper and a magazine. There was little time and opportunity for staff to support people to participate in meaningful activities or to sit and chat to them.

● Records showed there had been singers for a recent birthday celebration for a person who used the service. We saw 'one to one activity' was recorded generically in electronic records for every person who

used the service regardless of whether they participated in the actual event. This made it difficult to establish if they had participated and what benefit they had gained from the activity. One person who used the service said, "We used to go to a café down the road but we haven't been for a long time." A relative told us they saw very little activities taking place.

● Failure to assess people's needs effectively and plan for their care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns.

● The manager had maintained a log of complaints and we looked at two received since the last inspection in November 2018. This showed the complaints had been considered and a satisfactory response provided to the complainant. A relative told us they could raise issues. They said they made a complaint about the timings of medicines but it was resolved.

End of life care and support.

● Most people's care files had information about whether end of life care had been discussed and whether people wished to be resuscitated in the event of a medical emergency. The manager told us people could remain at Durham Care Homes for end of life care and would receive support from district nurses. There had been occasions in the past when people had remained at the service for end of life care; there was no-one currently in receipt of end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

- At the last two inspections in October 2017 and November 2018, the provider failed to assess, monitor and improve the quality of the service and to maintain appropriate and contemporaneous records. We found there had been no improvements in quality monitoring or records management.
- The manager was not registered with the Care Quality Commission (CQC). The previous registered manager left the service in October 2018. The new manager had been in post for six weeks and told us they had decided to apply for registration with CQC. However, during the inspection, they decided to resign without notice. Staff told us they had found it difficult to speak with the manager and they had not called a staff meeting since they started in their role.
- Staff told us their wages were not always correct and this had, on occasions, caused them hardship. The provider confirmed there were some issues with timesheets and wages, which had resulted in shortfalls but these were rectified as soon as possible. There was no-one other than the provider to oversee and check the timesheets before payments were made to staff.
- The atmosphere within the service was not good. Staff bickered and argued amongst each other and in front of people who used the service; they were also disrespectful to the provider. This went unchecked by management. Staff said, "Morale is low; people don't trust each other." A health professional told us they witnessed friction between staff and overheard raised voices about staff taking their breaks. A visitor to the service told us staff were disgruntled and had a poor attitude.
- The shifts were disorganised, which impacted on the care provided to people. There lacked a checking system to ensure care tasks had been completed and monitoring forms filled in. Comments from staff included, "I asked for things to be done on Tuesday on handover and I'm upset nothing has been done; it's really frustrating." A senior member of staff told us they did check to see if tasks were completed but didn't make any records to evidence this.
- The audits completed by the manager since the last inspection in November 2018 were ineffective and had not identified the concerns found during the inspection. For example, the infection prevention and control audit completed in December 2018, stated no action was required for bathroom floors as they were impermeable but we found the bathroom and toilet floor covering had gaps and could not be cleaned effectively. The audit did state there was action to be taken as bathrooms and toilets were cluttered and there were communal products in them. We found bathrooms and toilets were still used to store items and there remained communal toiletries in the bathroom. The action plan from the audit was blank.
- The environment audit completed in December 2018, had space to record hot water outlet checks and action to be taken if concerns were identified; this had been left blank. We checked four bedrooms during the inspection and found the hot water outlets had temperatures that ranged from 11 to 28 degrees Celcius.

The optimum temperature for hot water outlets to ensure safety and comfort for people was 43 degrees Celcius. Staff told us there had been lukewarm water in several bedrooms for months. The manager told us low temperatures had been reported to the provider but action to address them had not been completed. This meant the provider had been aware of issues with the hot water, the audit failed to record issues with hot water and timely action to address the hot water issue had not taken place. The lack of action had resulted in staff taking risk with carrying boiling water in bowls to use for personal care tasks with people in their bedrooms.

● There was no management oversight and 'sign off' of the accident reports so they could be analysed, lessons learned and prevent reoccurrence.

● The need for pictorial menus had been mentioned at the last two inspections but had not been actioned yet.

● There were gaps in records such as care plans, risk assessments, monitoring charts and medication administration records. There was inaccurate recording in electronic daily records. This meant the service did not have an accurate, complete and contemporaneous record in respect of each person. There were also gaps in other records such as audits and recruitment documentation.

● The manager told us care staff were unable to make entries in the electronic daily record system as the computer had broken down two days before the start of the inspection. The computer had not been repaired or replaced yet. In the interim, staff had been instructed to make written records but the manager stated these could sometimes not be located.

● Failure to assess, monitor and improve the quality of the service and maintain appropriate and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Working in partnership with others

● We were concerned that two reports of safeguarding issues raised by staff were not dealt with by the provider, a previous consultant, who was employed to provide support and advice, and the manager.

● People's care plans lacked important information about how care staff delivered care and support to people in ways they preferred.

● Staff reported one person was sleepy all the time and was prescribed medicines for Parkinson's disease; there was no record of management consideration to refer this to the person's GP or to request a review and include a specialist nurse.

● Poor practice such as moving and handling, infection prevention and control, and maintaining dignity and respect had not been identified; when it was identified, it was not addressed properly.

● The CQC had not been informed when people had deprivation of liberty safeguards authorised by the local authority, which is a requirement.

● This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

● There had not been a staff meeting in the service since a month before the last inspection. A staff meeting was called during the inspection to inform staff of concerns. Handover meetings were held during shift changes so staff could be made aware of issues to follow up.

● People and their relatives were not routinely involved in decisions about the service. People had reviews organised by local authority staff at which they were asked for their views about the care received.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to notify the Care Quality Commission when deprivation of liberty safeguards had been authorised by the local authority.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure all service user's needs were thoroughly assessed and care planned for.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure service user's privacy and dignity was maintained.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not worked within the Mental Capacity Act 2005, when service users lacked the capacity to make their own decisions.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure there was a safe system of medication management to ensure people received their medicines as prescribed. The registered provider had failed to properly assess risk and take steps to mitigate the risk of accidents and incidents occurring. The registered provider had failed to ensure there were good systems in place to prevent the spread of infections.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to ensure safeguarding procedures were used when allegations of abuse or poor practice were raised.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider failed to ensure all service users nutritional and hydration needs were met.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The registered provider had failed to establish systems and processes to effectively monitor the quality of the service and respond to shortfalls.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to ensure there was a safe recruitment system.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of suitably qualified. competent, skilled and experienced staff on duty at all times.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.