Mrs Lalitha Samuel

Friars Hall Nursing Home

Inspection report

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16 November 2016
17 November 2016
21 November 2016
30 November 2016
19 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and carried out over 16, 17, 21, 30 November and 19 December 2016.

Friars Hall Nursing Home provides personal care and nursing for up to 54 older people. There were 39 people living in the service at the time of this inspection.

There was not a registered manager in post at the time of our inspection. The new manager had applied to the Care Quality Commission (CQC) to be registered; however following our inspection they withdrew their application.

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.

Friars Hall is in Special Measures, which resulted from an Inadequate rating following the previous comprehensive inspection carried out in August 2016. At that time we also identified several breaches of legal requirements. There was poor management and leadership and no clinical oversight of the service which led to people receiving poor care and not being adequately protected from risk to their health and welfare.

Services in Special Measures are 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.

Following the inspection in August 2016 we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do immediately to address them. An action plan was returned to us the following day.

This inspection was undertaken within the six months timescale because it was prompted in part by notification of an incident following which a person died. This incident is subject to a criminal investigation and as a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk from falls and moving and handling.

We also received information from the local authority and a whistle blower which related to poor staffing levels, staff training, poor care, poor leadership and governance.

This inspection was initially carried out during various times of the day and night over a three day period to get a full picture. We found no improvements had been made to the overall quality of the service. Management and clinical oversight was failing, there was not enough trained, skilled and experienced staff which resulted in a continued poor quality of service which placed people at potential risk. There were continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took immediate enforcement action to restrict admissions and increase nursing staff. We revisited on 30 November 2016 to see if the enforcement action taken had made an effect. We found that even though the provider had increased the amount of nurses on each shift the clinical oversight, quality of the service and delivery of care to people remained poor. When we returned again on 19 December 2016 we found that more permanent staff had left or had given their notice.

The service relied heavily on temporary staff with basic training and some experienced difficulty with command of English language which meant they could not always understand or recognise people's needs.

People's dignity, privacy and independence was not always respected. The service was not working within the principles of the MCA and in some cases people were presumed to not have capacity when they in fact had. Therefore choice, preference and consent was also not respected and people were not safeguarded from improper treatment.

We immediately shared our concerns with commissioners (local authorities and Clinical Commissioning Group) because of the very poor care we had observed and because of the registered provider's lack of ability to demonstrate they were capable of taking effective action to address it. As a result commissioners started to find alternative care providers for some people.

The registered provider informed us that they did not know what they could do to improve and made a decision to close the service entirely on 23 December 2016.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to individuals were not managed consistently or effectively to keep people safe.

Arrangements were not sufficient for identifying and managing risk appropriately.

Staffing levels were insufficient and staff were not deployed effectively to meet people's individual needs and keep them safe. Staff did not have the skills, competence or knowledge to meet people's specific needs and a safe and appropriate way.

The provider had ineffective systems to manage people's medicines safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the appropriate skills needed to meet the specific and complex needs of people and people did not receive care that was based on best practice.

Staff did not understand Mental Capacity Act and the service did not practice within the principles of it.

People were not supported to have sufficient to eat and drink.

People did not receive consistent and on going support to meet their clinical needs.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity and respect and their privacy and independence was not always promoted.

People did not always experience good care at the end stage of their life.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People did not receive personalised care that was responsive to their diverse needs.

People did not have regular access to meaningful activities or stimulation to promote their independence, autonomy, choice and wellbeing.

Is the service well-led?

Inadequate

The service was not well-led.

The providers systems for assessing the quality and safety of the service were not effective and had failed to identify the shortfalls identified during this and previous inspections.

The provider and staff did not have a clear vision of the service they were providing and the culture was not focused on improving for the benefit of
those living there.

Friars Hall Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive rating inspection took place on 16, 17, 21 and 30 November and 19 December 2016, all our visits were unannounced.

The inspection of 21 November commenced at 3 am due to concerns regarding people's safety during the night.

The inspection team varied over the four day period but in total consisted of three inspection managers and three inspectors.

Before the inspection, we reviewed all of the information we held about the service, this included the notifications we had received. A notification is information about important events which the service is required to send to the Commission by law. We also reviewed the provider's action plan and information from the local authority safeguarding team and commissioners of care.

During the inspection we spoke with eight people who used the service. Because not everyone could tell us their views we spent time observing interactions between people and care staff.

We spoke with two relatives who visited during the inspection.

We reviewed fourteen care plans and other records which related to people's care.

We spoke with the provider, the manager, four nurses, head of care, two senior carers, six care staff and the chef.

We looked at documents associated with the management of the service such as staff recruitment and training records and staff rotas.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we received information of concern about people's safety, particularly in relation to falls and moving and handling. We reviewed moving and handling practices and equipment and found that some practices were not safe and staff training was not effective.

People using the service were very frail and/or had very poor mobility. The service did not demonstrate falls prevention where action could be taken to minimise the incidence of falls reoccurring. Particularly in relation to reviewing circumstances surrounding incidents where people had fallen from their chairs or wheelchairs.

One person told us that they had fallen from their wheelchair in their bedroom. They said they were partially stuck under their bed on the floor and had to wait some time for somebody to find them. The circumstances of this incident and others had not been investigated by the provider and actions taken to ensure it did not happen again.

Two staff were seen using an underarm lift to assist a person onto a turntable, often referred to as a drag lift. This type of lift has been deemed as an unsafe moving and handling technique because it can cause discomfort and places people and staff at risk of significant injury.

Moving and handling training for staff was delivered by the homes administrator; delivering theory and a senior carer carrying out one to one sessions on the practical elements. The senior carer told us they had attended a course on moving and handling a few years ago but they were not sure if it was still up to date and they had not attended any form of update training. We therefore were not assured that people received support from staff who were sufficiently trained and competent.

Two hoist slings and two toilet slings were hanging up in a bathroom. Staff could not tell us who they were for and confirmed they were being used for everyone. Slings should be measured and assessed for each individual to avoid accidents (due to being too large, small or inappropriate for the support needed), and multiple use increases the risk of cross infection. In addition we found changes in people's weight had not resulted in reassessments to ensure the slings being used were the correct size.

The service had supplied some people with an in-situ sling. These are slings that remain in place when seated. Their assessments gave no detail of the reason for their use or the safety measures required when using this type of sling. We observed six people who remained in their wheelchairs for the duration of each day, seated on hoist slings. Due to mobility and continence needs people were at risk of acquiring pressure ulcers if they are not frequently repositioned to relieve pressure, and have their continence needs met. We saw these people were not assisted to move, go to the toilet or taken to their room to receive personal care for over eight hours.

There were no systems in place to ensure safe management of food and drinks for people with swallowing problems, and at risk of choking. Care plans did not contain suitable and sufficient risk assessments to

effectively manage this risk. Staff did not demonstrate knowledge to support people with swallowing problems safely. For example where drinks needed to be thickened this had not been done to the right consistency. Ensuring this is a key factor in managing swallowing problems and the person's safety. We reported these incidents to the manager and/or shift leader but continued to see examples where this was still happening at each of our visits.

The nutritional risk assessment tool in use was ineffective because it did not identify people's long term and chronic healthcare needs which could affect their eating and drinking. In addition some risk assessments were completed incorrectly and did not give an accurate assessment of the individuals' risk of malnutrition or weight loss. A note on one assessment, indicated that an inaccuracy was identified in July 2016 but the assessment had not been reviewed or revised since.

Assessments for having bed rails in place did not reflect best practice. Where people did not have capacity and understanding the assessments did not show what other least restrictive options had been considered and the rationale for them being discounted. Bed rails were routinely in place for people with dementia but there was no clear rationale for this. We saw people at potential risk of injury. During our night visit we saw two people in difficulty with their legs hanging over the bed rails.

Our inspection in August 2016 found that improvements were required to ensure the safe management of wound care. The provider told us that training and further development would be given to staff to ensure wounds are identified, reported, managed and monitored.

During this inspection we saw an inflamed, swollen and open area on a person's toe. Despite the foot being exposed and staff delivering personal care; the wound had not been identified, reported or managed. The nurse on duty was not aware of it and there was no information about it recorded in their care records. We reported this to the manager.

There was no effective system in place to ensure wound dressings were carried out and monitored. A wound assessment and management chart dated 10 November 2016 stated that the persons wound should be re-dressed every four to five days. On 16 November there were no records to demonstrate that a dressing change was carried out in the preceding six days and it was not listed in the diary to instruct nursing staff. Staff could not tell us if, and when, the dressing had been changed. Without effective management and monitoring people with wounds were at risk of their wound deteriorating, and infection.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient numbers of suitable staff to keep people safe and meet their needs. One relative told us there was not enough staff especially at weekends. They thought that people who were quiet and in their rooms were forgotten and said that on some evenings there was only one nurse on duty. They had raised their concerns with management.

Assessments and care plans did not give a correct indication of people's current and changing needs, particularly with regard to palliative and end of life, dementia and nursing needs. The registered provider and manager did not have a clear overview of the complexity of people's current needs and levels of dependency and they could not identify the numbers of nursing and care staff required to meet people's needs safely. They confirmed 33 of the 38 people using the service had nursing needs.

Care was being provided in a task based way and staff were not deployed sufficiently to ensure people were

safe and spent their time in a meaningful way. One staff member told us, "We do not have time to spend with people as we are always short staffed" and "I am confident people's continence pads are not being changed and the records are not accurate." Another staff member said "Staff frequently run out of time which means people's continence pads are not changed and information is not recorded."

The service was having difficulties in recruiting and retaining permanent staff and there was a high level of agency and bank staff being used to cover shifts. Due to the limited number of nurses and lack of clinical oversight people's nursing needs were not being met in a safe and consistent way.

Rotas showed significant gaps in staff cover; particularly nurses and many shifts were covered by one nurse only. We also noted that many staff worked long shifts up to or over 12 hours. One care staff member told us that they were working in excess of 50 hours a week including a night shift. We found on one day the shift was being covered by two bank nurses (bank staff work on a shift by shift basis). They both worked at Friars Hall in additional to their full time employment in other services. Tiredness from working excessive long hours can impact on the quality of care being delivered and the safety of people being cared for. No risk assessments had been completed by the provider to consider the impact of staff working excessive hours.

Staff expressed concerns about the number of staff on shift at night. They told us and records confirmed that there was one nurse and three care staff on at night. We visited the service in the early hours of the morning and found this to be true. The nurse said that they were kept busy throughout the night providing support, managing medication and administration. The majority of people required the assistance of two carers to reposition them and provide personal care. There were two carers allocated to the first floor and one to the ground floor. People with advanced dementia were accommodated on the ground floor and staff informed us that they were usually very unsettled at night. If assistance was required on an urgent basis from two staff on the ground floor this was not always possible. We saw that the carer on the ground floor was carrying out repositioning and personal care on their own and therefore people may not have been repositioned safely, comfortably or in a dignified manner.

Three staff were unable to speak or understand English to a safe level were able to communicate with people effectively. For example they were unable to tell us about what they would do if people felt unwell because they did not understand our question.

On 22 November 2016 we took immediate and urgent action to address this situation and imposed conditions to the provider's registration to increase nursing staff.

On 19 December 2016 we observed there continued to be a lack of effective deployment of staff. At this time the manager had taken leave and there was no clinical leadership. The registered provider told us that they felt the shift leader was in charge. However they failed to identify that a nurse was unable to complete the morning medication until lunchtime.

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

Our inspection in August 2016 found that improvements were required to ensure the safe management of medicines. The provider told us in their action plan that systems had been put in place to ensure medicines were managed in a safe way and that people would receive their medicines as prescribed.

At this inspection we found that arrangements in place were not effective to fully ensure medicines were managed safely.

There were errors and a clear audit trail was not evident to ensure people's controlled medicines were managed safely. Controlled Drugs (CDs) are medicines that require additional safety precautions. When controlled drugs cannot be accounted for the registered person must report this to the Accountable Officer for Controlled Drugs in the NHS. The manager was not aware of the errors and therefor they had not been reported. Clear guidelines and a standard safety check system was not in place that required the administration or destruction of controlled drugs to be signed off and witnessed by two members of staff.

At our visit on 19 December 2016 we saw further poor practice in administration of medication which did not protect people from risks of cross infection, medication was given with not enough time in between doses and was 'potted up' before administration (a risk because of the potential for people's medication to be mixed up before it is administered).

This is a breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Our inspection in August 2016 found that staff were not receiving appropriate support and supervision for their role and day to day practice. This inspection showed that improvements had not been made. The provider could not demonstrate people were receiving effective care and support from staff who have the knowledge, skills and competency to carry out their roles and responsibilities.

Care staff told us that they were not supported in their role and had not had any formal one to one meetings with seniors or management that addressed their day to day practice or training needs. Our observations of care provision, care planning, risk assessments, reporting to healthcare professionals, medicine management, nutrition and hydration and end of life care did not reflect best practice.

Staff had not received training in relation to people's individual needs associated with long term conditions such as dementia, Parkinson's Disease, Diabetes, Stroke, Epilepsy and End of life care. This was reflected in their practice, for example we saw that staff had not considered comfort and safe positioning of a person's arm that they no longer had control over since suffering a stroke. They were seated in a wheelchair all day that provided no support. No reason was given for them sitting in a wheelchair all day. The person was holding their arm to support it because there was nowhere to rest it seated in the wheelchair. In another case there was disparity in the records for a person with regards to the type of seizures they experienced. There was poor understanding of the condition and placing the person at risk of receiving inappropriate and unsafe care.

People were at different stages of their dementia ranging from early onset to advanced stages; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. Staff had a limited understanding of how dementia affected people in their day to day living. Staff did not recognise poor practice or understand the impact this had for individuals they cared. For example, injuries due to poor moving and handling techniques, swallowing difficulties and risk of choking, pressure ulcer prevention and pain management.

Staff were unable to tell us how they could support people to reduce their anxieties. An incident record for one person living with advanced stage of dementia showed they sustained an injury whilst staff were delivering personal care. The person was communicating their anxiety and confusion physically. The manager had made a comment on the report about how staff should manage this situation. No action had been taken with regards improving staff understanding and practice. Their plan of care had not been reviewed and revised to include this important information to guide staff on how to support the person more effectively.

We observed another individual calling out, "Help me, help me, help me." Despite staff going in and out of the lounge they did not respond to them. We sat and spoke with the person and found that they were anxious and just wanted someone to speak with and be provided with reassurance. Training was needed to enable staff to develop the skills and expertise needed to carry out their roles and responsibilities effectively such as communication skills, person centred care, diversity and engaging with people in purposeful

activity.

Records and our observations showed that nursing staff were not supported or effectively checked to ensure that their practice and knowledge was up to date. For example we spoke to a nurse leading a shift about the risks posed to the person being given fluids that were not thickened. They replied that their knowledge was very limited in relation to this area and they knew very little about thickening agents. We also found disparity in the nursing report for a person who had experienced f seizures. There was a poor understanding of the condition which placed the person at risk of receiving inappropriate and unsafe care.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no structure in place to ensure that new employees or agency staff understood their role and the needs of people they were supporting.

Some staff were recruited from overseas and placed for long term work at Friars Hall by an external agency. An application record for one indicated that they had no previous experience working with older people or people with dementia and comments re language said, "English a little unsure, just needs to practice". The provider was unclear about how they ensured understanding and competency for those staff.

There was no structured induction process in place to ensure that new employees or agency staff understood their role and the needs of people they were supporting. There was no monitoring process in place to ensure that the quality of care expected from new staff was being delivered and identified any further support or training required. One staff member told us that when they started they had been shown the fire exits, shadowed a staff member for one day and was then left to work.

This is a 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.

We found that the service was not working within the principles of the MCA and in some cases people were presumed to not have capacity when they in fact had. Related assessments and decisions for people had not been taken properly and appropriate strategies had not been used to support a person's ability to make a decision for their self.

Care staff spoken with had limited knowledge of MCA and told us that this was managed by the nurses. As care staff had the majority of contact with people this lack of understanding meant issues of consent were overlooked. Staff were unaware of how to respond to apparent and fluctuating changes in people's capacity.

We observed that people were not given the opportunity or support to make choices and decisions throughout the day. Time was not given to enable people to express themselves and communicate in ways they were able to, and in their own time. This was also compounded by some staff who had difficulty in speaking and understanding English. People were not given the opportunity to choose when they got up,

when they went to bed, when they would like to eat, what they would like to eat, where they would like to sit or when they wanted to go to the toilet.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was poor monitoring and management of people's eating and drinking which put people at risk of dehydration and malnutrition. Support provided to people with complex and dementia related needs was not sufficient to ensure they ate and drank enough.

We found six people had significant weight loss over a short period of time. Whilst some care plans reflected actions to be taken by staff to prevent further weight loss such as the provision of finger foods, additional snacks, high calorific foods and nutritional drinks; we saw consistently over the period of our inspections that people were not being provided with these additional nutritional requirements by staff.

Where nutritional or high calorie drinks had been provided to people they were not always supported to drink them and they were taken away untouched. People left to eat independently had little interaction with staff which did not encourage or promote practical help to eat more either independently or with support. As a result some people ate very little of what they were served and staff did not explore this further.

People were not offered a choice of food we observed a staff member placing a sandwich in front of one person. They said that they did not want a sandwich but the staff member did not respond and then placed soup in front of them. There was a selection of other food on the trolley but this was not offered.

For the evening meal hot and cold food was placed on a dining table. The hot food was left to go cold while staff assisted others. Jugs of drinks were not accessible to people and placed out of reach. We only saw cold drinks being served to people at meal times and little support was given to people throughout the day to ensure they were adequately hydrated.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People were not experiencing good quality care at the end of their lives. There was no effective co-ordination of end of life care. The impact of poor or no co-ordination meant that there was a loss of focus on the individual and their needs. People with dementia did not have positive experiences because the lack of understanding by staff was preventing them from receiving good care. The provider had not ensured that staff who care for people who may be approaching the end of life had the knowledge, skills and support they needed to enable people to die without pain or discomfort, and with dignity. We raised safeguard alerts to the local authority in these cases.

One person had lost nearly half their weight since their admission six months previously. Staff told us this person was at end of their life, and was not eating or drinking. Records stated that they were drinking independently and yet the person told us that they could not manage to lift the water jug and help themselves. Their beaker of water was placed out of their reach. Meals were taken away uneaten. Nobody offered an alternative choice or tempted them with foods they may like or fancy instead, at meal times or at any other time. This person was left alone in their room throughout each day. The approach to meeting their needs was not caring.

The development of positive caring relationships was compromised by the lack of effective communication and interaction with people. In some cases this was due to difficulty for staff where English was not there first language. On occasions carers looked to us to help to explain what a person was saying, for example a request for a straw and a request to change the television channel over. This difficulty caused frustration for some people who were unable to make themselves understood.

Privacy, dignity and choice was not always respected and there was inconsistency in staff approach. Staff failed to explain to people what they were going to do or gain their permission. One person's bedroom door was left open while they were receiving personal care from two staff members. There was no interaction and the two staff spoke to each other in their own language. This person told us, "They get me ready so quick and then out, it is all a bit rough, they don't stop to think…they need to understand that when you get to my age you are not used to being handled, they treat you like an animal." This person said to receive a shower, "We have to make an appointment and fit in with them".

We observed a person being supported to eat by a member of staff and noted that their dentures remained in a beaker. When we asked why this person was not assisted to wear the dentures to enable them to eat the staff member shrugged their shoulders and said it was because they were, "Like a baby." One person told us that they preferred to receive personal care from female carers but they did not have a choice. They said, "I don't like men washing me down below, it upsets me." It was recorded in their care notes that they did not have a preference with regard to the gender of care staff. The care plan in relation to communication stated that this person was uncooperative with personal care but there was no exploration about why this might be or how staff could approach this.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Regulations) 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive care that was personalised and responsive to their needs and there was no consistent and planned approach to support people.

Care plans were prepared and written by nurses. Care staff were not involved in the planning and review process of care plans. They said they did not look at them or use them to inform their delivery of care. They told us they relied on information given to them during shift handover but this only included immediate changes and therefore did not include specific care and risk management that people required on daily basis. Staff told us that handovers lacked detail in order to provide the right care.

Care staff did not have a key to access the care plans to refer to; the key was held by the nurse and at times the nurse was difficult to locate. A folder kept in people's bedrooms provided a limited overview for staff of each individual's needs but did not inform staff of individual's specific needs or risks to be aware of. For example if someone has a swallowing problem and a potential risk of choking; they were not personalised and did not identify specific symptoms experienced by the individual or how their care should be approached to minimise this risk.

The folder included food and fluid charts and repositioning charts. One staff member said that they often had to question if the records were accurate as they found people "very wet" despite their records indicating they had received a change of their continence pad. In addition to this professionals visiting the service also found that records did not reflect the care people were actually receiving.

Throughout our inspection we saw activity staff interacting with people seated in the dining room and facilitating group activities such as flower arranging. On one day there was a visiting drama group. However on all the days of our inspection we saw the same people seated at the dining room table from when they got up until they were taken to bed to retire for the night. Some went to bed at 4.00pm; others went to bed after their tea at approximately 6.00pm.

During our night visit people were seated at the table as early as 4.00am and 5.00 am which meant they were there for a period of 11 hours or more. They were not assisted to leave the table at any time during the day, even when they received visitors or had fallen asleep. We were seriously concerned about this because lack of movement can affect the body systems, including deteriorating lung function, cardiac function, urinary drainage (creating an infection risk), digestion, muscle wastage, joint flexibility, and mental deterioration.

None of the care plans we looked at contained a care plan that adequately demonstrated how the service responded to individual's differing needs in terms of interests, social activities, types of dementia and the varying stage of dementia they were at. We observed people being left largely to their own devices on the days of our inspection which resulted in anxiety levels, distress and social isolation escalating.

People who spent their time in their bedrooms had little or no stimulation, only that from staff performing a care task or an activity co-ordinator performing a hand massage. We spoke with people who were distressed

at spending so much time alone. Some people were calling out for help but these were ignored by staff and feelings of loneliness, helplessness and boredom was not addressed. Staff told us that this was the way people were and had little understanding about how they could improve this experience for people. For example they lacked knowledge about people's backgrounds and past lives which would have enabled them to explore different ways of communicating and understand more about the person they were supporting.

Throughout our inspection we observed two people walking continually around the service. There was no management strategy in place for carers to provide consistent and effective support and their experience of day to day living at the service was very poor. We saw that by late afternoon they became very distressed and no action was taken to try and address this through exploring different approaches and routines.

One person had been wheeled from one room to another to enable a drama group to set up. The senior nurse was unable to give us an overview of this person's needs and approach required to meet their needs on a personal level. We were concerned because they looked unwell. We asked them if they needed anything and they replied that they would like a glass of water and would like to lie down. A nurse came over and said that it was lunchtime indicating that they could not go to bed. We intervened and asked that the person's wishes were attended to. We later determined from a relative that the person had been very unwell following two major health incidents prior to admission. There was no information in their care records relating to their health needs or wellbeing and how this was being monitored.

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

Inadequate

Is the service well-led?

Our findings

We found continued widespread and significant shortfalls in the way the service was led with regulations not being met. Improvements required from the previous inspection in August 2016 had not been addressed. Due to escalating concerns we visited the service over five days. On the last day, 19 December 2016 we found the service without any managerial or clinical leadership in place. A consultant who had been employed was not a clinician so was unable to fulfil this role. The provider advised that the manager had resigned and were now on leave. They had not been able to identify a person to manage the service in the interim whilst they advertised for a permanent replacement. The registered provider said they thought the lead nurse on shift would run the service. They told us they were unable to monitor this because they did not know what needed to be done and were reliant on their manager and clinical leads.

The provider had failed to ensure effective leadership and lacked understanding around what good quality care looked like. They had failed to retain a registered manager which had led to inconsistent governance and leadership of the service. This in turn had led to a failure to address recurring areas of risk to people's health, safety and welfare, and to sustain any improvements made. The registered provider was not identifying or acting on issues of concern within the service and therefore outcomes for people using the service continued to be poor.

Support and resources needed to run the service were not always available. Staff turnover was high and the provider was unable to recruit and retain staff. The service only had three nurses and seven care staff directly employed to support and care for 38 people with complex needs. To fill the gaps agency staff were used in high numbers. It had been a significant challenge to develop a positive staff culture in the service, with positive values and behaviours that benefited people who used the service.

Roles and responsibilities were unclear and staff were unsure who they were accountable to and what they were accountable for. One staff member said, "I have worked here a long time and know what to do, nobody tells me." Nursing staff told us that they saw the role of directing care staff that of the senior care staff, however, senior staff told us that they did not see that as their role. Agency and bank nurses told us that they were very reliant on the other nurse on duty for their knowledge and support with people's ongoing needs and conditions. This placed considerable strain upon the permanent nurse to oversee the shift on each floor.

Because there was no effective clinical leadership there was an over reliance on external professionals to support the service and provide care and treatment. Whilst it is positive to work with GP surgeries and other health care professionals, we found that responsibility for escalating issues and seeking further advice was not always taken and they relied on these visiting professionals to prompt or do this for them. In addition the lack of nursing leadership and oversight meant that the quality of the nursing was not being monitored to ensure it was appropriate and followed best practice.

The culture of the service was not focused on improving for the benefit of those living there, and the provider and staff did not have a clear vision of the service they were providing. None of the staff spoken with were

able to tell us what the aims and values of the service were.

People, relatives and staff felt that communication was poor. Many staff did not feel valued and respected by the manager or the provider. Reasons for this included that they felt they were not involved or informed about future plans or improvements for the service. They felt their views did not matter and they were not empowered to express their views. For these reasons many were terminating their employment.

Observation and discussion with staff showed that they had not had the training and support they needed to give them the skills to support people living in the service. They lacked guidance and understanding on how to respond to concerns about people's safety and manage people's behaviours. This did not ensure that people, staff and others were protecting people from the risk of unsafe care or treatment.

The provider did not understand the principles of good quality assurance. There were limited processes in place to assess and monitor the quality of the service and if it was operating safely and effectively. For example the provider and manager were unable to demonstrate how they identified any trends and themes in incidents and accidents across the service. Without this they could not see where improvements were needed in order to minimise risks of similar incidents happening again.

There was no plan about how the service kept up to date with developments in dementia care to ensure the care provided was appropriate and in accordance with best practice. The provider was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted. There were no arrangements in place to help people who had no one acting on their behalf to access advocacy services to enable them to voice any concerns if they needed to.

The registered provider was unable to demonstrate that they had the skills and competency to run a safe service. When we raised concerns with them they asked us what they should be doing because they did not know. Previous managers cited a lack of support and resources to make changes in the service. Other health and social care professionals also reported a lack of proactive action being taken to drive improvement in the service

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Regulations) 2014.