Rotherwood Healthcare (St Georges Park) Limited

St Georges Park

Inspection report

School Street
Telford
Shropshire
TF2 9LL

Date of inspection visit:
31 October 2016
01 November 2016

Date of publication:
05 January 2017

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 took place on 31October 2016 and the 1 November 2016 and was unannounced. This was the first comprehensive ratings inspection following registration of the service under the current provider.

St Georges Park is residential accommodation for people who require nursing or personal care or the treatment of disease, disorder or injury. They provide care for up to 70 older people with dementia and nursing needs. At the time of the inspection there were 60 people living at the service.

The registered manager had resigned from their post in August 2016. 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.

People were not protected from the risk of abuse. Staff did not always identify potential abuse, which meant incidents were not investigated and reported to the local safeguarding authority. People did not always receive their medicines safely. Medicines were not always available to people. Where people were at risk, staff did not understand how to manage the risks to keep people safe. People did not always have their needs met, as there was not enough staff to meet people's needs.

People received support from staff that did not have the knowledge to support people safely. We found not all staff understood how to provide some aspects of people's care. People were not always supported in a way that protected them from unlawful restrictions. Principles of the Mental Capacity Act had not been followed when people lacked capacity to make specific decisions. Care was not always provided in a 'least restrictive' way. People did not always have their food and fluid intake managed safely. Staff did not always make sure people had enough to eat and drink. Staff did not always seek support for people from health professionals when they needed it.

People did not have meaningful relationships with staff. Although some staff were seen engaging with people positively, in a most staff were too rushed to speak with people and sometimes missed the opportunities for interaction. People were not involved in making decisions about their care and support. Staff did not always treat people with respect and ensure their dignity.

People did not have their needs met in the way they preferred and choices they had made were not met. Staff did not always understand people's needs and preferences. People had access to group activities, but there was little evidence of people being able to follow their individual interests. Some people did not know how to make a complaint.

People did not always feel they had an understanding of who was leading the service. Staff did not have clear leadership and were unsure who was in charge. The provider had failed to monitor the quality of service provided and to ensure people were protected from risks to their health, safety and well-being.

People told us they had meetings to raise concerns; however, it was not always clear what happened as a result. The provider did not always notify us of incidents, which occurred at the service.

During this inspection we identified 8 breaches of the of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from harm. Systems in place did not always identify and investigate potential abuse.

Medicines were not managed safely. People did not get their medicine as prescribed.

People who were at risk did not have their risks managed effectively. Staff did not understand the risks to people's safety.

There was not enough staff to meet people's needs safely. People were not always receiving the care and support they needed.

Is the service effective?

Inadequate

The service was not effective.

People did not receive support from staff with the knowledge and skills to meet their care and support needs.

People did not always have their rights upheld in line with the Mental Capacity Act.

People did not always have support to ensure they were eating and drinking enough.

People's health was not always monitored effectively.

Is the service caring?

Inadequate

The service was not caring.

People and their relatives were not always happy with the care they received.

People were not involved in decisions about their care and support.

People did not always have their privacy and dignity respected.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always have their preferences met when they received care and support.

People's needs were assessed; however, staff were unsure of how to meet people's needs.

People could take part in some group activities; however, opportunities to follow individual interests were limited.

People and their relatives did not always understand how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

People told us did not understand the management structure and staff were unclear about the leadership in the service.

The provider had failed to notify us of incidents as required by law.

Arrangements for the quality monitoring of the service were ineffective.

People did not always have their views sought and feedback had not been used to make improvements.

St Georges Park

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 unannounced inspection took place on 31October 2016 and the 1 November 2016. The inspection team consisted of two inspectors, a specialist advisor, a pharmacy inspector and an expert by experience. The specialist advisor was a qualified nurse who specialised in end of life care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service. We also contacted the Local Authority Safeguarding Team for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with seven people lived at the service and 12 visitors. We spoke with the provider, the quality manager and the training director, who were providing management support to the home. We also spoke with 16 members of staff. This included nursing staff, senior care staff, care staff, the activity coordinator, domestic staff and the cook. Some of the staff members we spoke with were agency staff.

We carried out observations throughout the service to help us better understand the experiences of people living at the home and to review the quality of care people received. We looked at the care records for seven people. We also looked at other records relating to the management of the service including staff files, training records, complaint logs, accident reports, audit records, and medicine administration records.

Inadequate

Is the service safe?

Our findings

People we spoke with told us there were not enough staff members to support them effectively. We received widespread concerns about the standard of care provided and we were told this was due to there not being enough members of staff to provide the care they required. One person told us, "It normally takes a long time for buzzers to be answered which means I cannot make it to the toilet on time". Another person told us, "Sometimes [staff] take a long time to answer [the call bell], when they come they say they are delayed because they're short staffed". A third person told us, "You can't put a time on it but I hope I am up before 11am". A visitor told us "[My relative] had been waiting to be taken to the toilet for three hours". Another visitor said, "Initially there was enough staff, but now they are at capacity the staff are very good but they are too stretched".

Staff also told us they did not feel there were sufficient numbers of staff to support people and this sometimes meant people were not safe. One staff member told us, "More staff are needed. When [a person] needs assistance from two carers, you have to go looking for help. There are not enough staff, so sometimes you have to manage yourself". Staff told us some people wanted to get out of bed and go to the lounge; however, they said they did not have the time to support them. Staff also told us they did not have enough time to support people to get up before breakfast and sometimes people had to wait for care and support whilst people were supported to eat and drink. Staff told us there were high numbers of agency staff being used within the service and this added additional strain as some of these staff members did not know people or their care needs. Staff told us there was not enough staff to ensure the required deep cleaning of rooms was completed and they told us many rooms had not been cleaned for more than a month.

Our observations confirmed what we had been told and we saw there were insufficient numbers of staff available to support people safely. We saw people that required support to move, moving unaided, which meant they were at risk of falls, this was because staff were not available to provide assistance. People were shouting for help from their bedrooms to get out of bed and we had to seek staff members to provide support for these people on a number of occasions. We saw most people remained in bed until late morning both days we inspected, as staff were engaged in providing support to other people. We saw further examples of people not receiving the support they needed, for example with their food and drink. We saw one person drop a plate of food on the floor in the dining area and they struggled to pick it up with no care staff available to provide support. We spoke to the management team about the levels of staff available to support people and were informed that staffing levels had been increased by one during the prior week. The management team were in the process of reviewing the tools they used to calculate staffing levels and provided assurances they would review this urgently. People's needs were not effectively met and they were exposed to the risk of harm due to insufficient levels of staff to meet their needs.

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

People and their relatives told us they were not confident people had their prescribed medicines at the times they needed them and in the right way. One person told us, "I have to wait for my medicine until staff

come with them, I like to have them with my breakfast, but that doesn't always happen". One visitor told us their relative had been waiting over 40 minutes for pain relief, they said, "I asked the nurse for something for [my relatives] stomach pain, I'm still waiting for nurse to come back".

We looked at how the service managed people's medicines. Medicines were stored securely, and at the correct temperatures. We saw nurses returned unwanted medicines to the pharmacy for disposal and that staff kept records of all medicines that were disposed of.

Medicines were not being managed safely. Staff did not understand how or when to give people 'as required' medicines safely. We found two people had received 'as required' medicines to manage their behaviour on a daily basis for over one week, this meant people were receiving medicines when they may not have needed them. Managers confirmed there were not sufficient guidelines for staff around how to administer these medicines safely, which had potentially resulted in the people being over medicated.

Prescribed medicines were not always available for people. We found one person was waiting for a prescription from the doctor for three days; this person was visibly in pain. The provider had not taken action to obtain the prescription sooner or seek alternatives for this person.
People did not always receive their medicine as prescribed. We found there was no evidence people had received some medicines, for example staff had not signed the MAR chart to show one person had received medicine to prevent breathing difficulties. Some prescription medicines are controlled by legislation. These medicines are called controlled drugs (CDs). We found one person received an incorrect dose of their CD medicine. This had not been reported by staff and the training manager confirmed there was no system in place which would have identified this error. The manager began an investigation. We found CD medicine could not be disposed of in a timely and safe manner. There was limited assurance that people had received their medicines safely, consistently and as prescribed.

People were at risk of being given medicines that were no longer fit or effective. We found medicines, with a limited shelf life, did not have an opening date recorded. We found one medicine, which was in use past the expiry date, which meant the medicine might not have been effective. Guidance had not been sought from a pharmacist when people received covert medicines. For example, when medicines were being crushed. Some medicines no longer work when crushed or can cause additional side effects to the person. This meant people were placed at risk of receiving medicines, which were not effective or suffering from adverse effects.

People and their relatives told us they did not feel staff understood people's risks and how to support people safely. One visitor said, "I am worried about [my relative] being at risk due to not having enough fluid". Another visitor told us, "I am worried about the risk of [my relatives] pressure sores getting worse, they haven't been out of bed in a week". Visitors gave other examples of observing staff not following care plans for people who were at risk, such as with moving and handling and transfers in wheelchairs. We saw one visitor had to prompt staff to raise a bed to a sitting position whilst giving their relative a drink as they felt they were at risk of choking. We saw staff placed tray tables on top of people's crash mats, which created a hazard for people if they fell out of bed. When we spoke to staff about this they did not see the risk this created and explained it was so people could reach their breakfast and drinks whilst in bed. We spoke to the manager about this and they said they would take immediate action, however, on day two of the inspection we found this was still happening.

People were at risk of harm as staff did not understand risks and how to manage them. We found staff had inconsistent knowledge of people's risks and what action to take to mitigate the risks. For example, one person who had a known risk of choking had been left alone to eat their breakfast. Staff told us the person

was at risk, however the training manager felt the records for this person may be out of date. In another example, staff were not always aware of how to keep people safe when they displayed behaviours that could challenge. We found several examples where people had caused injury or harm to themselves and others. Staff told us they had not been given clear guidelines around how to protect these people and manage their behaviours. We found staff and managers were not monitoring incidents that arose due to these behaviours. As a result they had not identified potential 'triggers' and ways in which staff may reduce the risk of behaviours arising and harm being caused to people had not been identified. We confirmed with the clinical lead that care plans had not been developed to provide staff with guidelines around how to safely support these people. We saw one person was in a lot of discomfort and shouting out in pain due to a skin condition. They were in bed scratching with blood staining their nightclothes. Staff told us they were waiting for the GP to provide a prescription. However, we found no steps had been taken to alleviate the person's discomfort or to make further contact with the GP despite the person being in visible pain for several days. On the second day of the inspection, this person had received their medicines and their condition had noticeably improved.

Staff also told us some people were at risk of weight loss due to their poor food intake. They told us about two people who they thought had visibly lost weight and had been refusing food. Staff did not know how to monitor and manage this risk other than trying to encourage people to eat where possible. The management team were aware of the risks to these people however had taken no action to monitor these people's weight. They had also failed to provide guidelines to staff about how to reduce the risk of harm to these people. In another example, staff were not turning people in bed regularly, which meant people were at risk of developing pressure sores. We spoke to the manager about this and they confirmed staff had not been following the care plans for some people. This showed people were not supported to manage risks to their safety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

People were not always protected from the risk of abuse. Staff did not understand how to how to protect people from abuse and records showed not all staff had received training in how to protect people. We found some staff could not describe the signs of abuse or what action they would take if they had any concerns. As a result, we found incidents where staff had not identified potential abuse and therefore the incidents had not been investigated. For example, on the first day of the inspection we identified a person who had a visible bruise. Staff had not identified this potential injury and reported the concern to managers. The management team said they were unaware of the bruising and therefore had not identified the cause or taken any action to protect the person from further harm. In another example, we found a situation, which had caused harm to others that had not been reported to the local safeguarding authority. The local safeguarding authority has the lead responsibility for safeguarding people. All incidents of potential abuse should be reported to the appropriate body without delay to ensure they are fully investigated and action is taken to protect people. We found a number of concerns about people being at risk of neglect during the inspection. For example, staff had not identified one person was unwell and needed to have support from a doctor, another person was at risk of dehydration and staff had not identified this or taken action. We referred these people to the local safeguarding authority and they are now under investigation. This showed people were not always protected from the risk of abuse or harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

We looked at how the provider ensured staff members were recruited safely. We saw a range of pre-

employment checks were completed including identification checks, references and Disclosure and Barring Service (DBS) checks. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks. We found checks were completed prior to staff members starting work with people. We did however find where further investigations were required these were not always carried out. For example we found a staff member who had unexplained gaps in their employment history were not asked for an explanation about this before being employed. This meant the provider could not be assured this person was safe to work with people.

Inadequate

Is the service effective?

Our findings

People and their relatives told us they did not think staff had sufficient knowledge of their care and support needs or had the skills to meet their needs. One visitor told us when their relative needed help, "Staff didn't know [my relatives] name or which bedroom they were in. Staff expected [my relative] to get up from the chair, it was obvious information had not been passed to the staff member about [my relatives] capabilities and when they needed help". Another visitor told us, "Staff moved [my relative] from easy chair in lounge to wheelchair and did not use the hoist". This person should have had access to a hoist for all transfers to be done safely. Another visitor said, "Staff supported [my relative] to the toilet and they had not adjusted [my relatives] underwear properly".

Staff did not have sufficient support in their role. One staff member said, "We don't have a lot of guidance downstairs, we haven't had a manager for a while". Staff also told us they did not always receive supervision, many staff telling us they could not remember when they had last had the opportunity to discuss their role. Staff told us they did not feel agency staff always had the required knowledge to support people safely. Some agency staff agreed with this view and told us they did not receive sufficient information about people's needs before starting work with them. One agency staff member told us, "Sometimes you are working with a regular member of staff and sometimes it's another agency and we are both blind". Staff told us they had a two day induction and completed shadowing when they began their role. Staff told us about the induction and said it showed them the basic routine. Staff said they had not read all people's care plans as part of induction. One member of staff said, "The induction told me what the daily routine was and covered manual handling and safeguarding". Another staff member said, "It was a good job I worked in care before, I didn't do much shadowing, wasn't asked to read the care plans before going in, I asked other carers about people". However, the training plan showed less than half of the staff had completed an induction. The manager told us staff were working towards their care certificate. The care certificate is a set of standards that staff should cover as part of induction training. No staff members had completed this in full at the time of the inspection.

Staff told us they did not feel they had enough training to enable them to carry out their role. One staff member said, "I have not done any training since my induction and shadowing". Another staff member said, "We have had some training, but not all staff apply that knowledge". We found staff did not always have sufficient knowledge to support people effectively. People living at the service had complex needs, for example, people living with varying levels of dementia, people who displayed challenging behaviours and people with complex risks associated with their nutrition. Staff did not have the knowledge to support these people and keep them safe. We found this affected the quality of care provided and put people at risk. For example, we found medicines were not administered safely, staff could not recognise and report potential abuse and people were at risk due to insufficient monitoring of their food and fluid intake. We asked the manager to tell us about their training plans and they showed us their training records. The training records confirmed some staff had not received training in the areas where we found their knowledge and skills were insufficient. This showed us people were not always receiving care and support for staff that had the knowledge and skills to provide safe and effective care.

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

People told us staff sought their consent before providing care and support. One person said, "Staff always ask for my consent before helping me". We found where people could give consent this was sought. Staff told us it was important to seek consent from people ahead of providing care and support. We saw where people were able to give consent to receiving care and support staff asked if they were happy to receive care and support.

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's rights were not always upheld and staff were not working in line with the MCA. Where people lacked capacity make specific decisions about their care, principles of the MCA had not been followed. We spoke to staff about the MCA found they did not understand the principles of the act. For example, staff were asked about people's capacity to understand and make decisions and they gave mixed responses. We asked staff about the principles of the act and they could not describe what this meant. One staff member said, "I can't remember having any training about this". This showed the provider did not ensure staff worked within the principles of the MCA.

We found decisions had been taken for people with no MCA assessment completed and no discussion or consultation about what would be in people's best interests. For example, we found people were refusing food and drink, without understanding the impact on their health and three people were receiving prescribed medicine covertly. This means medicine is hidden in their food or drink without their knowledge. We spoke to staff who said these people did not have capacity to make these decisions, however the principles of the MCA had not been followed in ensuring people's rights were protected. We also found people's relatives had made decisions about care and support without having the legal authority to do so. For example, a restriction had been placed on a bedroom door. Staff told us the person did not have capacity to consent to the restriction; however, there had been no MCA assessment to determine this. There had been no best interest decision made for this person and staff told us family members had requested the restriction was put in place to prevent other people from entering the room. The provider had failed to follow key principles of the Mental Capacity Act when people lacked capacity to make specific decisions.

We found people were being cared for in a way that placed restrictions on them, without consideration of whether this was the least restrictive option. For example, we found people had a low bed and crash mat in place to prevent falls. There was evidence to suggest these people lacked capacity, however there was no evidence of a MCA assessment or a decision taken in their best interests. There was no consideration of whether a less restrictive practice could be applied, for example pressure mats or door monitoring alarms. In another example, we found two people were having medicine to manage their behaviours. We found this had been administered daily and there was no evidence that this decision had been taken in peoples best interests. Staff were unaware these people were receiving medicine to manage behaviour and did not understand why the medicines were given. This showed the provider did not ensure staff followed the principles of the MCA when placing restrictions on people.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw applications had been made to the authorising body for some people who were having restrictions placed on them. The applications had not been approved at the time of the inspection.

People had mixed views about the food. One person said, "The variety is excellent, the portions are generous and there is a big choice". Another person said, "The food is not very good. There is a choice of two things, today I chose salmon but I didn't enjoy it". We spoke with the cook and they told us the menu had been in place for some time and there was a plan to change this, they also said they carried out surveys about the food. The cook was aware of people's needs and requirements for any special diets.

People did not have their nutritional needs monitored. One visitor told us, "[My relative] has gone down rapidly recently and lost a lot of weight. [My relative] is no longer able to feed themselves and they are a very slow eater, the staff don't seem to have the time to help [my relative] to eat."

Another told us they were concerned about food and fluid intake for one person, staff confirmed this person required full assistance to eat and drink. We found the records showed this person had not had sufficient food or fluid, however the training manager said the records had not been completed adequately. In another example, a relative told us they were concerned about their relative's weight loss and they had requested a chart being made available to monitor their relative's food and fluid intake. They told us they checked on this twice a day, because their relative had lost weight. The relative told us the service had not taken action or sought advice until the person had lost 6 kg of weight over a five to six week period, the records we saw supported this. This showed us people did not have their nutritional needs monitored.

Staff told us a large proportion of the people using the service needed support to eat and drink. They told us in some cases it could take up to 40 minutes to support one person and giving this support meant other people had to wait. We saw that people who had not eaten their meals were not often encouraged to do so by staff. Staff told us about two people who they felt had visibly lost weight, they told us these people had been refusing food and drinks on a regular basis and records confirmed they had not been eating and drinking regularly. There had been no intervention to seek support for the lack of food and fluid intake and their weights had not been monitored. Staff told us they tried to encourage people to eat but they had received no direction from managers about how to monitor these people's health. We found people were not having their food and fluid intake monitored, despite concerns being raised.

People who had risks associated with their nutrition were not always supported to manage these risks. Staff were unaware of the risks to some people and did not follow instructions given to them by the speech and language therapists team (SALT). Where potential signs of dehydration had been identified, there was still no evidence of accurate monitoring. Staff told us people did not have enough fluids throughout the day. A nurse told us they had to tell staff to give people fluids, as sometimes they saw the early signs of dehydration and the nurse felt sometimes staff did not have time to encourage people sufficiently to drink. We saw records which indicated people had not had sufficient fluid. We spoke to the manager about this and they said people would have received fluids when having their care and support which may not have been recorded. However, as records did not show this fluid intake we could not confirm this. This showed us staff did not support people to manage nutritional risks.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. Meeting nutritional and hydration needs.

People and their visitors told us people received support from health professionals. One relative told us, "A chiropodist visits regularly, every 6 months, this is arranged by the service". Another visitor said, "An outside physiotherapist came recently to see [my relative]". However relatives told us they were not always kept informed of changes in people's health. For example one relative said, "[My relative] has been in hospital twice in the last few weeks, and neither time were we informed". Staff told us people had access to health professionals, however we found this was not always the case, and where health advice was given, this was not always followed. For example, some people's health needs were not met due to insufficient monitoring and medical attention had not always been sought when needed. Several visitors raised concerns with us about the monitoring of their family member's health needs. For example, one relative told us they had contacted their family member's GP as they were concerned about their temperature. They told us the person had recently come out of hospital following a serious illness and staff had not identified there had been a significant increase to the person's temperature. This person was seen to be unwell during the inspection and staff did not know how the GP had asked for this person's health to be monitored. We spoke to the quality manager about this and asked if they thought a doctor should be asked to visit. The quality manager said they would arrange to contact the doctor and discuss the concerns. We spoke to the relatives later that day and they confirmed the person had improved following our intervention.

Inadequate

Is the service caring?

Our findings

People told us they did not feel their privacy and dignity was always maintained. One person told us, "I want to make phone calls in private". The person told us they were unable to do this and the area was too noisy. A visitor told us they did not feel staff protected people's dignity and gave an example of a care worker supporting their relative to adjust their underwear in the bedroom whilst they were present, without asking the visitor to leave the room. Another visitor told us, "When I was visiting [my relative] staff entered lounge and preceded to empty [my relatives] catheter in the lounge, at least two other people were present to see this happening".

Staff did not maintain people's privacy and dignity. Staff told us people had to wait for their care and support, as they did not have enough equipment, such as shower chairs and hoists. Staff also said they did not feel they had sufficient time to maintain privacy and dignity in the way they would like. For example, staff said they often could not attend to people's personal care until after lunch, leaving them in their nightclothes. They told us people's personal care needs were often rushed which was traumatic for some people. One staff member said, "I don't feel we maintain people's dignity because we are too rushed". Another staff member told us, "I want to do things properly but I can't always". Another staff member said, "Some staff don't look at the detail, such as dressing people properly, or people wearing someone else's slippers".

The provider did not ensure people had their privacy and dignity maintained. We saw people in bed, with the doors open so staff could monitor them. However, people were not appropriately dressed or example one person had their chest exposed. We spoke to staff about this and they did not recognise this affected people's dignity. We also found details about people's care needs were left on trollies in the corridor. We asked staff about this and they told us the sheet told them who needed assistance and gave them basic information about peoples care needs. Staff used language to describe care needs that did not promote peoples dignity, for example, one staff member said, "Half of the people upstairs are doubles", with another using the term, "Doing a double". Another staff member referred to "Running breakfast" when describing taking breakfast to people in their bedrooms. This meant people did not have their privacy and dignity maintained by staff. The provider had not taken any action to change the terms used by staff, which described people as if they were a task, not a person. People were not treated with dignity and respect.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

People did not always have caring relationships with staff. People and their relatives told us the staff had very little time to talk to them. They said staff were rushed and provided their care and support quickly. One person told us, Staff listens if I raise a concern, some can be sharp". One visitor said, "In the main staff are considerate and kind, but some crack under the pressure". Another relative told us, "The staff are stretched, their conversation is quick, but they mean well".
There were occasions where we saw positive interactions between staff and people. For example, we saw a member of the domestic staff team asking if it was ok to go in a person's room, we then saw this staff

member encouraged this person to eat their breakfast, whilst sitting with them and rubbing their arm gently. However, this was not consistent, as staff had limited time to spend with people. We spoke to staff about this and we found staff wanted to provide support in a caring way but they were often too rushed to be sociable with people and acknowledge them or and respond to their needs in a timely manner. For example, we saw staff walked past someone who was clearly in distress in the corridor without stopping to see if they were ok.

Staff did not treat people as individuals or take time to find out what was important to them. We found staff, in some cases, did not know people's full name or which room they were in. They could only reference people's personal care needs for example which did not demonstrate people were being cared for with respect.

The provider had failed to ensure people had meaningful relationships with staff; opportunities for social interaction and that people were cared for in a kind and compassionate way. Staff told us they did not feel they could spend time to develop relationships. One staff member said, "I have a chat with people when I am doing things for them, but there is no spare time". However, we found staff did not take opportunities to engage in meaningful conversation. For example, We saw one person was being supported to eat their whole meal and the staff member did not converse with them at all whilst giving this support. In another example, we saw staff served lunch to some people in the dining room and the lounge, without much staff engagement with people. Staff told us relationships with some relatives were difficult as they often felt their relatives were not receiving the care and support they needed. Staff told us this was because they had difficulty in meeting relative requests due to the availability of staff. Most people were cared for in their bedrooms throughout the day and this reduced the opportunity for social interaction.
People were not always able to express their views and be involved in decisions about their care and support. People and their relatives told us they did not have choices about some aspects of their care and were not involved in decisions. For example, one visitor said, "[My relative] has been in hospital twice in the last few weeks, and neither time were family members informed". Another relative told us they had not been informed of a visit from a health professional. We confirmed in both these cases the people did not have capacity to express their views about their care and relatives had not been engaged in the discussions or decisions.

The provider had failed to support people to express their views and be involved in making decisions about their care. We found staff providing support without checking with the person how they would prefer to receive it. For example, people were given drinks without being asked about their preferred type of cup, even though the person said, "I do not like drinking through the lid" when staff gave them a drink in a beaker. In another example, one person told us they liked to read and do word puzzles, however staff had not ensured the persons books were in reach whilst being cared for in bed. Staff did not engage people in decisions about their care and they were focussed on tasks not people. For example, we found staff were focussed on the task of giving people their meals and did not use the opportunity to engage people in a social activity. We found most people were supported with meals in their bedrooms and when we asked staff about why people did not come into the dining room to enable them to socialise, staff told us they did not know why.

The provider failed to ensure staff understood people's wishes when they were at the end of their life. For example, we found staff could not tell us about peoples care and support needs, how these were being met and what people's preferences were. In some cases staff were unaware the person was at the end of their life. We found the care plans for these people lacked detail of their wishes or choices regarding end of life care. The training manager confirmed there had been no discussions with people to establish their wishes and choices, as the named nurse was not available to complete this. This showed us people were not involved in making decisions about care and support.

Inadequate

Is the service responsive?

Our findings

People told us they did not always get their needs met in the way they preferred. People were not asked about their preferences for care and support. When people expressed their preferences to staff, these were not followed. For example one person told us, "Sometimes I get up at 6am and ask for a shower and I am told it's not your turn go back to bed". Another person told us, "I wake up at 7am; I have to wait most mornings to get up until staff can fit me". One visitor told us, "I am involved in making decisions about [my relative] and have been involved with the care plan, however, I am not really kept up to date with changes, communication is not good". Another visitor told us, "[My relative] wanted to go outside last week a staff member said they were not willing to accept responsibility for decision to allow [my relative] outside". This showed us people did not receive care and support in the way they preferred.

Staff did not consistently understand people's needs and preferences. As a result, staff were unable to support people appropriately; this sometimes left people at risk of harm. Staff told us they did not always understand people's needs. For example, when asked about care plans, one staff member said, "I don't think I have seen everyone's care plan". Another staff member, when asked about managing people's behaviour said, "Not sure about a behaviour plan, they just give [the person] the drugs". We found some people displayed challenging behaviours that placed themselves and others at significant risk of harm and there was no management plans in place to monitor or manage these behaviours. We found examples of staff giving conflicting information about risks for people around falls, eating, drinking, and being resistant to care. We found one person, who was resistant to care, there was no plan in place to show staff how to support this person, and staff gave conflicting descriptions. We found staff did not understand how to manage risks, for example with swallowing. Staff could not tell us how to support this person to ensure they could eat and drink safely. We spoke with one of the nurses who said they were unsure about nutritional risks and how these are managed. They told us this was "dealt with by the clinical leads" and they would oversee. The provider did not ensure peoples risks were understood and as a result there was potential for inappropriate care to be provided.

We found people at the end of their life were not supported to express their needs and preferences. For example, we found there was no clear guidance for staff about how one person wanted to be supported. We spoke to the clinical lead about this and they said it was the responsibility of the named nurse to update the plans, however the named nurse was not available and the provider had not ensured this person was supported to identify their needs.

People were not supported to have their needs met in accordance with their preferences. We observed one person ask staff for help to get up several times before they received support. We saw one person had left a note for staff attached to their door asking to be got up at a specific time; staff had not seen the note or met this person's request. Staff told us people could not have their preferences and choices met. They said they used a list to decide what time people got up in the morning, and if someone wanted to get up early, the night staff would have to help them. In another example, staff told us unless people had a bed bath they would have to wait quite a while for support with a bath or a shower. Staff also told us everyone had their hair washed on a Friday, at the hairdressers request, however staff said people had not been asked about

their preferences about support with hair care. This showed the provider did not ensure people's needs and preferences were sought when receiving care and support.

We found that where people's needs changed, staff were unable to describe people's needs and managers could not confirm if their needs had been met. For example, one person had been recently discharged from hospital with changes to their needs which included difficulty in swallowing. Staff gave us conflicting information about how this person should be supported with food and drinks. We checked the records and found there was no updated risk assessment or care plan for this person and the manager could not confirm whether this person had been supported safely. People's care was not regularly reviewed to ensure staff had clear and up to date information on people's needs.

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

People did not always feel there was enough to do. One person said, "I just walk around, there is nothing to do". Another person told us, "There are not enough staff for us to be able to play board games". Another person told us, "There is nothing to do, I just wander around until people join me". We also observed people spent considerable amounts of time on their own, with minimal support to follow individual interests or hobbies. There were some group activities on offer throughout the week, and people did take part in these. We saw a party was taking place on each floor to celebrate Halloween, which some people attended. People were listening to the singing and were smiling and joining in. Staff told us people had an opportunity to decide what type of activities took place during the week. We spoke to the manager and they told us there was a plan in place to introduce one to one activities with the activity coordinator. These plans had not been developed or put into place at the time of the inspection. This showed us people were not supported to undertake meaningful activity.

The provider had a complaints process in place, however some people and their relatives told us they were unsure how to make a complaint and others said they did not understand how their complaints had been managed. Where people had made a complaint they told us they did not feel their complaints were responded to effectively. One visitor told us, "We spoke to a nurse sitting at a table in the corridor and explained things we are unhappy about. Nurse thanked us for information and said to speak up at any time but didn't say anything would be followed up". Another visitor told us, they had made a complaint and had been promised a meeting but this had not taken place. We spoke to the manager about this and they took action to speak with the relative immediately. We saw records of complaints from family members about the lack of care and support received or the quality of the care and support, these complaints were about similar issues to those we identified throughout the inspection. For example, one relative had complained because their relative had lost weight and no action had been taken. The response indicated that the person would have their weight monitored weekly and supplement drinks would be provided, we could see staff were monitoring this person and providing the drinks as agreed. We saw people had used the comments cards to make complaints about things such as staffing levels. Staff told us they felt there was extra pressure put on them when relatives complained. We spoke to the quality manager about this and they told us they were aware the complaints procedure was not effective. There were plans to implement a new system to capture people's complaints and ensure they were responded to. However, at the times of the inspection, the complaints process was not fully embedded and understood. This meant the provider did not always listen to people's feedback, concerns and complaints.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection, there was no registered manager in post. The previous registered manager resigned from their position in August 2016 but had not yet de-registered. We did not receive notification from the provider about the absence of the registered manger as required by law The provider had recruited a new manager and deputy manager however they had not yet started their roles

This was a breach of Regulation 14 Care Quality Commission (Registration) Regulations 2009 (part 4) – Absences.

When we were planning our inspection, we looked to see if we had received notifications about incidents involving people who used the service. Providers have to notify CQC about some significant events as required by law. We had not received notifications about all safeguarding incidents; we did however receive notifications about other incidents as required. We spoke to the training manager who said the previous manager had not always sent in notifications. The provider confirmed they did not undertake any checks to ensure safeguarding incidents had been notified as required. The training manager told us they were taking steps to ensure historic notifications were sent in.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (part 4) – notification of other incidents

People's health and well-being was not sufficiently protected as the provider had failed to implement systems that ensured people received the care and support they needed. We found people's food and fluid intake was not being recorded and monitored and steps were not being taken to protect people's health. This was despite some people refusing food and drink and staff identifying that some people appeared to have lost weight and others sometimes showed signs of dehydration. The management team did not have sufficient systems in place to monitor daily care records. They had not identified that daily care records were not being fully completed and that records indicated some people had not had sufficient amounts of food and drink to protect their health for several days. As a result no action had been taken by the provider to ensure these people were protected from harm and any healthcare interventions sought.

We found further examples where people were at risk of developing pressure sores and required regular turns or where people needed close monitoring of their health. There were no checks completed to ensure these people had received the care they needed and records indicated their needs had not been met. We were told by the management team that named nurses or the clinical lead were responsible for checking daily care records and investigating any concerns. They told us that when these staff members were absent there were no systems in place to ensure people's needs were monitored. We found no examples of where concerns had been effectively identified and resolved through the daily monitoring of people's care and support. As the provider was not able to provide assurances that some people's health needs had been met we reported our concerns to the local safeguarding authority for further investigation and requested the provider addressed specific concerns immediately.

We looked at how the provider identified concerns and improved the service they provided to people through their quality assurance and auditing system. We found audits and quality checks were insufficient and did not identify risks to people. We saw that inadequate medicines audits were completed. Checks were completed on the number of medicines available but there were no checks made to ensure people received their medicines as prescribed. As a result the provider had not been aware of the issues we found during our inspection; including new medicines not being available for people, out of date medicines and errors including a controlled medicine being administered at an incorrect amount. They had also not identified that some 'as required' medicines were being given to people regularly without sufficient guidance. The management team confirmed the 'as required' medicines had been given frequently due to inadequate guidelines being provided to staff on when people needed these medicines.

Audits were not taking place on cleaning schedules and as a result it had not been identified that deep cleans were not being completed as scheduled. Staff told us all rooms should be deep cleaned once each week however many rooms had not had this deep clean for over a month. We saw daily cleans were being undertaken however these were not always sufficient to ensure the home was always clean. For example, we saw tables in lounges and crash mats in people's bedrooms that were visibly dirty. We also identified some parts of the service where there was a strong smell of urine. We spoke to the management team about the quality checks that were being completed. They told us an external organisation had completed an audit of the service prior to the inspection. They had made some recommendations including the implementation of a new quality assurance system. The provider's new Quality Manager provided an overview of a new quality management system they had developed and were in the process of implementing. However, the implementation of this system had not yet been completed and had not identified any improvements or successfully managed risks to people at the time of the inspection. We saw this external audit highlighted other areas of concern found during our inspection; including, gaps in staff training and supervisions, gaps in peoples care plans and risk assessments, concerns with the management of controlled drugs and gaps in medicines records. Despite these concerns having been identified by these external consultants, the provider had not taken sufficient steps to address the issues raised and make improvements by the time of our inspection. People were not protected and the risks to them effectively identified and managed due to inadequate quality assurance systems.

The provider did not use people's feedback to make improvements to the service. We found that there were systems in place for people to raise concerns or make compliments directly to the quality manager by placing a card in a box. We saw people had used this to make comments about the provider having too many temporary staff; however, we found no action had been taken to address this. Some positive comments about the entertainment had also been shared, however, the system did not ask for contact details so comments could not be followed up by the management team. The quality manager told us there was a system in place for people to raise concerns directly with them. They also said they had introduced a system where they would contact relatives of people who had been admitted to the service after the initial two weeks so they could check on their experiences. However we did not see any evidence of these conversations or how they had been used to improve the service people received. A relative told us "There was a resident and relatives meeting held in September, people raised their concerns about staffing levels. We were told what staffing ratio to expect. We did not receive any minutes following the meeting and no feedback despite that being promised at the meeting. The previous meeting was in November 2015." There was no evidence to show the provider had acted on the meetings held and the views people shared. This showed us although people's views were sometimes sought, this was not used to improve the service.

The management team recognised improvements were required within the service and could demonstrate they had action plans in place. However, some of the actions identified had not been completed and others did not focus on the greatest risks to people. For example, work had been completed to make

improvements to the internal décor within the service without first ensuring that people's health, well-being and safety were protected.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

People had different views about the relationships they had with the management team, and in some cases, people and their relatives did not appear to know who was in charge or who they could go to with problems. One relative told us, "I am not sure who the manager is". Another visitor told us, "When I was complaining I felt patronised. The manager called some staff into the office and ticked them off in front of me. After, the staff told me they felt it wasn't their fault".
Staff told us they did not feel managers were always approachable or accessible to them. One staff member said, "Everyone [The mangers] congregate upstairs and just come down when there is a problem". Another staff member said, "You only see the provider when there are complaints, they are around a lot more at the moment". Another staff member said, "Some of the managers are approachable but others don't put anything in place". We found staff did not have consistent support from the management team. One staff member said, "We don't have much [management support], it's a free for all most of the time". Another staff member said, "Support is hit and miss". Another staff member said, "I don't feel I get enough support". We found staff were not asked for their views about people's care and support needs. One staff member said, "As a collective we feel like we are talking to a brick wall". Another staff member told us, "I wish carers were asked more, we are with people 12 hours a day, we know more about them".

We found staff were unclear about the management structure and could not determine who to go to when there were problems. Staff told us they did not always know who was in charge, or who to go to when they needed advice. For example, where agency nurses were used they were unclear if they were in charge or if the senior care assistant was responsible for making decisions and taking action about peoples care and support needs. One staff member said, "There is no one at the top giving direction". Staff told us they did not feel they could approach the nurses for support and that when they did this was often refused. Staff told us when agency nurses were covering they did not know who was in charge and where they should go to report things or seek advice. A nurse told us, "Staff come to me the nurses for support, I speak to the manager about the issues they raise every day, but there is no formal process". A staff member told us, "The place has been in turmoil but they are working to make it better".