Four Seasons (Evedale) Limited

The Oaks and Little Oaks

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 12 and 20 June 2017. The Oaks and Little Oaks provides accommodation, nursing and personal care for up to 73 older people. On the day of our inspection visit there were 33 people who were using the service.

We carried out an unannounced comprehensive inspection of this service in 16 March 2016 Breaches of legal requirements were found and we took action to ensure the necessary improvements were been made to make sure people received safe care and support. The provider sent us an action plan detailing some of the improvements they intended to make.

At the time of this inspection the service did not have a registered manager in place. The previous registered manger left the service on 9 June 2017. 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 may be left at risk of harm or abuse because there was a risk that the procedures designed to protect them might not be followed. Some risks to people's health and safety were not being identified and people faced risks in their daily living that could be prevented or reduced.

People were not being provided with their care and support when this was needed by staff on duty. People received their medicines as prescribed but the arrangements for the storage and recording of these needed some improvement.

People were being cared for and supported by some staff who had not kept their training up to date. People's right to make decisions for themselves may be overlooked as the Metal Capacity Act (2005) was not being correctly followed.

People were not provided with a positive mealtime experience which could affect their nutritional and fluid intake. Staff understood people's healthcare needs and their role in supporting them with these.

There were times when people were not shown respect and also had their privacy and dignity compromised. More effort could be made to involve people in planning their own care.

People received their care and support in a task oriented manner rather than in a person centred and proactive way. People's care plans were not always kept up to date and staff rarely referred to these. The system in place for people to raise any complaints was not being followed.

The systems to monitor the quality of the service and identify where improvements were needed were not effective. Quality assurance questionnaires did not capture people's concerns and dissatisfaction with the

service.

"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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's risks were not appropriately assessed or managed because ways of minimising these were not identified or acted upon.

People's needs were not being met by sufficient number of suitably qualified, competent and skilled staff.

People received the support they required to take their medicines as prescribed although some improvements were needed in how these were managed.

Although people felt safe some staff might fail to act to protect them if needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by a staff team who did not all value the training available to them.

People's rights were not always upheld as the provider was not applying the principles of the MCA.

People could not be confident that they would receive the support they needed to have sufficient to eat and drink.

People received the support they needed with maintaining their health.

Is the service caring?

Inadequate

The service was not caring.

People were not consistently treated with respect and did not

always have their dignity promoted.

More effort could be made to include and involve people in planning their care.

Is the service responsive?

Inadequate

The service was not responsive.

People's care and support was not planned in a way that showed how their needs should be met and they did not always receive the care they needed.

People could not be assured any complaints would be dealt with according to the provider's complaints procedure.

Is the service well-led?

Inadequate

The service was not well led.

The culture in the service did not encourage and enable people who lived and worked there to express their views.

The service had not had strong and stable management.

Quality assurance systems had not brought about improvements that were required.

The Oaks and Little Oaks

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 20 June 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought the views of other professionals who have contact with the service and commissioners who fund the care for some people. We used this information to help us to plan our inspection.

During the inspection we spoke with 12 people who used the service and four relatives. We also spoke with 16 staff, including housekeeping, care and nursing staff and management.

We considered information contained in some of the records held at the service. This included the care records for three people, staff training records, three staff recruitment files and other records kept by the management team as part of their management and auditing of the service.

Requires Improvement

Is the service safe?

Our findings

During our March 2016 inspection we found that the provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider they needed to make improvements and they submitted an action plan stating how they planned to make the improvements needed. During this inspection we found the provider had not made, or had not sustained, the required improvements.

People who used the service did not feel there were sufficient staff available to meet their needs. One person told us the staffing arrangements had "Gone downhill a lot recently. It's got a lot worse in the last couple of months. I'm not very happy about that." Another person said, "I don't think that there are enough staff. There are often times when I need more help and I have to wait for people (staff) to come to me." A third person told us, "Sometimes I do feel like there are not enough staff." One person described how another person who used the service did tend to unsettle them by walking near their room in the evening and during the night when staff were not in the vicinity. They said that on one recent occasion they had been startled by the person standing in their doorway. The person said, "I don't think anyone should have to put up with that."

People could not be assured they would receive safe care. A relative said, "Sometimes there are no staff in the lounge and so the staff aren't aware when there is a problem in the lounge." They went on to say, "The staff aren't alert to looking after the residents. They don't notice what's happening. They don't see what the residents are doing. There have been people who have fallen because the staff haven't noticed that they were standing up when they shouldn't have been." We saw one person who appeared to be unsteady on their feet attempting to stand up when staff were not present. This person had been assessed to be at risk of falls and had a sensor mat in their room to alert staff if they got out of bed due to their risk of falling.

During these inspection visits we noted there were occasions when people's alarm call bells were being rung for significant periods of time before they were responded to. We saw occasions when staff were not working effectively and spending time talking with each other rather than attending to people's needs .This was also an issue which had been raised in the most recent relatives meeting. We also heard people who were cared for in their rooms calling out for attention, however staff were not available to respond promptly to them. Some of these people were waiting to have their breakfast and had not had their morning wash at 10.00am, which was not a choice they had made.

Staff told us they did not feel there were enough staff on duty. One staff member said, "There is never enough staff for the jobs you have to do." Staff also referred to the different effectiveness of shifts depending on which members of staff were on duty because there were some staff who didn't work together well as a team. Staff also said the amount of paperwork they had to complete took up a lot of time. One staff member told us, "There are never enough staff for the jobs you have to do." One of the ancillary staff told us they were leaving their position because, "I can't keep up with the workload, it is horrendous."

The provider based their staffing levels on the dependency and needs of the people living at the service. The acting manager told us they always staffed "at least" to the staffing level determined by this tool. However we identified occasions when people were not having their needs met in a timely way due to there not being a sufficient number of suitably qualified, competent and skilled staff.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons is an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had fallen on three recent occasions and it was written in their mobility assessment they should be referred to the falls prevention team. There was no record made to show that this referral had been made and the acting manager did not know if this had happened. In addition we saw that when the person had fallen this had not been recorded in the daily notes on two of these occasions. It was recorded in the person's pre admission assessment that they had "recent falls" but it did not say how many times the person had fallen. This information was needed to complete their falls risk assessment accurately to determine the severity of the risk of them falling.

The support people required was not accurate because their care needs were not being accurately assessed. We saw a person walking in the service with the support of a walking stick, however there was no mention that this person was able to walk with the use of a walking stick in their care plan. It was stated in the person's care plan that they were unable to walk more than a few steps and needed the support of two staff. It was also stated in the person's pre admission assessment that bed rails were required, however these were not being used for the person.

Another person was being repositioned every three hours to protect their skin integrity. This conflicted with the information in their care plan which stated this should be done every two hours. Additionally the acting manager told us the person no longer needed to be repositioned as their skin was now intact and they were able to reposition themselves. This meant that the person was being repositioned unnecessarily which would have included disturbing them when they were asleep. On our second visit we saw the person was still being repositioned every three hours.

A relative told us that when they had been visiting a relation recently the fire alarm had sounded. They had seen staff all move towards the front door of the service. However this left ten people who used the service sat in the back garden of the service with no staff present to ensure their safety and prevent any form of accident, or to move people to safety if the fire alarm had been for a genuine fire. The residential experience manager explained this had happened because the fire procedures had not been updated when they had made some changes to the use of the building several months ago. Following our visit we requested and received an assurance that the procedure had now been updated and staff were aware of this. We asked some staff about people's personal emergency evacuation plans (referred to as PEEPS), but they did not know what these were so would not have been able to make these available to the emergency services if needed.

We saw in one person's daily notes that a relative had informed staff that their relation had a diet controlled health condition. This person's nutritional needs care plan had not been updated to show this health condition and the kitchen staff had not been informed about this. This posed the risk that the person's condition could be aggravated as staff who needed to know about this had not been made aware of food items the person needed to avoid.

Our second visit followed a period of particularly warm weather and a unit manager told us they had put

room temperature charts into people's care records so their room temperature could be monitored to identify which rooms were too warm and needed measures followed to reduce the temperature. None of these forms we saw had been completed so the temperature of people's rooms was not being monitored.

The failure to assess the risks to people's health and safety and mitigate any risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some staff were clear about the risks people faced and how they should respond to these but other staff were not. When we were speaking with one member of staff they made an allegation about how one person had been treated in another care setting. When we asked the staff member for more details about this they told us they were just repeating something they had "overheard" and they had not reported this. They were unable to give us any further details about this. The acting manager was aware of this but was unsure what action had been taken about this.

On other occasions we found the provider had informed MASH about concerns to people's safety that had been identified so that plans to ensure people were safe could be made. MASH is the acronym used for the multi-agency safeguarding hub where any safeguarding concerns are made in Nottinghamshire.

Overall people told us they felt safe at the service although one person told us they had been startled by another person standing in their doorway one evening recently which had made them scream. Another person told us, "There is no risk to anyone here, we're all safe." A relative told us their relation was "safe here".

The acting manager told us there was a shortage of nurses at the service so the provider was relying on agency staff to provide nursing cover as they were the only nurse employed at present. This was supported by our observations where on the first day of our visit the only nurse on duty was also providing management cover for the service. On the second day there was a new agency nurse on duty.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicant's suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. In the recruitment files we reviewed we found most of the required checks and processes had been followed but one file which did not have clear previous employment dates and there was no record that these had been checked. Another file did not have a copy of the provider's pre-employment DBS questionnaire in.

People were supported to have any medicines they needed when these were required. One person who used the service told us, "I have been prescribed medication by my doctor. It's given to me by the staff and they do it properly." Another person said, "I do have medication and it is administered by the staff correctly. A third person said "I do take medication and these are done correctly by the staff here. I have eye drops and the staff bring them for me."

We observed the administration of medicines and saw staff administered medicines in a safe way. We also looked at whether medicines were stored and managed safely. We found these to be in order with the exception of a few errors with the storage and recording for people's medicines who received residential rather than nursing care. These included medicines that were no longer required had not been removed from the medicines trolley to ensure these would not be given in error and a medicine had not been administered at the intended time. The unit manager said they would be taking prompt action to ensure

these were addressed and staff followed the correct procedures in future.

Requires Improvement

Is the service effective?

Our findings

During our March 2016 inspection we found that people's nutritional and hydration needs were not being met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider they needed to make improvements in relation to this and they submitted an action plan stating how they planned to make the improvements needed. During this inspection we found the provider had made some improvements and they were no longer in breach of the regulation, however further improvements were required.

We received mixed comments from people about the food and whether they enjoyed this. Some people said they did but others said they did not. Comments included, "The food is not as good as it used to be" and "The food is poor." People also commented there was not a great deal of choice Some people commented that they were not always asked for their meal choices. Positive comments we received about the meals included. "I usually get what I like or something else", "The food is good" and "We have a good chef. I always enjoy my meals." We saw people who were not eating well were given encouragement to eat more.

After lunch on our first visit some people told us they had not enjoyed their lunch. When we asked one person if they had enjoyed their meal they replied "no". We asked the person why and they said "Just look at it" indicating their pasta dish which looked dry and unappetising. We mentioned the comments people had made to the staff in the kitchen. They said the meal had been drier than intended as once they put this in the heated trolley it dried out if it is not served promptly, which had been the case that day. Another person told us, "Today I didn't enjoy my meal it was too dry. The main course needed a sauce. The sponge for the pudding was dried up and the custard was cold."

People's requests for food and drink were not responded to promptly. We saw one person had not been offered a pudding who said they wanted one and we had to request this for them. We also saw someone had not been brought a drink to have with their meal. We requested this for them but one was still not brought so we had to make a further request.

The mealtime experience people had on our second visit was considerably more positive than it had been on the first day. On our second visit we saw staff made a concerted effort to show it was lunchtime and asked people if they wanted to have their lunch in the dining room. Whilst most people did not there were some that did. This enabled one person who did not eat well to receive extra support and a unit manager said they would be changing this person's care plan as this had led to them eating better than they usually did.

There were jugs of drinks available for people who could help themselves independently in the communal areas as well as a morning and afternoon tea trolley. Some people told us that they were often bought their mid-morning drink and snack just before it was time for lunch. One person told us, "I say no, It's too late." We saw the drinks trolley was taken to people upstairs close to midday on both days of our visits.

Several people told us that the morning and afternoon tea trolley round did not always take place. One

person said, "Sometimes we don't get one and other times it's near lunch time which is just too late." We saw people were provided with a choice of snacks, including fruit with the drinks trolley. However some people said the snacks were was not always provided, which was confirmed to be the case by a member of staff.

We received mixed comments from people about whether staff were suitably trained. One person said, "The staff don't appear to be well trained." Whereas another person said, "I do feel that the staff are well trained and they know what they are doing."

The residential experience manager told us that they had written to some staff to inform them they were due to update their training, but only one staff member had responded to this and completed the training they were due to. The residential manager was therefore having to pursue this matter further with these staff. They also said that they had written to a further group of staff to remind them that their training had either expired or was about to, and they must ensure they updated this. Some staff commented they found it difficult to find the time to undertake their on line training (ELearning).

Staff told us they received regular supervision and said they could request an extra session if they felt they needed some additional support. The acting manager said new staff had an induction and that all new staff were enrolled onto the Care Certificate as part of their induction. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

We received mixed comments as to whether people were asked if they consented to being provided with any care and support before receiving this. One person said, "The staff don't explain to me what they are doing they just get on and do it." Another person said staff, "Don't ask permission to do something." Our observations confirmed what we were told. We saw this to be the case when we were speaking with the person in their room when a staff member knocked and then came in without being invited. We also observed one person being hoisted who was repeatedly saying they did not want to be. Once the procedure was completed the person said it was alright now, however staff had not offered any reassurance or listened to the person whilst they were saying 'no'.

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 saw mental capacity assessments had been completed to assess whether people could make specific decisions. However some of these were not being completed correctly and did contain all of the information they were expected to contain. For example it was stated in one assessment that the person was able to give verbal consent as they understood what was being said, yet a decision had still been made in the person's best interest. Additional information that explained how the process had been followed was not included and the views of those who had been involved were not recorded.

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

We checked whether the service was working within the principles of the MCA. The provider had informed us

when a DoLS had been granted. Some staff were unclear about what a DoLS was and did not know which people who used the service had a DoLS in place. This put people at risk of not receiving care that had been agreed was needed for their safety and well being.

Staff mentioned one person did have some physical intervention used when they were being provided with personal care. The acting manager told us an application for a DoLS had been made for this person due to this and had been visited by a DoLS assessor the previous week.

People were supported to maintain good health and had access to healthcare services. One person told us, "If I need a doctor I just ask. The doctor will come to see me here." Another person said, "If I need to see a doctor I only need to ask." An optician was visiting the service on our second visit and was undertaking eye tests for a number of people. Staff spoke of understanding people's health needs and said they would accompany people to appointments if needed. During our second visit staff had called a paramedic when they were worried about one person's health and they took the person to hospital.

Inadequate

Is the service caring?

Our findings

We received mixed comments from people as to whether they received their care and support in a caring and sensitive way. One person told us, "Most of the staff are kind to me, but one or two aren't." Another person said, "I don't feel listened to or supported, they (staff) are in too much of a hurry." Yet another person said, "I don't think that they (staff) know me, not really." A relative said, "I would say that there is just a general lack of care. I feel that this home is run more for the benefit of the staff rather than the residents."

We saw a number of examples where people did not have their needs met in a caring way. The lunchtime meal on our first visit was poorly organised. We saw that initially there was some confusion and slight agitation between staff over the meal choice list. There was no announcement or attempt to make the mealtime a social event where people would be stimulated and encouraged to eat well. People were not asked if they wanted to have their meal in the dining room and it was brought to them where they were already sat. This therefore did not provide an opportunity for people to enjoy the social side of the mealtime. The residential experience manager and regional manager told us that there were a number of people who liked to have their meals in the dining room which they had not been given the opportunity to do.

A number of people had their food just placed in front of them with little or no communication. We saw one person request a staff member for a smaller portion of their dinner. The staff member took the plate away and scraped about half of the meal off the plate and then returned this to them. This left a smear across the plate and left the meal looking most uninviting. We also saw a member of staff blow onto someone's food to cool this down.

One person who was cared for in their room had not had their breakfast by 10am and told us they would have liked to have this much earlier. We informed a unit manager who asked them what they would like for breakfast, which a staff member was then asked to fetch for them. The person was not brought what they had requested and they told us they had just been brought this different breakfast by the member of staff. We also found that the breakfast the person had requested was available so their request could have been complied with.

One person told us, "I don't know whether they (staff) listen to me or not. The staff don't talk to me very much", "A few of the staff listen to me but not all of them." We saw occasions when staff spent time talking with each other instead of interacting with people. This was particularly evident upstairs where a number of people were cared for in their rooms and their social interaction was dependent on having staff and visitors spend time with them.

People who used the service were not always treated with respect and could not rely on their privacy and dignity being protected. One person told us staff, "Knock on the door before they come into my room, but they don't ask if it is okay to come in." Another person said, "The staff sometimes knock when they come into my room and sometimes they don't." A relative said, "There is no privacy here or dignity. I've been in the lounge when the staff have shouted across the room 'you can't go to the toilet [name] because [name] is in

there." Our observations confirmed what we were told. For example, a staff member knocked and then walked into one person's room when we were sat with them and interrupted our conversation. We also overheard staff speaking of private matters about people's care in communal areas where they could be overheard by others who used the service and visitors. There was some inappropriate language spoken by staff and used in records. This included using infantile language and uncaring terminology. For example when we looked at one person's daily notes we saw an entry described the person as becoming 'nasty'.

A member of the inspection team walked past one person who was being hoisted by two staff with no care taken to respect their dignity. This resulted in the person's dignity being compromised. One person was being taken to hospital by paramedics and was being accompanied by a care worker from their room. The person was wearing only their nightclothes and an agency nurse intervened to ask that the person was given a blanket for their dignity. A staff member told us there were occasions when they did not feel people had their privacy and dignity respected in the way that it should be.

The provider had notified us of a recent incident where a person had been provided with some inappropriate and intrusive personal care by a member of staff which they had reported as a safeguarding concern. In the minutes of a recent relatives' meeting it mentioned that people did not like to ask to be taken to the toilet for "fear of being told off". We saw one person was responded to slowly when they had asked to go to the toilet and another person who had returned from a hospital trip was not supported to use the toilet and consequently had an accident.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had limited opportunities to be involved in planning their care and support and making decisions about this. Whilst some people said they did talk with staff and felt they listened to them there were some people who told us they did not. Comments made about this included, "I don't think that I would be able to talk to the staff here" and "I don't think that I'm involved with my care plan but I do get very good care."

There were certain senior and nursing staff who were responsible for preparing people's care plans. We saw these staff rewriting care plans we had found to be out of date, which they told us was a lengthy process. We asked one of these staff how they involved people in preparing their care plans and obtaining their views. The staff member told us they would go through the plan with the person once they had completed this. We suggested to the staff member that this could limit people's opportunity to shape their care as they may be more inclined to agree with what had already been written rather than involving them at the start.

No one who used the service at present had the support of an advocate. Advocates are trained professionals who support, enable and empower people to speak up about issues that affect them.

Despite the negative comments people made some people did also make a number of positive comments about staff and how they were supported. These included, "The staff here are kind to me", "The staff are caring", "I could talk to anyone, they're all good" and "If they have the time the staff can be kind and caring".

Whilst we witnessed some poor responses and interactions by staff we also observed others that were positive. One person was clearly distressed and we saw a staff member give the person sensitive support which clearly had a positive effect on their wellbeing. Another staff member went and got a more suitable chair for a person to use when they wanted to sit in the activities room. Staff also spoke of working at the service because they cared for people and wanted to help them. A staff member told us, "I go home with a great sense of satisfaction knowing I have made a difference."

Inadequate

Is the service responsive?

Our findings

Some people did not receive the care and support they required because their needs were not recognised or understood. We saw one person who had appeared distressed throughout the morning of our first visit was left on their own. The person was calling out and pleaded with us to help them. We raised this with staff and told them this person was in need of some support. A staff member told us the person had deteriorated over the last week. The person was later visited by a healthcare professional who arranged for the person to go to hospital. On our second visit we were informed by a unit manager that the person had been prescribed anti biotics for a possible infection which would have explained the person's distress.

During our visit we questioned how staff responded to one person who was displaying signs of agitation. Staff were unable to give any clear description of how they supported the person when they displayed any distress and felt there was nothing they could do. There was no guidance written in the person's care plan as to how they should support the person when they were showing these signs. At one point we saw the person was in bed with a staff member sat in their room with them. The person was repeatedly saying "Help me" and the staff member replied each time "I'm here". We observed the staff member was sat eating their lunch as they did so. At other times we saw staff ignore the person when they shouted out and other times there was a disjointed approach where different staff would ask the same question and then move on.

One staff member we asked about the most effective ways to support this person was unclear of any strategy in doing so. We then asked them if they had read the person's care plan to which they replied they had not had time to do so. When we looked at this person's care plan with the acting manager we found that there was no guidance provided for staff about how to support this person at a time of heightened agitation which affected their behaviour.

Some people did not receive the care and support they needed and their needs were not being met. A person who was also cared for in bed had fingernails that showed signs of several weeks growth. Their personal care record showed that this person had refused several aspects of personal care, including nail care over recent weeks. This was not reflected in their daily care records and their care plan had not been updated to show the person was not receiving their personal care as planned, so other strategies could be followed.

We spoke with a person who was cared for in bed at 10.00am. They told us they had not yet had any support with their personal care or had their breakfast which they would have liked to have done. The person told us that, "Occasionally I don't have a wash until the afternoon" which they said they did not like. A staff member confirmed that this had happened on occasions and had occurred recently.

People's care records did not accurately show what care and support people had received, and at times these gave a false impression of the care people had been given. The personal care chart for one person who was cared for in their room was marked to show that their fingernails had been attended to that morning. However when we spoke with the person we saw that their fingernails were dirty and had not been cleaned. Other people's care records did not state the frequency they should be repositioned to protect

their skin integrity or the setting their pressure relieving mattress should be set at.

There was a file in each person's room to keep people's care records in so they were in order and less likely to be misplaced. However in several people's rooms we saw that these had been taken out of their files and left loose which increased the likelihood of these being mislaid. We found care records for one person's repositioning and food and fluid in the activities lounge. This had resulted in no record being made for the previous day and night as no new records had been started to show the person had been provided with the care they needed.

One person's care plan we reviewed did not provide an accurate description of the person's needs or how to support them. For example the care plan stated throughout that the person needed two people to support them, but the daily notes showed only one staff member did so. A staff member confirmed to us they had assisted the person to get up that morning on their own and said that was how the person was supported each morning. The description of the person's mobility was incorrect despite the person having fallen three times recently. It was also stated in the care plan that the person was compliant with taking their medicines, however we saw from the daily notes made that the person had recently refused to take their medicines. A unit manager told us they had come in to update this person's care plan as they were aware it was not correct and they then spent the majority of the day updating this. This meant the person may not receive the care and support they required due to a lack of accurate information about how to provide this.

Another care plan we selected to review was taken back by a staff member before we had time to look at this. They told us that this needed to be updated as there had been a significant change in the person's needs and how these needed to be met. This was following a recent discharge from hospital, but this had not yet been updated to show this. The acting manager told us that a lot of the plans needed to be updated, but these had not been done as they had not had the time to do this due to staffing issues.

The third person's care plan we selected was not receiving the care and support as described in their care plan. The person was cared for in bed. It was stated in their care plan that they enjoyed a bath, although it was stated in other places that they preferred a shower. The person's personal care records for the last three and a half months showed the person had only had a strip wash or bed bath. We also identified that this care plan had not been updated. When we returned for the second visit the person had still not been supported to have a bath or shower despite us raising this as a concern during the first day.

The failure to provide people with appropriate care that meets their needs and reflects their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place, however this was not effective as people's complaints and concerns may not be recognised or acted upon. Prior to our first visit we had been contacted by a relative who had made a complaint about the service. They told us they had not received a response to this. There was a record of this complaint made us in the complaints log, however this had not been acknowledged or responded to. When the residential experience manager became aware the relative had not been sent an acknowledgement of their complaint they said they would rectify this as a matter of priority that day.

The failure to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt able to raise any concerns and there had been complaints made previously that had been responded to. One person told us, "I have no complaints but if I did I would feel comfortable telling the staff.

A relative told us they had made complaints in the past which had been investigated and resolved.

We did see occasions where people were provided with positive support and encouraged to have fun together. Some people were clearly enjoying taking part in a variety of armchair activity games and were laughing together.

Inadequate

Is the service well-led?

Our findings

We had previously completed two focused inspections where we had checked that improvements had been made following our inspection in March 2016. We had found concerns about people not receiving safe care and treatment and the governance of the service. In the focussed inspections we found that improvements had been made, however at this inspection we found these had not been maintained. We asked the regional manager and the residential experience manager what their views were on the service since those last two inspections and they both agreed with our findings. When we finished giving them our feedback at the end of the inspection they commented that the feedback had been fair and they were extremely disappointed.

People's experiences of using the service were affected by ineffective management and a lack of leadership. Some people spoke positively about their experience at the service but some other people did not. One person told us, "Overall I would rate this home as below average. I don't know the manager." Another person said, "I'm happy here at the present time but this home is not like (as good) it used to be."

Issues raised in residents and relatives meetings were not acted upon to bring about improvements that were needed. One person told us, "We have made complaints about the food and our complaint hasn't been resolved." The person added that things raised in meetings were not followed through. Other people referred to having made complaints about missing clothing. A relative said, "We go to the relatives meetings, changes are suggested but not actioned." The relative added, "It seems to me like the staff are in charge and they are resistant to change."

Those present at the most recent relatives meeting had discussed a number of concerns that we had found during our visit. These included problems with people's clothing not being returned from the laundry and people not getting regular baths. There was also a record made in the minutes that some staff did not appear caring, tending to always be chatting and gossiping. There was an action recorded in the minutes of this meeting to label all clothes and to discuss ways of improving the laundry arrangements. However the improvements needed had not been made and two of the people we spoke told us they had clothing recently gone missing.

We asked a laundry assistant about the problems we had been told about with people's clothes going missing. The laundry assistant told us the main problem was unmarked clothing. They told us they used to have a machine to label people's clothes with but this was not working. We asked them for how long this had not been working and they told us approximately two years. They said they had raised this on a few occasions but nothing had been done about this.

The most recent staff meeting minutes in April 2017 showed that there were some areas of improvement needed in the service and these had not been responded to as positively as the management would wish. This included completing on line training courses, which we found remained an issue during this inspection. Other issues were clearing dirty crockery from people's rooms and communal areas, not completing monitoring charts properly and a lack of team work. There was also a comment made about the attitude some staff came into to work with. We found when we were speaking with some staff they did not speak

positively about working at the service. One staff member told us there were times when there was a "lovely atmosphere in the home", but this was affected by some divisions within the staff team.

We found some staff spoke of their workload being too great. One of the comments revolved around the amount of paperwork they had to complete prevented them from spending time with people who used the service. One staff member told us that they felt the paperwork was "astronomical" and diverted from people's care. We noted this paperwork was not being completed correctly meaning that staff were spending a lot of time completing paperwork that was inaccurate. For example one assessment for a person's nutritional needs showed a sudden change in the level of risk to the person. The acting manager told us that this latest entry was correct and this form had been completed incorrectly on the four previous occasions, which had not been picked up through the provider's care plan audits.

One person's care file showed the person had a pressure ulcer some months previously but there was no entry to show what had happened about this. The acting manager told us this had healed and it was a case that the care plan had not been updated to show this.

The provider had a system of monthly audits undertaken by the regional manager. The last three of these audits had fallen short of their expected standard and actions that had been identified to be done had not been completed. We reviewed some survey forms that had been sent out to people who used the service, relatives, staff and visiting professionals. The responses in these were very positive about the service. However this gave us concerns about the effectiveness of these surveys as they differed strongly from our findings. For example the analysis of the most recent survey carried out three weeks previously to our visits on dining scored the service 100% positive. This differed from our findings which were that people were not provided with a positive mealtime experience. People had mixed views about the quality of their meals and people were served their meals in an unorganised and insensitive way where people's wishes were not sought or respected.

The failure to operate systems or processes effectively in respect of assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people who used the service and others who may be at risk which arise from the carrying on of the regulated activity is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not been consistently managed. A registered manager was appointed for the service in March 2017, however they left this position after three months. Prior to that the service had not had a registered manager in post since December 2015. Between those dates there had been four management changes involving three different acting managers. Yet another acting manager had taken over the service after the registered manager left in June 2017 and one of the previous acting managers was about to return to that role.

Our records showed we had been notified of events in the service the provider was required to notify us about. Providers are legally required to display the rating we give them in the service and on their website if they have one. The rating from the previous inspection was displayed as required.