Leonard Cheshire Disability

Saltways - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 09, 15 and 30 May 2018 and was unannounced. The previous inspection was undertaken in January 2017 and at that time the provider achieved a rating of 'Requires Improvement.'

Saltways Care Home with Nursing and Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Saltways Care Home with Nursing and Physical Disabilities is registered to provide accommodation and nursing care for a maximum of 24 people. There were 17 people living at the home on the day of the inspection.

There was a registered manager in post. 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. The registered manager was not present at the time of our inspection.

Risks to people's health and wellbeing were not always identified, and risk management plans were not always in place to instruct staff on how they should manage risks to people consistently and safely.

People were not fully protected from harm and abuse. Accidents and incidents had taken place and had not been reported to the appropriate authorities. Potential safeguarding concerns had not been recognised and acted on appropriately. Systems were not in place to collect this information and learn lessons.

There were not always sufficient trained staff, on duty to care for people safely, and to meet their needs. We found there was no current analysis and overview of accidents, incidents, and safeguarding concerns at the home to assess whether any trends or patterns were identified and future risk could be mitigated.

People were supported to maintain a healthy diet and staff were aware of people's dietary needs and preferences. However, where people received their food supplements via a Percutaneous Endoscopic Gastrostomy [PEG] feed the provider had not ensured all nursing staff had received training and had their competencies checked.

People were not routinely involved in the planning and development of their care. People were not supported to access a wide variety of activities during the day, and did not always have their wishes respected if they did not want to participate in some of the activities. End of life care planning had not been considered and so did not focus on people's preferences and wishes.

Relatives were confident that if they raised a complaint, it would be dealt with appropriately.

The provider had quality monitoring processes which included audits and checks on medicines management, care records and staff practices. However, existing quality assurance procedures did not always identify where improvements were required. Quality monitoring procedures needed improvement to ensure these were undertaken regularly, to monitor service provision.

There was a lack of oversight of the service by the provider and the registered manager. There was a distinct lack of audits in place that would provide the registered manager with a view of what was happening at the service. The audits that were in place were ineffective, inconsistently completed and did not highlight the areas of concern that came to light during the inspection. The provider had not informed CQC of important events that occurred at the service, in line with current legislation.

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 six breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 did not consistently have risks identified and assessed, or their identified risks mitigated.

The registered manager and provider did not consistently report and investigate accidents, incidents and safeguarding issues when they occurred.

There was a lack of infection control audits and actions taken to prevent people being at risk of cross infection.

Is the service effective?

Inadequate

The service was not consistently effective.

People were not consistently supported by staff that had up to date training and the skills to meet their needs.

Staff competencies has not always been checked to ensure they could provide safe care.

Is the service caring?

Requires Improvement

This service was not always caring.

People said although staff were kind and caring, they did not always speak to people with respect.

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Staff did not always protect people's privacy and confidentiality.

Is the service responsive?

Requires Improvement

The service was not responsive

People did not consistently have their needs met, and the service was not always responsive to their changing needs and preferences.

People did not always have interesting things to do with their time.

People who lived at the home and relatives knew how to raise concerns.

Is the service well-led?

Inadequate

This service was not well-Led

Systems and processes to monitor assess and improve the quality and safety of the care provided to people was not comprehensive or effective.

Audits did not always identify shortfalls and when shortfalls were identified, it was not clear what action, if any, the provider had taken.

The registered manager and provider did not have adequate oversight of the service. There was a lack of audits in place to ensure lessons were learnt, accidents and incidents were reported and acted upon and ensure CQC registration requirements were met.

Saltways - Care Home with Nursing Physical Disabilities

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.

The inspection was prompted in part by a notification of an incident which reflected concerning information about the management of risk of Percutaneous endoscopic gastrostomy (PEG) feeding. We looked at some of these concerns during this inspection.In addition, we knew the police were investigating some of these concerns at the time of this inspection. We continue work with other agencies, such as the local authority, clinical commissioning group and the police following this inspection. This was because we wanted to ensure the provider had acted to mitigate risks to people's safety and welfare.

This inspection took place on 9, 15 and 30 May 2018 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who was a registered nurse, [they attended the inspection on 9 May 2018].

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the local authority and the Clinical Commissioning Group [CCG] about information they held about the provider.

Prior to our inspection the provider had completed a Provider Information Return [PIR]. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to formulate our inspection plan.

We spoke with eight people who lived at the home and five relatives. We met and spoke with five members of care staff, a senior care member of staff, two registered nurses, an agency nurse and the physiotherapist. We also spoke with a member of the kitchen staff, the operations director and quality director, the service improvement managers, the deputy manager, the covering manager, and the nominated individual. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for six people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service. This included audits carried out, staff rosters, training records and actions plan that were in place. We also looked at staff files so we were able to review the provider's recruitment process.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017, the provider was rated 'Good' in the question 'is the service Safe?' Following this inspection, we have changed the rating to 'Inadequate' based on our inspection findings.

At this inspection we found that people living at the home were at risk of harm. This was because not all risks had been identified with appropriate actions put in place to reduce these risks and to protect people. The provider had failed to implement systems and processes to keep people safe from avoidable harm and abuse. We saw a number of potential safeguarding concerns were not being identified by the provider including incidents and potential restraint. The provider had failed to notify the local authority and the Care Quality Commission [CQC] of these events, as is required by law. When we spoke with the management about these events they acknowledged the local authority and CQC should have been notified. Following our inspection, we received the notifications. Staff we spoke with told us they had received training in safeguarding so knew how to recognise and protect people from abuse. However, some staff we spoke with told us they had tried to raise concerns with the registered manager but felt incidents were not always reported to the relevant authorities. For example, one staff member told us, "I have raised concerns but [registered manager's name] did nothing." This meant the provider was not always aware of all safeguarding concerns and as such was unable to act on these to ensure people were protected from abuse and improper treatment.

This was a Breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

We found that systems were not in place to ensure lessons were learnt when things went wrong. There was a collection of information regarding the number of incidents people were involved in and the time, date and location of the incidents. However, there was no analysis of this information. Although the incidents were logged electronically there was no evidence to reflect the provider's oversight or auditing had identified there were shortfalls in their management team's actions upon analysis of incidents to reduce risks.

Some people did not feel safe living at the home. We had mixed responses when we asked people how safe they felt living at the home. One person told us "I don't feel safe living here because [person's name] frightens me. They shout and scream at night, throw objects out of their room and enter other people's rooms." When we asked the person what measures staff had taken to help them feel more secure they replied, "They [staff] told me to lock my door, but I'm not physically able to do that myself. I can't get help." This was because the person's emergency call system was not working properly. The person went on to say, "I've told [registered manger's name] but it's not been repaired." We checked the records and found the person's emergency call system had been discussed at a staff meeting in November 2017 and there were plans to call out the company to repair it. We spoke to the interim manager on the first day of our inspection and were assured the emergency call system repair would be prioritised. However, the person told us when we returned for day two of our inspection the equipment was still not working correctly. We highlighted the person's concerns to the senior management with the person's consent to gain assurances action would be taken to repair the person's emergency call system.

When we spoke with relatives we received different responses as to whether they thought their family members were safe living at the home. One relative told us they thought their family member was "Happy living at the home." Another relative told us, "I can't tell you how concerned and disappointed we are with the home." A further relative said, "Staff did not have an understanding of working with people with a learning disability but felt physically their nursing needs were met."

Prior to our inspection the Care Quality Commission [CQC] had received concerns about how the provider was meeting people's specialised needs such as Percutaneous Endoscopic Gastrostomy [PEG] feeding. We looked at people's care plans to check the information and guidance available to staff. We were alerted to a concern when a staff member alleged staff did not always follow the directions given in the care plan. The staff member said, "Sometimes one nurse doesn't always wait an hour after [person's name] has their PEG feed before putting them to bed. This puts them at risk". We discussed this situation with the senior management on site so they were able to take action to mitigate risks to people's welfare.

We observed an agency nurse attend to a person's PEG feed, we noted they did not wear protective gloves and were unsure how to connect it correctly so took several attempts, to do this. We raised these concerns with the regional manager. They gave us their assurances all staff who were supporting people who required a PEG feed had been trained and their competencies checked. However, the regional manager assured us they would review all staff and any agency staff's training and practices to ensure they were competent. In addition, the regional manager confirmed a review of the procedures for PEG feeding would be undertaken to ensure staff had these written instructions in people's care plans to inform their practices.

Environmental risks had not been done and considered by staff, which could potentially put people at risk. For example, we found razors left on the side in the communal bathroom. Infection control audits although periodically had been completed they failed to identify risks. Another example was the bins had no lids or were not foot operated, despite staff placing used gloves and aprons in these. When we discussed this with the senior manager's they told us, the infection control leads were the registered manager and another nurse. However, the provider's quality checking systems had failed to identify and take actions to improve staff practices so risks to people, from cross infections were reduced.

The provider had not prevented people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This was a Breach of Regulation12 Safe care and treatment HSCA 2008 (Regulated Activities) Regulations 2014.

Staff told us the required checks were made before they started to work at the home. Records confirmed these checks included if prospective staff members were of good character and suitable to work with people who lived at the home. Where nurses were employed checks were made with their professional body to show they could practice as a nurse. At the time of our inspection the provider was using agency staff and staff from the other provider's homes to help cover shifts. We were told that on some occasions the agency had sent staff without the necessary skills or qualifications to deliver the nursing care required. Following our inspection, the provider told us they had written to the agencies used. This was to outline more specifically what skills set and qualifications staff must have to provide the clinical care people required so they were not at risk of receiving unsafe care and support.

We received varied responses from people about the staffing arrangements. Some people told us, they felt there was enough staff to meet their individual needs, whilst other people said they sometimes had to wait for staff assistance for short periods. On the days of our inspection call bells rang frequently with staff responding promptly. However, some people we spoke with felt at night they had to wait longer for assistance. A person told us, "There are only two care staff and a nurse at night, since they changed the shifts

to twelve hours, day staff go home at eight pm. So, night staff, have more people to put to bed and the buzzers are going off all night." When we spoke to the night staff we received different views. One-night staff member said, "There is enough staff on night duty but we are very busy. It's okay now we are not at full capacity and have seven vacancies." Another night staff member said, "There is not enough staff on duty at night; it's difficult to have the time to support people with their emotional needs as well as their physical needs. Which I feel is very important. We don't always have twilight staff [staff who works until 9.30 pm to assist with getting people drinks], so we have to do that whilst trying to get people ready for bed. "

A staff member we spoke with told us due to staff pressures, there were times when some staff were rolling people themselves, rather than using two staff members. Again, we brought this to the attention of the senior management team, so they were able to take action so people's safety was not at risk.

We checked the provider's call bell monitoring system it stated that at night 37 call bells were not answered until after a wait of 15 minutes, [during the month of April 2018]. One relative raised a concern with us that only one nurse was available at the weekends and felt this was insufficient to meet the needs of people living at the home. When we spoke with one of the nurses they told us they felt two nurses were required on shift at all times to keep people safe. They said, "I've brought this up with [registered manager's name], but they said there is not enough in the budget." Another relative told us, "I feel sorry for the nurses they are run 'ragged' as it's such a large building to cover."

We saw people had a Personal Emergency Evacuation Plan [PEEP] in the case of a fire; however, the plans did not sufficiently detail for example, where each person should be taken to as a holding place if there was a fire. To keep people safe.

People we spoke with told us they were given their medicines on time and they were happy for staff to support them with their medicines. One person told us, "I get my medicines on time." We saw the nurse supported people with their medicines providing reassurance where needed and offered drinks. We saw that medicines were managed safely. There were appropriate facilities for the storage of medicines. For example, safe storage of controlled drugs and the storage of medicines that required refrigeration so they remained effective in treating people's health needs. Staff told us the nurses were also responsive in a medical concern or where a person had become unwell to ensure people had the right care at the right time.

Inadequate

Is the service effective?

Our findings

At our last inspection in January 2017, the provider was rated 'Requires Improvement' in the question 'is the service Effective?' Following this inspection, we have changed the rating to 'Inadequate' based on our inspection findings

Staff told us they had received supervisions, so were given the opportunity to reflect on their practice and discuss their training needs. We saw in the Provider Information Request [PIR] it also stated under the question "What do you do to make sure your service keeps up to date with good practice?" The registered manager had answered, "Within Saltways, we have regular team meetings and we discuss good practices within the team and the wider organisation…. Staff competency assessments…All staff receive Annual refreshers in all areas of importance, [Gastrostomy/PEG feeding]."

Staff were not suitably trained to meet all the care requirements of people living at the home. When we looked at the provider's training records we found deficits in the staff skills and competencies, in order to deliver the care required. For example, not all nursing staff had received tracheostomy and Percutaneous Endoscopic Gastrostomy [PEG] feeding. A staff member told us how they felt the staff team had not always been trained in the clinical skills necessary to meet peoples' need before they came to live at the home. This was confirmed by comments we saw in the staff meeting minutes where one staff member had said, "Can we have some training on the ventilator, as it feels like the blind leading the blind." When we looked at the staff training records we found only 55% of the nursing staff had received training in tracheostomy care and 44% of the nursing staff had received PEG feeding.

We were given another example of how staff had not been trained to meet the needs of people living at the home. A staff member described how one person's behaviour could become physically and verbally aggressive. During our inspection we consistently heard from people who lived at the home and staff how the person's behaviour impacted on how safe people felt. However, the provider had not ensured staff had received any positive behaviour training or mental health awareness training to assist them to support the person and other people in their care.

In the PIR it stated, "We have improved the process of admitting new customers by developing the initial assessment form to allow us to work in a more person-centred way and identify areas where staff may need further training to ensure we can provide safe and effective care for the individual from the moment they move into the home." However, we found the provider's arrangements to ensure they were able to meet each person's needs before they came to live at the home were ineffective. This was because we found staff did not always have the skills and knowledge they required to effectively meet all the needs of people living at the home.

At the time of our inspection the provider was using a high level of agency staff. On the first day of our inspection we spoke with a new agency staff member and found they had not received an induction to the home. When we brought this to the attention of the management, they gave assurances agency staff would receive an induction in the future.

The provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed. This was a breach of Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014.

The management told us they were going to address this deficit and was in the process of planning training and checks on staff competencies. This was so staff were supported to provide good care and keep people safe. We spoke with staff about the training they received from the provider when they started their employment. New staff completed the provider's own induction procedures linked to the Care Certificate. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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 service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The provider was aware of the need to and had submitted applications for people to assess and authorise that any restrictions in place were in the best interests of the person. Although when we asked staff who was subject to a DoLS restriction they were not sure and had to refer to people's records to confirm. We brought this to the attention of the senior management and they told us this would be discussed with the interim manager and request they reminded staff.

People told us they enjoyed the food served at the home. One person told us, "The food is really nice." Where people needed support from staff in order to eat safely or to choose from a range of food and drink options this was provided.

We looked at how people were assisted to stay healthy. We could see from people's care records they had accessed health professionals such as chiropodists, opticians and district nurses when required. The provider had employed a physiotherapist who was available at the home five mornings a week. We saw although people were weighed one person had lost six kilograms in weight over the last three months. However, the provider had only just referred the person to a dietician rather than reacting in a timely way. Despite stating in the PIR, "We also refer customers to nutritionists if there are changes in weight."

We saw that people's bedrooms were personalised. The provider told us they were embarking on a programme of redecoration for the communal areas in the home, although the provider was not able to show us a programme of redecoration during our inspection.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2017, the provider was rated 'Good' in the question 'Is the service Caring?' Following this inspection, we have changed the rating to 'Requires Improvement' based on our inspection findings.

Staff we spoke with showed warmth and affection for people they supported. There were some positive examples where staff showed they knew people well and considered their needs in a caring way. However, we heard a staff member speaking to one person in a disrespectful manner. Which resulted in the person asking, "Am I in trouble?" Their relative also told us they were concerned because this person had allegedly been told off for becoming incontinent. Another person told us they became distressed because they had a personal care routine at a time during the day, they said. "If they [staff] don't come I have an accident, it's very embarrassing for me." This was reported to the senior management who told us this would be investigated and appropriate action would be taken.

People's care plans and associated risk assessments were stored securely and locked away. This made sure that information was kept confidential. However, we saw staff were not always mindful about people's right to confidentiality. For example, a health professional and staff member, discussed a person's medical condition in front of everyone having their lunch in the dining room. One person told us, "I wish they [staff] wouldn't talk about other people in front of me, it's not right." We saw this practice was discussed at a staff meeting in August 2017 but the practice was still happening. We reported this to the management who told us they would act to make sure staff were reminded about their practices around people's confidential information.

People who we spoke with told us staff were kind to them. One person told us, "They [staff] are very friendly; I like it here very much." Another person said, "They [staff] are all good to me." A relative told us, they were made welcome and staff were friendly towards them. We did hear examples of kindness from staff. We heard how one staff member took time to speak to a person in a European language as the person particularly enjoyed conversing in this. Another example was how staff took time to paint a person's nails when they realised their nail polish was chipping off.

When we asked people who lived at the home and their relatives if they were involved with the planning of their care we had mixed feedback. One relative told us, "We have not had any home reviews." Another relative told us, "I have not been involved with their [family member's] care plan but yes, I have attended a review."

We saw there were opportunities for people to be involved in making decisions. Meetings were held with people where they were informed and consulted about some aspects of the running of the home. Although the provider had sought the views of people who lived at the home and relatives, at a national level, we were told there had been a poor response from people who lived at the home and relatives using Saltways services.

People told us staff respected their privacy and they were never made to feel uncomfortable or embarrassed when assisted with personal care. We saw staff ensured people's privacy was protected. We saw staff knocked on people's bedroom doors and waited before entering. We heard staff used people's preferred names when speaking with them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2017, the provider was rated 'Good' in the question 'is the service Responsive?' Following this inspection, we have changed the rating to 'Requires Improvement' based on our inspection findings.

All people we spoke with had negative views about the activities on offer at the home. One person told us, "I've not been out for months." Another person told us "I get bored there's not much to do here." Relatives we spoke with were of the same opinion. One relative commented, "Activities and lack of them is an issue, I think they effect [person's name] mood, making them frustrated and angry." Another relative said, "We'd raised money for a new minibus, but it has not appeared yet. The idea was to help people get out and about more. The old minibus is used to take people to appointments." Another person told us, "I have my own car. I get to go out about once a month, I'd like to go out more but there isn't always a driver to take me."

In the PIR the registered manager had written, "The wellbeing of customers [people who lived at the home] is encouraged through the provision of a variety of activities both in house and in the local community… These all help to highlight what the person wants from life, what makes a good day or bad day, and how we can support that person to have the most meaningful and enjoyable life."

However, a relative gave us an example of a person's social activity was not met. The person had arranged to meet up with friends but on the day, it was cancelled due to the staff and the minibus being unavailable. They told us this had upset the person greatly." We saw in the Service user guide given to people when they came to live in the home written, "There is a consistently strong focus on meeting individual needs, maximising independence, community participation along with support to enable disabled people to access mainstream social, leisure, education, volunteering and employment opportunities."

An activity coordinator was employed but they told us, they found it difficult to meet everyone's needs. This was because they were often working on their own as staff were often helping people with their personal care. We saw on the days of our inspections no personalised activities for people. The provider had encouraged the use of volunteers to assist people with their individual interests. We heard how one volunteer visited a person to do arts and crafts of their choice. This constitutes a Breach of Regulation 9 Person- Centred Care. HSCA 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the interim manager who on our third day of inspection told us they had organised for another member of staff to arrange further activities for people starting that day.

People were enabled to have choice and control over their lives. Most people told us that the routines of the service were flexible to allow them to get up and go to bed when they wished at their preferred time. Staff were aware of any protected characteristics and had ensured these were considered when planning their care. For example, people were asked about their spiritual and cultural needs as part of the assessment. People were supported to practice their religion and were enabled to attend religious services if they wished. However, we did hear one example on the day of our inspection of how one person had been

escorted into a religious service despite this being against their religious beliefs. When their keyworker saw what had happened they intervened by asking the person if they wanted to leave the service and escorted them back to their room.

People's bedrooms had been personalised with their belongings, personal items and photographs. Although one person told us they bought tins of paint for their bedroom two months ago and was still waiting for it to be decorated. We saw this had been completed on the third day of our inspection

When we looked at peoples health care plans we found that these had not been reviewed in a timely manner and we could therefore not be sure if they were meeting people's current needs. Relatives we spoke with told us, they had been involved with their family member's reviews. One relative told us they had attended a review and raised some concerns but was concerned they had not received any feedback on the agreed actions recorded at the meeting.

In people's care plans we saw the provider had missed the opportunity to record people's end of life wishes. Therefore staff had not consulted with people to express their personal preferences.

People told us they knew how to complain. People we spoke with told us they had not raised a complaint about the service. A relative told us where they had raised minor concerns these had been dealt with by the registered manager.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2017, the provider was rated 'Requires Improvement' in the question 'is the service Well-Led?' Following this inspection, we have changed the rating to 'Inadequate' based on our inspection findings.

People living at the home were not protected and supported to be safe as the registered manager and the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home.

Accidents and incidents were inconsistently recorded and there was no auditing of these records to ensure the appropriate actions were taken and lessons were learnt. Safeguarding concerns were not routinely identified, investigated and reported to the appropriate authorities. The provider had failed to identify the training needs and competencies of staff in order to meet the clinical requirements of people living at the home compromising people's safety and welfare. Staff competencies were not always completed to ensure staff were carrying out their role and responsibilities in an appropriate manner.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Services that provide health and social care to people are required to inform the Care Quality Commission [CQC] of important events that happen in the service. The Registered Manager and deputy manager had not fulfilled their responsibilities to inform the Care Quality Commission of notifiable incidents at the service. During the inspection we found two incidents that although reported by staff on the provider's accident and incident forms had not been raised as safeguarding referrals to the local authority or CQC by the Registered Manager.

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

At the time of our inspection there was an on-going external investigation. Staff told us they were unaware of the reasons why and this had impacted on their morale. One staff member told us, "Communication in the home is very bad. There are some good staff working here but the
'Management' don't tell us what is going on. It's been very stressful for staff."

Relatives we spoke with told us they felt the management of the home was approachable and if they had a concern they could speak to the registered manager. One relative told us, "It's obvious things have happened, there has been a change in management and there has been some improvement. The home is now cleaner."

Staff we spoke with gave us varied feedback on how they were supported to do their jobs. One staff member commented, "We need better communication here. The service is manager system led not patient led. We

have good staff here; it's the management we need."

Staff had opportunities to contribute to the running of the service through regular staff meetings and supervisions. We saw the registered manager and provider had discussed their expectations of staff during meetings. Although we could not see any evidence of how suggestions and improvements had been implemented to improve the quality of the care people received. For example, where staff had requested further training in January 2018 it had not happened at the time of our inspection in May 2018.

Staff were also aware of the provider's whistle blowing procedures which they told us they would not hesitate to use if they felt their concerns were not addressed by the registered manager or the provider. However, we did hear an example of one staff member who had missed the opportunity to raise concerns because they felt the situation would be covered up. We asked the staff member to report their concerns to the local authority or CQC in the future.

People we spoke with told us meetings were held where they could give their views and experiences about the services they received whilst living at the home. We saw minutes of these meetings were displayed in the hallway for everyone to read. The provider had attempted to seek people's views through a national survey but we were told the feedback responses from people and relatives using Saltways, had been very low. We saw there were plans to do a local home survey to seek peoples' views in December 2017 but this had not occurred. This was a missed opportunity for the provider to get customer feedback and identify improvements for people.

As part of our inspection we spoke with the nominated individual to share our concerns. They told us they would suspend any admissions to the home and so take the opportunity to make the necessary improvements.