Astral Care Limited

# Manor House

## Inspection report

Manor Road
Lydd
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Kent
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Tel: 01797321127

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05 May 2016
06 May 2016
07 May 2016
08 May 2016

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We undertook an unannounced inspection of this service on 5, 6, 7 and 8 May 2016. Manor House is registered to provide accommodation and personal care for up to 22 older people who may be living with dementia. The premises are a detached house with a garden, situated in Lydd. The service has 19 bedrooms, three of which are twin rooms. Eight rooms have ensuite facilities. Bedrooms are spread over two floors which can be accessed by the use of a passenger lift. People had access to two bathrooms, separate toilets and a dining room, lounge and quiet lounge. 14 people were living at Manor House at the time of the inspection.

Our previous focused inspection, on 9 February 2016, found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to staffing levels, safeguarding people from abuse, staff recruitment processes and to protect people in the event of an emergency. The provider gave us an action plan, although this did not address the actions required. At this inspection we found that no improvements had been made.

The service had a registered manager. 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 provider and registered manager did not have oversight of the service. The quality of all areas of the service had not been checked to make sure they were of the required standard. The registered provider and registered manager were not aware of the shortfalls in the service that we found at the inspection. The registered manager had not informed us of important events that happened at the service without a delay.

People did not always receive care at the time that they needed or wanted it. Staff did not always respond to people's needs or calls for assistance.

People were not protected from abuse and avoidable harm as incidents had not been recognised or recorded and responded to appropriately.

The provider had not ensured there were enough staff to meet people's needs. Staff said, "There are not enough staff and people don't get the care they need."

Safe recruitment practices were not followed to help ensure only suitable people worked in the home. Not all staff had received a criminal records check.

Staff did not monitor people's risks appropriately, although we saw risk assessments in people's care files we found staff did not always follow relevant guidance. People were left at significant risk of developing skin

sores as they slept in old beds or divan beds with mattresses which were not fit for purpose.

The provider had failed to maintain the environment. Furniture was old and falling apart, padding from some armchairs was missing and seat cushions were old and worn. The smell of urine was overpowering, from being greeted at the front door and throughout the service. Carpets were stained and dirty. In people's bedrooms, mattresses and bedding were covered in urine stains and some curtains had faeces on them, which had been left to build up for months, in some areas the smell was unbearable and eye-watering.

The provider and staff did not understand their responsibility in relation to infection control. The home was dirty. There were stained toilet seats, old dirt and grime around baths and carpets were covered in crumbs and dirt.

Staff did not receive an adequate induction when they started working at the service. Most staff had received training, although some had not received recent updated or refresher training to ensure they followed current best practice guidance. Training was not effective as staff were not providing support to meet the needs of people and ensure their health, welfare and dignity.
The provider failed to support staff or ensure they did not work excessive hours. Some staff regularly worked over 50 hours a week.

People who required encouragement to eat were not provided this. Some people did not eat their lunch at all although staff failed to notice this or offer an alternative.

We did see some examples of kind actions from staff. However, we saw many examples of people being treated in an uncaring manner. Some people sat for long periods of time and staff did not acknowledge them, or enter the room to check they were ok. People's privacy and dignity was not maintained.

The provider had not ensured people had the opportunity to participate in regular activities or social interests relevant to them. The provider had allocated 6 hours to 'activities' each week, although this was more often than not used to care and support people due to the lack of sufficient staff being employed at the service. People were left sitting with nothing to do and no social interaction from staff.

The provider did not have a hold on the day to day management of the home and did not offer support to the registered manager. The provider told us that they had appointed a 'consultant', who was in control of the day to day running of the service. During discussions with the provider they did not demonstrate a suitable understanding of the running and organisation of the service. Furthermore, the provider had knowingly appointed an individual with a history of cancelled registrations with the Care Quality Commission, to oversee the management of a service for vulnerable people.

We raised our concerns about what we had seen and found during our inspection with the provider. Over the four days of our inspection the provider failed to take action in response or mitigate the major risk to people with regard to their health, safety and well-being. The provider did not take any action to ensure people who lived at Manor House were treated with care, respect and dignity and lived in an environment that was caring, fit for purpose, free from risk and free from infection.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of our findings we applied to Folkestone Magistrates Court for an order to urgently to cancel the provider's registration under our powers set out in section 30 of the Health and Social Care Act 2008. The

Court ordered that the provider's registration be cancelled on 9 May 2016. The home was closed on 9 May 2016.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe. People's safety was compromised in a number of areas and people were exposed to harm.

There were not enough staff to provide safe and effective care. Pre-employment checks and processes were not robust to ensure suitable staff were employed.

People's medicines were not managed, administered or stored appropriately.

The provider did not notify the safeguarding authority of relevant incidents. Risks to people were not managed to ensure their safety.

Infection control was poor and people lived in an environment which was not clean or safe.

### Is the service effective?

**Inadequate**

The service was not effective. Staff did not receive supervision. Significant gaps were identified in training staff received. There was no system in place to support staff and identify their training and development needs.

People did not receive appropriate support to eat and drink enough. Food and fluid charts were not completed when people were at risk of malnutrition or dehydration. Action was not taken when people lost weight.

People's health care needs were not recognised or met. People did not receive appropriate support when their health deteriorated. People were not supported with their assessed healthcare needs.

The requirements of the Mental Capacity Act 2005 were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation. People were not offered choices about their care or treatment.

## Is the service caring?

Inadequate

The service was not caring. People were not treated with kindness by staff.

People's privacy was not protected and their dignity was not maintained.

People or their relatives were not involved in decisions about their care
and treatment.

## Is the service responsive?

Inadequate

The service was not responsive.
Care plans did not contain sufficient and up to date information about people's needs to allow staff to deliver care
in a responsive and personalised way.

There was a lack of activity provision to meet people's individual needs.
People received no mental stimulation or interaction from staff.

Complaints were not recorded or responded to. When people or their relatives were unhappy about the service they received, they were not listened to.

## Is the service well-led?

Inadequate

The service was not well-led.
Action had not been taken to address previous breaches of regulations we had identified.

The leadership of the service was poor and placed people at significant risk of harm. There was no quality monitoring in place, and no plan to improve the quality of service people received.

The management of the service had an impact on the day to day culture. Staff morale was low. People and staff were not actively involved in the service. Staff views were not sought by the provider and there was no evidence people were consulted about the home.

# Manor House

**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 5, 6, 7 and 8 May 2016 and was unannounced. The inspection was carried out by two inspectors and one inspection manager. This inspection was brought forward and undertaken as a result of concerns received by the Commission. Therefore the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed information we held about the service. This included notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with two relatives, the provider, the registered manager and six members of staff. Most people were not able to tell us about living at Manor House, therefore we observed staff carrying out their duties, communicating and interacting with people to help us understand their experiences. We reviewed people's records and a variety of documents. These included 11 people's care plans, risk assessments, medicine administration records, accident and incident records, daily reports made by staff, policies and procedures and the staff rotas. We asked for information on how the quality of the service was monitored and managed but this was not available.

We contacted eight social care professionals before and after the inspection that had had recent contact with the service and received their feedback.

Inadequate

# Is the service safe?

## Our findings

One person's relatives commented, "It's not a home I would recommend. We didn't get a choice. There is never enough staff. Stuff goes missing – ornaments, teddies. You try to make her room homely but it always goes."

People's needs were not met by sufficient staffing and this had a major impact on people's safety; there was no dependency assessment tool in place that was used to identify how much support people required. The provider had not completed an assessment of the environment or each person's support needs to ensure that staffing levels were safe and met the needs of the people living at the service. No activities took place during the inspection, observations showed that during the inspection most people slept in the lounge, watched TV or wandered around. One person was calling out "help" from the lounge, inspectors could not locate staff, there were 2members of staff on duty and one new member of staff who had started that day and was not providing direct care to people. This was not sufficient and placed people at risk. The provider told us they were not planning to increase staffing, despite the registered manager stating that current staffing levels were inadequate. We observed that people did not receive the support they needed with their personal care, healthcare, mobility needs or with eating and drinking. On a number of occasions we had to intervene to ensure people's needs were met by asking staff to assist people. The provider told us they would not use agency staff to cover vacancies or sickness as this cost too much money. There was no system in place to ensure enough staff were on duty at all times to support people with their needs. The service did not have a dedicated maintenance person, the provider had taken the decision to take on the responsibility of maintenance tasks themselves. The service had a vacancy for a domestic assistant and, at the time of the inspection, increased levels of staff sickness meant that there were few hours dedicated to cleaning the premises.

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The poor condition of the environment had a major impact on people's safety and their dignity. The lack of suitable staffing had had an impact on the environment: doors, walls and radiator covers were badly scuffed, damaged and peeling. One wooden radiator cover in an upstairs bathroom was hanging off the wall. Carpets were dirty, stained and malodourous throughout. Curtains were hanging off rails in some instances. Cobwebs and dead insects hung from ceilings, bathrooms and wash facilities remained uncleaned and the entire building had an overwhelming smell of urine.

The furniture in the service was in a poor and dirty condition. Three out of four armchairs in the quiet lounge had their padded arm rests missing and would have been uncomfortable to rest on. Chairs were stained and the seat pads heavily depressed with wear. Sheets and some duvet covers were thin and worn and rubber pillows had degraded so that they were worn and unhygienic. In people's bedrooms, bed linen, mattresses and pillows were heavily stained and giving off strong odours. In one person's bedroom the curtains were smeared heavily with faeces. Staff were aware of this but had not changed the curtains. This presented an

infection control risk, did not uphold the person's dignity, and caused them to sleep in a room in which the smell was so strong a member of the inspection team experienced nausea.

In one communal toilet there was no way of locking the door, inside or out. The light pull in one person's en-suite had broken off at a height of over 6 feet. It would therefore be impossible for this person to put their light on and the RM confirmed that they could not reach to do it either.

Doors to the sluice room (not in use as a sluice) were unlocked, as was a wall cupboard in the quiet lounge which contained cleaning products and personal items such as hairbrushes. The upstairs laundry room had a notice on it to say it should be locked when not in use, but it was open and ajar throughout the inspection. In one person's bedroom the TV was not working. Staff told us that this had been the case for several months and was "A shame as they really likes their TV".

The provider had failed to ensure that premises and equipment were clean, fit for purpose, properly maintained and had failed to ensure standards of hygiene were maintained. This is a breach of regulation 15 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place in people's care files, however they were often generic for all people and either not current or staff did not follow the directions, For example, one person was identified as being at high risk of skin breakdown. The risk assessment stated that this person should be encouraged to move around the home, despite them being immobile. Another risk assessment stated that a person could be at risk of falling from their chair, despite this, staff did not check on them throughout the day to make sure that they were comfortable, well positioned and safe. This person also had a risk assessment that instructed staff to move their position frequently to reduce the risk of skin breakdown. During the inspection we observed that this person did not receive this care or support.

The door to one bedroom could only be closed and opened with difficulty, because the closing mechanism was not working properly. This was a fire door with a sign on it to say it should be 'Kept shut'. The manager had made a laminated sign to place on the door to remind staff to 'Pull the door to' but it was observed to be ajar for much of the inspection. The manager said the door had been in this condition since January 2016 and that she had reported it to the provider on "Many occasions", but it had not been repaired. The fire door leading into the downstairs corridor near the lift had a broken handle and as such could not be shut. Throughout the inspection, this door was wedged wide open.

On the first floor, there was a door marked as a fire exit on the landing at the top of the stairs. This had unglazed panels in the top half, but was a solid door below this. The door was kept locked and access to the key was only by putting an arm through the unglazed panels and reaching to a glass-break key safe on the wall. The registered manager told us that this fire exit would be the only one accessible by people in four bedrooms in the case of fire. They also stated that only one person would have the cognitive ability to be able to unlock the fire door to escape; if staff were not available. Another fire door was situated through a bedroom. The door led out onto a flat roof and some stairs and was kept locked. The key to this door had been concealed by staff, high up on the wall and tucked alongside the door frame. The registered manager confirmed that people would not be able to access this key to let themselves out of the building in a fire. There was a risk that in a smoky or dark environment, staff would not be able to find the key either.

The annual fire risk assessment had been carried out by the providers 'Consultant'. There was a certificate on file to show that he had been trained to carry out such assessments in 2006. There have been significant changes to fire regulations since 2006, but there was no information to show the consultants training had been refreshed.

Although PEEP's (personal emergency evacuation plans) had been completed for people, they did not describe the evacuation route for each person and therefore did not take into account the restrictions created by locked fire doors. PEEP's identified that at least 4 people would require the assistance of two staff to exit the building, and that some people could not be left alone once outside. With only two staff on duty from 8pm until 8am, this meant that there would be insufficient staff to support people to safety in the event of an emergency. When asked about this, the provider stated, "They would have to wait their turn."

All staff had received Fire Safety training in 2015. However the services 'Fire Evacuation Plan' dated 25/4/16, which described how people should be evacuated, was supposed to have been signed by all staff when they had read and understood it. At the time of our inspection it had only been signed by the registered manager.

The provider had failed to ensure assess and mitigate risk as far as is reasonably practicable. This is a breach of regulation 12(2)(a)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm because medicines were not managed effectively. Creams were found in people's rooms and in open cupboards. In the sluice room there were 2 pots of opened Conotrane cream (A barrier cream). One of these had been recently prescribed with the instructions: 'Apply to the affected area regularly'. There were no reliable records to show regular cream applications for this person. The other pot had no dispensing label but was also opened. In an unlocked wall cupboard in the quiet lounge there was a tube of Metanium ointment, it had been opened. There were no records of the application for the person it was prescribed for. Many rooms had unlabelled tubs of cream, and in one room, an opened tub had a dispensing label for a past resident. The registered manager told us that this was not necessarily prescribed for people but that the service purchased it to ensure people did not get pressure wounds. There was no risk assessment in place about the potential risk of leaving creams out in the rooms of people living with dementia. A senior member of staff confirmed that there was no record on the MAR (medication administration record) of when creams were applied. They stated that there were no alternative creams applications sheets and that the only record would be a general one within care notes. This did not just apply to barrier-type creams but to other prescribed items such as Clomitrazole and Anusol creams. Both these items had been prescribed with the MAR direction 'Apply twice daily' or 'Apply 2-3 times per day'. The MAR instruction did not state PRN or 'As necessary' for these creams but we were told that staff had made a decision to apply only when needed as "Otherwise we could be doing creams five or six times a day". In the medicines room, there was a pot of Lorazepam, which had expired on 15/2/16 and a further cream for a past resident.

Bottled medicines, such as Lactulose and liquid Paracetamol had not been dated on opening. Handwritten entries and additions to MAR had not been double-signed by staff to confirm they were correct. Two medicines for one person, had 'When required' written alongside in handwriting, but with no explanation on the MAR, which is not good practice as recommended by the Royal Pharmaceutical Society. Staff could not tell us why this addition had been made to the MAR.

One person was also prescribed two different doses of the same medicine each day, there was nothing on the MAR entries to distinguish between the different strength doses when they were administered. One person had a medicine prescribed which stated 'One at night with food', but all the doses had been administered at 13:00 hours. The registered manager and staff said they had cleared this with the GP but could not produce any confirmation of this. This could result in people not receiving these medicines consistently or safely.

The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people.

This is a breach of Regulation 12(1)(2)(a)(b)(c)(d)(e)(g)(h) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Temperatures of the medicines room and fridge had been recorded daily. Controlled medicines were appropriately stored and recorded.

People were not protected from avoidable harm or abuse. People had experienced neglect which had a major impact on their safety and well-being. Staff lacked knowledge about keeping people safe and did not understand the types of event which should be reported and escalated. Staff displayed no understanding that their lack of care towards people constituted abuse in the form of neglect. There was not a robust system in place to recognise, prevent and investigate any allegations or evidence of possible abuse. We observed that people experienced neglect. A number of people were at risk of developing pressure areas, and were incontinent of urine and faeces. Several people had skin conditions which required them to be supported with regular bathing. We observed that a number of people were in need of personal care, including having a bath, their hair washed and being assisted to shave None of the people had been supported with a bath or any other personal care for at least 10 days prior to this inspection as staff had refused to undertake this due to the bath hoist requiring a service. The registered manager confirmed that the hoist was working, and they had put measures in place to ensure people and staff were safe to use it. However, staff continued to refuse to assist people with personal care. The registered manager told us that everyone had been supported to bathe up to the first week of April 2016, following that, most staff refused to assist people, and only a few people who the manager described as "very incontinent" were assisted to bath. However, all bathing ceased at least 10 days prior to this inspection. The registered manager told us "I can't get the staff to do it". The failure to ensure people were clean and had appropriate personal care put people at risk of harm and impacted on their dignity. During this inspection when people needed help to eat or drink this was not given, and people were ignored. Food and drink was left untouched and removed by staff with no assistance or alternatives offered. When people needed support to be repositioned due to their mobility needs this was not done. When people needed support to go to the toilet they were not taken. People were left in continence pads all day and they were not changed. We were told about incidents of abuse that had happened but there were no relevant records made or actions taken. A number of involving people being assaulted by other people in the service, this was not referred to the safeguarding team at the local authority and therefore steps to protect people from future harm were not taken. All these failures by staff constituted neglect.

The provider had failed to ensure that people were protected from harm. This is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection some of the background checks required to be made before staff were employed to work for the service had not been completed. During this inspection we found that the registered manager had taken some steps to put systems in place but had not met the original requirement actions. Staff recruitment practices continued to not always be robust and thorough. We looked at three staff files in order to assess how the provider carried out checks to ensure that they were employing people who were suitable for the role. All files contained application forms; however one did not have a full employment history or an explanation of gaps in employment. One did not have evidence of a Disclosure and Barring Service (DBS) check being in place. DBS checks help employers to make safer recruitment decisions. One file did not contain proof of identification which included documents such as passports, driving licences, birth certificates, and proof of address.
References had been sought for people to ensure that they were of good character and would be suitable for the position. Where people were unable to provide prior employment references, education and personal references were received instead.

The provider had failed to undertake robust and safe recruitment of staff. This is a continued breach of Regulation 19(2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

Relatives told us that they were not satisfied with the care and support their family members received. One relative said, "They say she has a bath twice a week but I'm not sure. Sometimes she doesn't look like she has and her hair is greasy, like today."

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager told us that she had made applications for DoLS but that these were taking a long time to be assessed and progressed. We saw evidence of DoLS applications within care files. MCA assessments had been carried out by the registered manager which assessed that people lacked capacity to make general day-to-day decisions about such areas as: washing and dressing, opening their post, and changing of pads. However, staff practice demonstrated a lack of understanding about living with dementia and capacity. For example; staff did not ask a person if they were cold before shutting a window and generally ignored them. This behaviour by staff was witnessed with other people too. We spoke with staff about people's dementia and although staff said they continued to offer choice; we saw that this did not happen. Staff did not give people the choice to move to the dining room for their meals, people were not offered a choice of drinks, people had food protectors placed on them without consent being verbally sought and people were not shown 2 meal options to help them make a preference. One staff member said that acting in a person's best interests meant doing what they thought was best for the person. Staff did not know about least restrictive options to consider. Another person had hit out with their walking stick in the past. An assessment chart recorded that as a 'Consequence' X's stick had been taken away from her. This would have had the impact of restricting their mobility and showed that staff did not understand the principles of the MCA. There was no evidence of involvement or signed consent/best interest decisions in relation to care and treatment, within people's care files.

The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People did not receive effective care because staff did not have the skills and competence to meet people's needs. This had a major impact on the care and treatment people received. Staff had received training in areas such as First aid, Fire Safety Awareness, Dementia Awareness, Infection Control, Manual Handling, Health and Safety and Dignity, Choice and Diversity, this training had not been effective in ensuring that people's needs were met. Many had not received recent updates which were necessary for them to carry out their roles and responsibilities. For example some staff had not received updates in manual handling training in line with current guidance. The Provider and Registered Manager had not assessed that staff were competent following training. Staff files showed records of inductions being completed but did not refer to the Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an

identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The registered manager told us she felt staff were not competent, and was worried about the care people were receiving. The registered manager gave an example of her concerns about staff's competence, and told us that staff did not accurately complete daily logs (these are records which record the care individuals have received every day) and when they had spoken to them, they didn't feel that staff understood or would ensure they were completed correctly.

To ensure staff were providing effective care to people, the provider must have processes in place to ensure their training and development needs were discussed with them, and actioned. These discussions take the form of supervision meetings and yearly appraisals. Most staff had not received supervision since 2015 and therefore had not had an opportunity to discuss their development or support needs. Staff had last received an annual appraisal in 2015, under the previous provider. The registered manager told us they had not received any supervision from the provider. The provider had not undertaken any training in how to manage or supervise staff, and had not had any prior experience of this management role. When we asked the provider about supervision and support, he told us that he had literature on supervision and could follow the forms. He stated that he had not undertaken supervision with the registered manager to date as he did not "think that it was necessary at this time". The staff and the registered manager told us they felt unsupported in their roles, and that morale at the service was low. They stated that this was having an impact on the care people received. Both the provider and registered manager were aware of the morale in the service. Despite this, staff had not been given the opportunity to meet with their line manager to discuss their support, training and development needs.

The provider had failed to ensure staff received appropriate support, training and supervision. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's health care needs were not met. This had a major impact on people's health and well-being. When people were unwell, had a specific health need or an accident, advice and treatment from health care professionals was not always sought in a timely manner. There was an additional risk that people's health would deteriorate further before they were seen by health professionals and appropriate action could be taken. One person's care plan had a handwritten note that they had been recently diagnosed with a new health condition. The note was undated and the registered manager had not followed this up to determine whether they should have a special diet or required medication. There were no further notes about this. One person's risk assessment stated that staff should 'Allow their freedom but be vigilant of their whereabouts'; despite this person being completely immobile without staff assistance. Another person was observed by inspectors to be unresponsive and was slumped in a chair. The person appeared to be unwell. Staff did not provide any assistance or care to this person, and only called the GP when requested to do so by professionals. This person was ignored by staff for the duration of the first day of the inspection (eleven hours), and their signs and symptoms of illness were not responded to by any staff at the service.

When people's healthcare needs were known and recorded in their care plans, staff failed to carry them out. Some care plans identified that people were incontinent and required support with this; one person's stated that they should be supported to go to the toilet and repositioned every 2 hours, throughout the inspection we observed that this did not take place.

A relative told us they were not informed when their relative was unwell, and when they raised a concern about this they were told they would not be informed of every illness unless it "was a matter of life or death".

The provider had failed to properly assess risks to people's health and put in place safe procedures to ensure their health and welfare. This is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act

2008 (Regulated Activities) Regulation 2014.

We were unable to accurately assess whether people had adequate food and drink due to a lack of reliable records. During one day of the inspection we observed one person to eat nothing, other than two small bites of a sandwich, between 9am-8pm. Their daily report recorded that they had "Good food and fluid intake". Their care plan stated "If X does not want a meal staff are to offer a sandwich or some soup." We observed that this did not happen, at lunchtime the meal remained untouched, it was moved by a staff member and replaced with a desert, and this also remained untouched until staff took it away. For supper, they were given a triangle (a quarter) of a sandwich, and offered no assistance. At no point did any staff spend time with this person to encourage them to eat. The registered manager told us that this was because the person wouldn't accept assistance, and that the meal should be left in front of them, the inspector expressed concern that the person was sitting under an open window, the registered manager said, "this is the problem but sometimes they can take up to an hour to eat it." About 2 minutes later a member of staff removed the meal. Another person's log also stated "Good food and fluid intake", with a picture representing over ¾'s of the meal being eaten, we observed that the person had eaten 2 forkfuls of their meal before it was replaced with desert, which they also did not eat. During lunchtime in the dining room, 1 member of staff supported 1 person to eat their meal, they engaged in conversation with this person and the person sitting next to them. The remaining 4 people who were eating in the dining room received no interaction from staff during the meal time, other than to offer desert. There were no condiments or cutlery on the tables; everything was passed from a metal trolley.

Records showed that many people had not been weighed since January 2016. One person's risk assessment stated they were at risk of weight loss. They had not been weighed since January 2015, their weight had gradually decreased over the previous twelve months and we were unable to confirm whether or not this person continued to lose weight due to a lack of records. They had not been referred to a health professional and no meaningful monitoring of their dietary intake took place. Another person's care plan stated, "All diet to be monitored and documented, weights to be monitored monthly to assess weight. Any concerns should be made known to the dietician. This person had not been weighed since January 2016, did not have their diet monitored or documented and had not been referred to the dietician.
One member of staff told us "The food budget has been cut and I have to buy food out of my own money. We even run out of basics like potatoes. There is low morale amongst the staff and no enthusiasm. It's hard to run a kitchen when you haven't got what you need".

The provider had failed to ensure that the nutritional and hydration needs are met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The premises had not been designed or decorated to meet the needs of people living with dementia. There was no signage or colour coding on doors or walls to assist people to find their way around. Bedroom doors did not have signs or pictures to help people to identify which was their room. Appropriate signs could assist people living with dementia to maintain their independence. Adapting the décor and surroundings could make it easier for people to see and use, for example, hand rails blended in to the walls and did not stand out and toilet doors/frames and toilet seats were not in contrasting colours.

People did not benefit from an environment which was suitable for the purpose for which it was being used. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service caring?

## Our findings

The provider of the service told us, "I would not want my mum to live here".

A relative stated, "It's not a home I would recommend. We didn't get a choice. There is never enough staff." The registered manager told us that staff would not respond to their reasonable requests to care for people. At the time of the inspection we were told that staff were refusing to bath people and would not replace curtains. The registered manager said, "There is no motivation. They are not working as a team." A senior staff member said: "The curtains (in a person's bedroom) are covered in faeces. Because of health and safety staff can't change the curtains. They have been this way since January 2016. They are smeared nightly. We're only going by the health and safety course we have done". We asked the provider about this and their response was, "I don't understand what the issue is. We can't change them all the time", "we can't do it every day".

On more than one day of the inspection, two people were observed to be asleep or dozing for at least 45 minutes in the dining room, staff were not around for most of this time, but when they were they did not offer to assist people to sit in more comfortable chairs and we did not see or hear staff offer an alternative meal, drink or snack. One person looked particularly uncomfortable, slumped over in a chair and at one point was trying to pull themselves up into a different position. Despite their care plan stating that 2 members of staff should reposition every 2 hours, staff made no attempt to support this person until after an inspector requested they provided support. Staff did not offer people regular toileting. We observed that 2 people sat in the same position all day. Both required assistance to move with a hoist, but the hoist was not seen in use at all throughout the inspection. One person had a large wet patch on their trousers but staff did not react to this.

People's dignity and respect was not being upheld. People were dressed in dirty stained clothes; many had no footwear or socks. People's hair looked greasy and male service users were not shaved. The service had an overwhelming odour of urine. One inspector observed 3 occasions where people were using the toilet with the door wide open. Each time a staff member also observed but walked past without offering support or closing the door. The inspector asked staff about this. One said "I couldn't leave the drinks trolley", another said "I usually close the door". Another said "I always try; I'm not sure why I didn't do it."

The provider had failed to ensure that people were treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were living in a dirty, odorous and unpleasant environment; which afforded them little dignity. There was a pervading odour of urine throughout the service: which was strong enough to cause inspectors to cover their noses and faces at times. The inside of the lift smelt particularly strong: as did several bedrooms. In one bedroom the carpet was heavily stained all over. The Permapad mattress was stained and had a strong odour or urine. The duvet cover was stained with what looked like dried faeces and smelt very strongly of stale urine and there was no hand wash or paper towels in the en-suite bathroom. In another bedroom there was urine residue in a commode pan and the mattress was very heavily stained and smelt so

strongly or urine that the inspector had to excuse them self to go outside for fresh air. There was also no hand wash or paper towels available at the sink in this room. A further bedroom smelt of faeces and urine. The cream curtains were heavily stained and dotted with a brown substance; which appeared and smelt like faecal matter. This person's care plan made no mention of any behavioural issue that would lead them to smear faeces; It did however highlight that they were 'Very sensitive to mood changes in the home' and that these might upset them.

Throughout the inspection we asked the provider what they were doing to make sure people were treated with dignity, on the third day, the provider said he had done nothing. No audit had been completed to identify what mattresses needed replacing. Alternative mattresses were available at the service, and a carpet cleaner had been purchased. The inspector asked why nothing had been done. The provider replied, "because we just haven't done it". He stated he would not use the carpet cleaner and expected staff to do it.

Some staff had worked at the service for years and had built up relationships with people. However as care plans did not contain detail about people's life histories, new staff would not know this information, which would help them understand people and their needs and also use the information to engage with people.

Staff spoke to people across rooms, such as the lounge, without approaching the person and responding to them directly. The conversation was therefore shared amongst everyone in the room, was not personalised and gave no opportunity for private comments, questions or discussion. Staff engaged in tasks without any dialogue with the person concerned, such as removing dinner plates and drinks without asking people if they had finished. Opportunities for positive social interaction and inclusion which demonstrated an interested and caring approach were missed because staff focussed on completing tasks rather than on the person.

The provider had not ensured that the service was caring because they had not recognised the poor practice in relation to people's rights, privacy and dignity. They had not taken any action to ensure that people were treated in a respectful manner.

The provider had failed to ensure that the care people received was personalised. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

# Is the service responsive?

## Our findings

The registered manager told us "I feel completely helpless-you can't care for these people properly" and "I wouldn't want my family here-I'd take them straight out". A relative told us "I've never been asked to contribute to care plans".

People did not receive personalised care and support that reflected their needs, wishes and preferences. This had a major impact on people. Care plans contained information about how people's care should be delivered. Care plans contained information about people's personal hygiene, getting up and going to bed, continence/toileting management, mobility, activities, communication, medication, medical history, mental capacity and dietary needs. However they lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support, to ensure their support was delivered consistently and in a way they wanted. Much of the information was generic and the same phrases were repeated between different people's care plans. For example, most people's dietary risk assessments stated 'All diet to be monitored and documented', but this had not happened or happened accurately in practice. Another stock phrase used in care plans was that 'X is to be included in all aspects of daily life at the home'. It is unclear what this means, but in practice, people were left for long periods without any stimulation or interaction whatsoever. Care plans had not been updated to include the most recent information about people's care and needs. For example; One person's care plan said that staff should 'encourage to walk around home every couple for hours to ensure it relieves pressure on bottom'. However, this person was no longer independently mobile.

Care plans did not contain full or accurate information about people. People's care plans did not describe behaviours that we observed or staff told us about. People's care plans recorded that they should be weighed monthly or fortnightly, but this had not happened in any of the 11 care plans reviewed. Tippex had been used in one care plan and left unfinished sentences in some cases, about how their care should be delivered. There was no guidance in place to help staff manage behaviours that may challenge. If people became anxious there was no guidance about how staff should manage this. This meant staff may deliver care and support in an inconsistent way and not in line with people's wishes and preferences.

Most care plans were dated 2013 and contained information that was not up to date and did not reflect people's changing needs or deteriorating health. Files contained a 'review sheet' which had been signed but was of little meaningful value.

All of this placed people at significant risk of receiving care that would not meet their needs or ensure that their health and wellbeing was maintained.

There was no stimulation whatsoever for people throughout the inspection. People sat in chairs and either slept or stared ahead of them. There was little meaningful staff interaction or engagement for anyone. People were not supported to maintain their hobbies and interests. During the inspection the TV was on in the lounge, staff failed to check whether people wanted to watch the programme that was on or indeed wanted the television on at all. No one sitting in the lounge area was engaged with it, at one point the TV

turned itself off, which the registered manager told us it did after a period of inactivity in the room. We were told that 6 hours per week were allocated to activities but that this rarely took place, due to the lack of staffing the hours were often used on the care rota.

The provider had failed to ensure that people received person centred care based on an assessment of their needs and preferences and had failed to ensure care plans reflected people's assessed needs, preferences and remained up to date. This is a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We were told that no complaints had been received; there was not a complaints file. One person's relatives said they have raised a number of complaints but only ever received one call from the registered manager about one complaint. There were no opportunities for people's views to be listened to. The provider had failed to recognise poor care and had not taken opportunities to talk with people using the service to find out their views and act on any shortfalls to improve people's experience.

The provider had failed to establish an effective complaints procedure. This is a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

# Is the service well-led?

## Our findings

The registered manager told us "The consultant and [The provider] don't know anything about people living with dementia. The consultant shouts at every visit. The staff are always anxious and it affects everyone including people living here. He is rude to clients and called X a crook. He is rude to relatives and told one relative they were lower class". Staff commented, "He [The consultant] is a bully. He takes your confidence away. I feel very sorry for X [Registered manager]. He does nothing but pester them all the time. He shouts and swears at the registered manager, as he does all of us. The morale has gone down. We have no funds. It's embarrassing. X likes to watch TV in her room but he won't put an Ariel in. The consultant argues, shouts and swears at staff in front of the residents. They are scared of him".

The leadership and management of the service was placing people at significant risk of harm and there was a serious risk to people's health and wellbeing. At the time of the inspection the provider informed us that they had allowed the service to be run by their consultant, who has had a registration previously cancelled by the CQC.

The provider stated that although he was the responsible person, the consultant was running the service in all but name and that he would not be able to stop him being involved in, or visiting Manor House. During the inspection we saw emails sent to the registered manager from the consultant, giving instructions and orders about the running of the home.

The leadership of the service was chaotic with directors and their consultant undermining and failing to support the registered manager, yet seeking to blame them for the failings. There were overwhelming systemic failures which had led to the serious shortfalls in people's care with the potential for serious harm to come to people who were vulnerable because of their dependence on staff to meet their needs. The provider had failed to ensure that there were robust governance systems in place that worked to identify shortfalls and improve the quality of care people received. In addition the provider had failed to work effectively with Local Authority representatives who attended the home to review the service.

The registered manager had worked at the service for several years, they told us that the provider expected them to be on call 24/7 and that they were contacted frequently with instructions by the providers appointed consultant. There was also a deputy manager, their hours were all on shift and they did not provide any administrative or management support to the registered manager, this was a change that the provider's consultant had introduced. The manager told us that this, and the expectation that they covered care shifts left them under pressure and unable to fulfil their role. They told us they had raised this issue but were told it was their job.

Despite the registered manager's experience we found at the time of the inspection they lacked knowledge of systems and processes or an understanding of the challenges or concerns of the service. This was evident in their ability to the address concerns and shortfalls with the speed and effectiveness which was required when a service had so many identified shortfalls. For example, on the first day of the inspection, we spoke to the registered manager about the urgent need to monitor and record the nutritional intake of identified

people. When we returned on the second day, this still had not been put into place. Discussions with the provider identified similar issues; the consultant had no knowledge or understanding of the support needs of the people living in the service. When asked if he knew the people, he said he did not know them but recognised some by face.

At the end of the first day of the inspection we were so concerned that we requested the provider put into place an action plan to address the immediate, urgent concerns. When we arrived the next evening, we asked the provider what they had been doing today to address the issues. He stated he had not done anything but had been working on an action plan. He said he had not thought about arranging for any deep cleaning of the environment or taking any immediate action in respect of people's health and welfare needs. The action plan we were given was basic and contained no dates or detail. We gave the provider a letter, stating our serious concerns and the possible action we were considering.

There were no systems to assess, monitor and mitigate the risks relating to people's health, safety and welfare. Accidents, incidents and falls were not properly recorded, investigated or analysed for trends and patterns. When accidents and incidents had occurred management had not taken appropriate action, such as referrals to health professionals, safeguarding or carried out a review of staffing levels. There was no analysis of accidents and incidents to look at patterns and trends to help reduce future risks to people's health and welfare and to ensure that accidents and incidents were monitored appropriately in the future. Any learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

There had been no recent resident or relative meetings to gain views about the quality of the service, and there were no plans for any to take place in the immediate future. There had been no staff meetings or survey of staff opinion about the standards of the service. This meant that staff concerns or views about how the service operated had not been fully considered for the purposes of making positive changes.

The provider had not put in place any systems to audit the quality of service provided to people. No formal audits had been carried out that had resulted in an action plan with timescales to address shortfalls. The registered manager told us they felt like they were drowning and that they did not feel that the provider would make the necessary improvements. The provider told us that they could not get involved and expected the registered manager and staff to address the issues and "At the moment we are not purchasing any equipment until we know the outcome of what CQC is doing." This meant people could not expect the service to improve in the near future.

Policies and procedures were stored in the registered manager's office and had been developed by the previous provider although they did not always reflect current legislation. They did not give clear guidance about what staff should do in situations, such as when an accident or fall occurred. This meant there was inconsistency in staff's practices when these events happened and appropriate action was not always taken or taken in a timely way to keep people safe and well.

The provider had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not put in place systems to monitor the quality of care people received. This is a breach of Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes any allegation of abuse or any serious injury to a person. The provider had not consistently notified the CQC when incidents had

occurred in the service.

The failure to notify these incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The failure to notify these incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure that the care people received was personalised. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.<br>The provider had failed to ensure that people received person centred care based on an assessment of their needs and preferences and had failed to ensure care plans reflected people's assessed needs, preferences and remained up to date. This is a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider had failed to ensure that people were treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure assess and mitigate risk as far as is reasonably practicable. This is a breach of regulation 12(2)(a)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.<br>The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people. This is a breach of Regulation 12(1)(2)(a)(b)(c)(d)(e)(g)(h) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2 |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure that people were protected from harm. This is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider had failed to ensure that the nutritional and hydration needs are met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had failed to ensure that premises and equipment were clean, fit for purpose, properly maintained and had failed to ensure standards of hygiene were maintained. This is a breach of regulation 15 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not benefit from an environment which was suitable for the purpose for which it was being used. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had failed to establish an effective complaints procedure. This is a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not put in place systems to monitor the quality of care |

people received. This is a breach of Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to undertake robust and safe recruitment of staff. This is a continued breach of Regulation 19(2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>The provider had failed to ensure staff received appropriate support, training and supervision. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities |

**The enforcement action we took:**

Folkestone Magistrates Court ordered that the provider's registration be cancelled on 9 May 2016.