Elmbank Residential Care Home Limited

The Limes Residential Care Home

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on the 26 October 2016. The Limes provides personal care and accommodation for 16 older people. There are people at the service that are living with dementia. Bedrooms are situated on the ground and first floor. Access to the first floor is by a stair lift. At the time of our inspection there were 13 people living at the service.

The registered manager had recently left the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Instead we were supported on the day by the Provider and the newly appointed deputy manager.

There were not always enough staff deployed in the service to consistently meet people's needs. People were left on their own for long periods of time without the support of staff. Not all of the care staff on duty provided care to people; some were undertaking kitchen and laundry duties which left one member of staff to provide the care for 13 people.

Risk assessments for people were missing and other assessments were not always detailed. There was not enough information to guide staff in how to reduce the risks to people. Incidents and accidents were not always recorded and those that were recorded lacked detail and actions put in place to reduce the risk of incidents. Staff were not following good infection control. There were aspects to the environment that were not safe for people including windows in a bedroom that did not open. The premises and equipment was not well maintained. However people's medicines were managed in a safe way

Although staff and the provider had knowledge of safeguarding adult's procedures they were not putting this into practice. Safeguarding incidents were not always being reported to the local authority. There was a safeguarding adult's policy in place however staff were not following this. People who had capacity were having their liberties restricted.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect them from harm. Assessments had not been completed specific to the decision that needed to be made around people's capacity. DoLS applications had been submitted to the local authority around whether people's liberties were being restricted however these had also been submitted for people who had full capacity.

People were not always receiving care from staff who were competent, skilled and experienced. There was a risk that people were receiving care from staff who were had not had training to meet the needs of people with mental health issues or behaviours that may challenge others. Staff competencies were not always

assessed as they did not have appropriate supervision or appraisals.

People at risk of dehydration or malnutrition did not always have effective systems in place to support them. People were not always provided choices that met their reasonable preferences. Where people's food intake needed to be recorded this was not being done even when people's weights had fallen. People had not always have access to health care professionals to support them with their health needs in a timely way.

Staff at the service did not always treat people with dignity and respect. There were times where people were ignored for periods of time throughout the day and people's dignity was not always maintained. People were not always consulted about the care they wanted. The routines of the home were imposed for staff convenience rather than to meet the personal choices of people. We did see times when staff were caring and considerate to people and relatives did say that staff were caring to their family members.

People's preferences were not consistently being sought by staff. The provider was not always responsive to people's needs. There was no detailed information in people's care plans around the support they needed. There was a lack of detail around care for people with a mental health diagnosis.

There were not enough activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. People that wanted to go out did not always have the opportunity.

There were not effective systems in place to assess and monitor the quality of the service. Although some audits had been undertaken these had not been used to improve the quality of care for people. Records were not always completed or accurate. 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 provider had not informed the CQC of significant events.

There was a complaints procedure in place however not everyone knew how to access this. Complaints were not always appropriately responded to.

Recruitment practices were safe and relevant checks had been completed before staff started work.

Personal evacuation plans were in place for every person who lived at the service. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 time frame. If not enough improvement is made
within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement

action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed at the service to meet people's needs.

People were not always safe because risks of harm had not always been managed. People were not always protected from environmental risks.

People were not protected against the risk of abuse and improper treatment. Staff were not aware of their roles and responsibilities in how to protect people.

Medicines were administered, stored and disposed of safely.

Safe recruitment practice was followed.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their assessed need.

Staff did not understand how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

People did not always have enough to eat and drink. There were no appropriate arrangements in place to identify and support people who were nutritionally at risk. People were not always offered choices around meals and drinks.

People were not always supported to have access to healthcare services and healthcare professionals were not always involved in the regular monitoring of people's health.

Is the service caring?

Inadequate

The service was not always caring.

Staff did not always treat people with dignity and respect. However we did see occasions where staff were kind and attentive.

People's preferences, likes and dislikes had been not always been taken into consideration and support was not always provided in accordance with people's wishes.

There were restrictions on when people's relatives and friends were able to visit.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed when they entered the service or on a continuous basis and the care plans were not updated to reflect changes. There was not always detailed information regarding people's treatment, care and support.

People did not have access to activities that were important and relevant to them.

People were not encouraged to voice their concerns or complaints about the service. Complaints were not always responded to appropriately.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not have systems in place to regularly assess and monitor the quality of the service the service provided. The provider had not met breaches in regulation from the previous inspection.

The provider failed to seek, encourage and support people's involvement in the improvement of the home to improve the quality of care.

Staff and the provider were not following their own policies and procedures in relation to care.

We could not effectively monitor what was happening in the service as notifications were not always sent to the CQC.

The Limes Residential Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 26 October 2016. The inspection team consisted of three inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed information on the 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. We also reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

During the visit we spoke with the Provider, the deputy manager, two people and four members of staff. We spent time observing how staff interacted and cared for people. We looked at a sample of four care records of people who used the service, medicine administration records and supervision records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. After the inspection we spoke with two relatives, one social care professional and the Quality Assurance team from the Local Authority.

The last inspection was on the 8 July 2015 where breaches were identified regarding the lack of systems in place to protect people from the risk of abuse, the lack of appropriate mental capacity assessments and the lack of governance. We also made recommendations around safe management of medicines and providing appropriate care for people living with dementia.

Inadequate

Is the service safe?

Our findings

On the previous inspection in July 2015 we had identified a breach in safe care and treatment. Risks to people were not being managed safely, risk assessments lacked guidance for staff and staff were not always using best and safe practices when helping people to move around. The provider sent us an action plan in October 2015 that stated that actions had been taken to address the shortfalls. However we found on this inspection that they had not improved sufficiently to keep people safe from the risk of harm.

On this inspection we also found that people were not always protected from the risks of unsafe care. The care plans did not contain detailed information about actions required in order to provide safe care. For example, we noted one person had been admitted to the service two weeks previously. Information on the care plan from the funding Local Authority stated that the person was at 'moderate to severe' risk of displaying challenging behaviour. It stated that they were also at high risk of falling and had frequent falls before moving in to the service. We found no documentation or assessments had been undertaken by staff at the service that related to these risks. Through the day we saw this person become very unsettled whilst sitting in their chair and staff were unable to tell us how to manage the person's anxiety. One member of staff was not aware of the person's challenging behaviour and told us that the person was 'unsteady' on their feet but was not aware of the risk of them falling.

Another person was at risk of falls. There was conflicting information in the care plan for staff on how to manage this. It stated that they needed two carers to assist them to move and in another part of the care plan it stated only one member of staff was needed. Guidance stated that they needed to wear slippers when they walked. We saw the person on several occasions trying to stand up without the support from staff. When staff did support them at times there were two members of staff and on other occasion's only one. The person was not wearing slippers and just had socks on.

Appropriate equipment was not always provided to people that were at risk. One person's care plan stated '(The person) is able to mobilise independently around the home with a frame but is at high risk of falls.' The care plan also stated that staff must observe the person at all time when they were mobilising. However the person was not using the frame to walk with during the inspection and staff were not observing the person every time they walked around. Another person was using a frame when walking however their care plan did not have a falls risk assessment in place. One member of staff told us. "(The person) can walk but we make her use her frame." In all of the care plans that we looked at there was a lack of detailed risk assessments around mobility, nutrition, skin integrity and behaviours.

Accidents and incidents were not always recorded. Where people had incidents of challenging behaviour staff were not recording this as such. Staff made us aware of incidents involving two people's behaviours on a regular basis but there was no evidence of how each incident was managed. There was no evidence of how staff reduced the risk of the incidents re-occurring. The provider told us that they were aware that these were not being recorded and had just implemented systems to ensure that this was being done however we saw no evidence of this on the day.

There was a lack of infection control being practiced by staff. The sluice room on the top floor was permanently locked and staff had been unable to use it to clean commodes. Commodes in people's rooms smelled very strongly of urine which suggested that they had not been cleaned appropriately. Most of the people at the service were only wearing slippers. Where there had been urine spillages in the toilets this was not cleaned up quickly enough by staff to stop people walking through the urine and back out into the communal areas. None of the bedrooms had soap and staff had to leave the rooms to wash their hands. The provider told us that they had not allowed soap in people's rooms or in the communal toilets for the past three years. This was despite at least two people needing to be barrier nursed in their rooms the previous week. The laundry area was not set up in a way to help prevent the risk of infections spreading. The laundry was a converted shed in the garden. There were no separate areas to keep clean clothes and nowhere for staff to place clean clothes once they had been washed. The shed was dusty and filled with cobwebs and the flooring was old carpet tiles that were dirty and in need of replacement. Clothes were on the floor of the laundry cupboard and we observed large packs of sanitary pads had been stored on the floor of a shed in the garden that staff used for smoking in.

Care and treatment was not always being provided in a safe way and risks were not being identified or where identified had not been mitigated. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other aspects of the service that did not promote safe care. The environment was not always clean or well maintained. In the lounge areas several of the chairs were wet with urine; we saw staff move cushions from chairs where people had been sitting that had been soaked with urine. They placed the cushions in the bathrooms that people were using through the day. Equipment stored in the bathrooms was rusty and needed replacing including a hoist used to lift people into the bath, a broken toilet set (that people had been using), stained commodes, one person's bedroom window could not be opened and another person's double glazed window was filled with condensation. In the lounge a portable fan had been placed by the television on the floor which presented a trip hazard for people. There were damp patches in people's rooms and people's clothes that were hanging in the wardrobe felt damp to the touch. One person told us, "My clothes are damp in the morning." There were handles missing from a chest of drawer and the walls around the service were scuffed and in need of painting.

The kitchen area was not clean and presented a risk to people. There was a build-up of black grime around the floor of the fridges and rust and mould on the doors of the fridges. The cupboards used to store food were dirty as were the containers used to store food. We raised this with the provider who told us that they were aware of the lack of cleanliness in the kitchen but had not taken steps to address this. We reported our concerns to the Environmental Health Department at the local authority.

As the premises and equipment was not maintained to a safe standard this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to meet people's needs. One person told us (when asked about staffing levels), "I can do most things for myself so I don't always need them (staff). But I can see that the staff are really busy. I can go a long time and not see anyone". Throughout the day people were encouraged to remain seated, when people did get up they were often encouraged by staff to sit back down again. There were two carers on duty during the day and at night. When we looked at the needs of people we saw that there was at least two people that required two members of staff to assist them to move. This meant that whilst these people were being assisted with their care no other staff were present in the lounge to support other people. We saw one person calling out to use the bathroom for a period of ten minutes before staff were available to assist them. This person kept trying to stand up on their own and it was left to another person to keep telling

them to sit back down until a member of staff was free.

The provider told us that along with personal care duties the two members of staff were required to undertake activities with people, do people's laundry, clean the service at weekends and cook in the evenings as the chef finished work at 14.00. One member of staff told us, "It's okay most of the time but we usually just have two carers on. We have some people here who can be aggressive and if we need to attend to them we can't see to anyone else. We need another staff member then". Another member of staff told us that two members of care staff were not sufficient in the evenings particularly when one person became more challenging through the night and required both staff to support them. Staff told us that people were got out of bed at 08.00 every morning as it was easier to manage when only two members of staff were on duty. The provider told us that they used a service dependency tool to help determine the numbers of staff needed. However this was not used effectively and did not highlight the need for more than two carers on shift at any time.

There were insufficient staff employed and deployed to meet people's needs which is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of abuse or improper treatment. Staff were able to tell us the types of abuse that may occur including verbal and physical. However they were not using this knowledge in practice to protect people. Staff told us that one person regularly hit out at people who lived in the home and verbally abused them. This had not been recorded as a safeguarding incident. The Local Authority or the CQC had not been informed of these incidents and steps had not been taken to protect people against this. Of the 18 staff that worked at the service only one member of staff had received training in safeguarding. There was a service safeguarding policy in place that detailed what staff needed to do to protect people however this was not being followed.

People were being deprived of their liberty unlawfully. One person (who had full capacity to make decisions) had been told by staff that they could not go out. The person told us "I can't go out, even with someone with me. My daughter has told them (staff) that I'm not allowed to. I don't know why that is. I did have an infection a few weeks ago before I came here and I was aggressive and agitated then but I'm fine now. I'm not that kind of person. I'd love to go out but I haven't been allowed to for weeks". The provider had submitted an application to the Local Authority as their liberty was being restricted however this was unnecessary as the person had full capacity to make their own decisions. Their care plan stated 'They (the person) are alert with good insight. Sometimes they feel lonely and miserable due to having no visitors and not being allowed to go out with anyone". In addition, an assessment by the person's GP on 29 September 2016 also concluded X possessed the mental capacity to make their own decisions. One member of staff told us, "We have DoLS (Deprivation of Liberty Safeguard) in place for people who we can't let out because they are at risk". We asked how people with mental capacity were treated. We were told, "Much the same really."

As people were not being protected from the risk of abuse and people were being deprived of their liberty unlawfully this is a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were being managed in a safe way. The administration of medicines followed guidance from the Royal Pharmaceutical Society. There were no gaps in the MAR charts showing people had received their medicines as prescribed. We noted MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held

with their MAR chart. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. Staff were knowledgeable about the medicines they were giving.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in lockable cabinets. There was a lockable room for the storage of medicines. Medicines requiring refrigeration were stored in a fridge. We noted it was used for other purposes but medicines were kept in a separate container within it. The temperature of the fridge was monitored daily to ensure the safety of medicines.

People were protected from being cared for by unsuitable staff because robust recruitment procedures were in place. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. Notes from interviews with applicants was retained on file and showed that the service had set out to employ the most suitable staff for the roles. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Inadequate

Is the service effective?

Our findings

On the previous inspection in July 2015 we had identified a breach that related to the lack of Mental Capacity Act (MCA) assessments. There was a risk that decisions were being made by staff at the service that were not in the person's best interest. The provider sent us an action plan in October 2015 that stated that actions had been taken to address the shortfalls. However we found on this inspection that this had not been done.

People's rights were not always protected because the staff did not always act in accordance with the MCA. MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. The staff we spoke with told us they had undertaken recent training in MCA. However, they did not have any understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We looked at care plans and noted no mental capacity assessments had been undertaken when they were needed regarding specific decisions. We also noted consent had not been sought and obtained from people, relatives and representatives in areas such as information sharing and photography for identification purposes. The provider showed us that CCTV was being used in all communal areas however no consent had been sought from people or their representatives to be filmed.

We spoke with the provider about the lack of capacity assessments and consent forms. We asked how they ensured how people without mental capacity's best interests were met in the light of the lack of documentation. They were unable to produce evidence to show people were properly assessed and protected. We also asked about the involvement of relatives or representatives in people' care. We noted one person's care plan stated their son was next of kin when in fact they had no son. As a result of this we asked how the provider ensured decisions about people's care were only made by those authorised to do so, by virtue of having Lasting Power of Attorney for Health and Welfare. The provider told us they did not ask representatives to produce evidence that they were authorised. They said, "I've never requested proof of Power of Attorney". We asked the provider if it was then possible that people living at the home were having their care directed by those with no authority to do so. The provider confirmed this to be the case. We saw that the provider had put themselves down as the Next of Kin for one person (who did not have people acting on their behalf) and had completed and signed their 'End of Life Care' form for them without any advice or guidance from a GP. Since the inspection we prompted the provider to ensure this situation was resolved. They have now contacted the person's funding authority to request an advocate so the person can be assisted to make decisions with the help of someone independent from those caring for them.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We noted that DoLS applications had been completed in line with current legislation to the local authority for people living at the home. However these applications were not always supported with the appropriate mental capacity assessments. Staff had not received training in Deprivation

of Liberty Safeguards (DoLS) for the people they were supporting. It had been recorded that one person (who lacked capacity) wanted to leave the service and had made several attempts to leave. There was no evidence that an urgent DoLs had been submitted to the Local Authority.

As care and treatment was not always provided with the appropriate consent this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff were not always suitably qualified, skilled and experienced to meet people's needs. There were people at the service that had a mental health diagnosis. One member of staff told us that staff were not equipped to deal with some of the people that lived there and had not had training around mental health. They said that they and other staff did not have enough knowledge around one person's particular behaviours and felt sufficient training had not been given. After the inspection the provider gave us a list of what training the staff had received. No training had been provided to staff around challenging behaviour or understanding mental health. On the list provided by the provider 18 staff had not received training in health and safety and safeguarding, 16 had not had training in moving and handling and food hygiene, 13 had not had training in fire safety and MCA, 11 had not had training in infection control and dementia and eight had not had training in first aid. We spoke with staff about the training opportunities on offer. One staff member told us, "The training is okay. I do a lot for myself". We did observe some good practice by staff on the day particularly in relation to how people were helped to move using a hoist.

We also looked at the provider's supervision matrix and supervision policy. We noted the latter stated staff should receive six supervision sessions per year. We noted no staff had received supervision more than three times in 2016; the majority had received it once or twice. This was not in line with the provider's policy.

As staff were not always receiving the appropriate training and supervision to undertake their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment did not always meet the individual needs of people living at the service. There were no memory boxes outside people's rooms or other indicators or signs to help orientate them and the carpets were patterned which can be confusing for people who live with dementia. There were no particular areas of interest or sensory items for people around the service to keep them occupied or engaged. We did see that there was signage on the doors to help guide people if they needed to use the bathroom.

We recommend that the environment is improved to assist people living with dementia.

People were not being provided with food and drink that met their reasonable preferences. We asked people about the food on offer at the service and we also observed care in communal areas at lunchtime. One person told us, "It depends really. Some days are better than others. There isn't really (choices). If you don't like it I think they'll give you something else". During lunch there was no choice given to people. We observed three people sitting in the dining room. They were talking amongst themselves trying to decide what food was on the plates they had been served and were unsure. At no point did staff approach to explain what the food was. We were told by staff that people were asked the day before what they wanted. However one member of staff said, "There are teething problems with menu choices, staff fill in the choice sheet the night before but some people forget the next day." Despite staff knowing this there had been no action to address giving people choices of meals at the time the meals were served. Everyone had access to a drink at all times, although not necessarily their choice of drink. When people asked for a drink, they were given one but they were never asked what drink they wanted.

People's weight was not always been managed appropriately. Staff told us that people needed to be weighed monthly. According to the care records people had not been weighed since August 2016. Two people had lost weight over several months however no action had been taken to address why the person was losing weight and no health care professional advice had been sought. The chef confirmed that no one at the service was being provided with additional supplements to help with the weight gain. There were no healthy snacks (other than biscuits) being offered to people from breakfast (which was served at 8.00) to lunch which was served more than four hours later. Where it may have been appropriate for people to have their food and fluid recorded this was not being done.

As there was a lack of choices to meet people's reasonable requirements and it could not be determined that people were receiving adequate nutrition and hydration there is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did note those requiring assistance to eat and drink were helped in a caring and discreet manner. There was a lively and inclusive atmosphere in the dining room and people did comment that they were enjoying what they were eating.

We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included GPs and community nurses. However, we did not find evidence that advice and guidance given by these professionals was followed and documented. There is more detail about this under well led as a recording concern.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity and respect. People were not given choices about when they wanted to get up or go to bed. One member of staff told us, "We make sure we get people up for eight so we can get into their room to clean it." They told us that if people were not up by 8.00 they would ask staff to wake them. Another member of staff told us that breakfast was served at 8.30 in the morning and that in their opinion breakfast "Went on too long." This showed that the routines were for the convenience of staff rather than centred on each person as an individual. The chair cushions that some people were sitting on (although they looked clean) smelled of urine and there were bedrooms in the service that had a strong urine smell. This did not show that care, compassion and dignity was at the heart of this service.

There were no life stories or background in people's care plans. This is particularly important for people that live with dementia that may have problems remembering. One member of staff told us about a person whose life story was sensitive. The care plan had no mention of this and the care plan made incorrect references to what family the person had. There was a risk that new staff reading the care plan would have the incorrect information about the person and cause upset to the person. The living room chairs were not arranged in a way to make it easy for people to look at the television. One person had to look to the right to watch the television due to how the chair was placed. Other people's chairs were not in the line of sight of the television.

Some staff members did not display compassion when speaking about people. One staff member told us, "I'm not sure sometimes what goes on in their little heads". One member of staff told us that it bothered them if people requested breakfast after 9.30 and that they did not like to get involved with "Them lot out there" referencing people that lived at the service.

As people were not always treated with dignity and respect this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were times where staff did not treat people in a caring way. During the morning people sat in their chairs in the lounge with little interaction from staff (as they were busy) apart from to offer them a drink. One senior member of staff came into the lounge and started to replace light bulbs. At no time did we see this member of staff acknowledge people; they carried on their duties without engaging or speaking. On another occasion a person started to cough when they were having their drink and the provider just reminded the person to carry on drinking.

There was no evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. There was a lack of information on how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference for a male or female carer. People rooms were not always personalised with personal items so that they were surrounded by things that were familiar to them. Each room was sparsely decorated and rooms were not individual to the people who lived there. We noted the service operated a rota for bathing particular people on particular days. This was not consistent with a person centred approach to care. We asked staff what they understood by the term

'person centred care'. One staff member told us, "We decide what care people need".

Relatives and friends were encouraged to visit and maintain relationships with people but there were restrictions on when they were able to visit. One relative told us that they were not allowed to visit before 9.30, during lunch or later in the evening however they did add that they did not have a concern with this.

We recommend that visiting times are reviewed so they suit families and people rather than routines in the service.

Relatives felt that staff were caring to their family members. One told us "The staff know how to care. Staff communicate with her. Staff are friendly and genuinely care for residents." One social care professional told us that staff were caring with people.

Some individual staff showed kindness and care when talking with people. We observed some good interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between some staff and people. One member of staff took time to talk to people and listen patiently for their responses. If people looked confused when walking around the service staff would reassure them and encourage them into the lounge to sit with people. Despite the time pressures some staff were seen to be interacting with people and enquiring as to how they were. One member of staff was seen to gently kiss a person on the forehead and reassure them when they were being supported to move. Another member of staff was seen asking people what they enjoyed doing.

Inadequate

Is the service responsive?

Our findings

There was a risk that staff would not be able to respond appropriately to meet people's needs. This is because they did not have the most up to date and appropriate information available to them when caring for people. Where a need had been identified there was not always guidance or a detailed care plan for staff to follow. We were told by staff that no one at the service had been diagnosed with epilepsy. In one care plan we saw evidence of one person having epilepsy. There was a hospital discharge letter dated in August 2016 stating that the person had presented having had a seizure and the outcome was to continue with their medicine. There was no epilepsy care plan in place and nowhere was it written what types of seizures they had or how staff needed to support the person. There was no medical history for this person in the care plan. There were people that displayed particular challenging behaviour. There was no guidance in people's care plans on how staff needed to support people with this. One member of staff told us that they felt that one person's need could not be met at the service however there was no evidence in the care plan that supported this. One social care professional told us that one person's needs could not be met and that they were seeking an alternative placement for them. Again this was not clear from their care plan.

Pre-admission assessments were not always accurate (and at times absent) and were not effective as a way of identifying whether people's needs could be met at the service. One person had been at the service for two weeks. An assessment of their needs had not been carried out before they moved in and there was no care plan for the person. A pre-admission assessment was undertaken for another person however this stated that they were able to communicate and express their needs fully and assessed as needing help with their mobility. We saw that the person was able move around the service without assistance and lacked capacity to make decisions in their best interest. Each review of care undertaken by staff was not detailed and did not reflect people's changing needs. Where care plans stated that the person's specific preferences are respected and followed there was no information for staff on what these were. One member of staff told us that care plans were not up to date and did not reflect the needs that people had.

Care and treatment was not always planned for or provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we did see other care plans that were detailed around the guidance staff needed to provide care. For example, one person had developed a sore on their foot. There was an up to date wound care risk assessment and care plan in place, which contained detailed instructions concerning how the dressings should be cared for and staff were following this guidance.

At the previous inspection in July 2015 we had made recommendations that the provider reviewed individual hobbies and interests for people. On this inspection this had still not been addressed.

We asked people and relatives about activities. One person said, "There are no activities whatsoever. I like to do exercises, I always have. I think we all should but people here are just sitting about, staring at the walls." One relative said, "(The family member) is not as good as she was. She could have more outings."

There were not enough activities taking place to meet the needs of people. During the day we saw one activity taking place in the morning. Two members of staff were playing a game of skittles with two people. Most of the other people were not engaged in the activity and slept in their chairs. One member of staff said, "They (people) could do with more activities and maybe even going out. They (people) get so bored. They could do more in the garden and music could be put on." Another told us, "Activities needs sorting out." They told us that they wanted to see what people were interested in and we did see them go around to people ask them what their interests were. One person asked to do some drawing and staff supported them with this and another person was taken into the garden for a walk however no one else was asked if they wanted to go outside. A report from the Local Authority Quality Assurance Team was sent to the provider in March 2016 where it had highlighted the lack of activities for people however this had still not been addressed. The provider told us that they had been advertising for an activities coordinator (we were not provided evidence of this) and that activities were being undertaken by the care staff.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the provider's complaints policy and procedures, which were displayed in communal areas. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission and the Local Government Ombudsman. Despite there being a policy in place there was no evidence that people were aware of the complaints procedure. There was no evidence that people were spoken to about how they could make a complaint or encouraged to do so. One relative told us "I have complained about her wearing other people's clothes. They help themselves from the laundry baskets. They deal with it as much as they can." However this was not recorded as a complaint and there was no evidence to show this had been addressed. The relative said, "Sometimes it's easier for them to wait for me to deal with it." There was no record of any complaints being made at the service.

As complaints were not always responded to in an appropriate way this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in July 2015 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to how the service was managed and the quality monitoring processes that were undertaken. The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the provider had not made the required improvements to ensure the service was well led.

We asked people how staff involved them and their families with their care. One person said, "No, not at all. I hardly see the staff and I don't know who the manager is".

The service was not well led. The registered manager had recently left the service. There was a lack of leadership at the service which impacted on the care and treatment people received. The provider had failed to ensure that effective management systems were in place to assess, monitor and improve the quality of service people received. The provider told us that they relied upon the previous registered manager to make the necessary improvements but the provider had not taken steps to ensure that this was actually being done. After the inspection the provider told us that they were aware of the shortfalls in care at the service but had been prioritising care at another of the providers care locations.

We spoke with the provider about how the service was managed and what improvements had been made since the last inspection. We were told that all policies and care plans had been updated since the last inspection. We found that policies had been updated but staff were not following them and no one had oversight to check that staff understood and implemented the policies. The care plans had not significantly improved. The provider told us that they received a weekly report from the previous manager concerning people's care needs and that this was done in person or by phone. They said that they visited the service at least twice a week. However, the weekly reporting process had stopped in August 2016 as the previous registered manager had been on annual leave. The provider was unable to tell us what systems had been put in place since then. The provider told us that they were aware of shortfall in the care records but had not taken steps to address this.

The Health and Safety audit was examined in detail. It did not contain any meaningful information. For example, one entry under 'action required' simply stated 'washing machine'. Areas of concern identified during our visit, such as the state of the laundry area, the kitchen and the safety of stairs, were not included in the audit. We looked at audits undertaken by the provider to ensure the safe management of medicines. We noted no audits had been undertaken since June 2016. Those that had been done did not provide enough information to demonstrate safe management. For example, the audits we saw only concerned themselves with the quantity of medicines received and quantity dispensed. It did not examine any other areas, such as whether MAR charts were signed or whether storage and disposal procedures were fit for purpose. The staff member we spoke with told us they had been given the responsibility of auditing medicines without training or support from the provider.

The provider told us that had been aware that one member of staff had not been performing their duties as

expected however no action had been taken to address this with the member of staff.

We asked where incidents and accident reports were kept. We were told, at first, they were kept in people's care plans. We told the provider that this was not the case. We were subsequently told the responsibility for these had passed to a senior carer who had returned last week from four months' absence. They were now stored in a single file. We found when records were located that accidents and incidents were not properly recorded and no one had ensured that all measures had been taken to identify and mitigate risks or learn from incidents.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not effectively monitor what was happening in the service. 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 provider had not informed the CQC of significant events. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

During the inspection the provider was not open and transparent about the shortfalls at the service. They initially told us that they had met all of the previous breaches from the inspection in July 2015. It was not until we pointed out the areas of concerns that the provider told us that they were already aware of this. For example in relation to the cleanliness of the kitchens, the poor infection control and the lack of activities. The statement of purpose for the service stated that people would receive high quality care however we found that this was not the case. We asked the provider to send us an action plan of how they were going to address the shortfalls in care that we had identified. This has been provided to us and we will review the actions taken at our next inspection.

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 Appropriate notifications were not being sent to the CQC

The enforcement action we took:

We took action to remove the Providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always provided that met people's individual and most current needs.

The enforcement action we took:

We took action to remove the Providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the appropriate consent

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

	Care and treatment was not always being provided in a safe way.

The enforcement action we took:

We took action to remove the Providers registration.

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 People were not being protected from the risk of abuse and people were being deprived of their liberty unlawfully.

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a lack of choices around nutritious food and drink and people's weight was not always being monitored

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment was not maintained to a safe standard

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively

The enforcement action we took:

We took action to remove the Providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet the

needs of people and staff did not always receiving the appropriate training and supervision to undertake their role.

The enforcement action we took:

We took action to remove the Providers registration