Raymond House Care Homes Limited

Raymond House

Inspection report

7 - 9 Clifton Terrace
Southend on Sea
Essex
SS1 1DT
Tel: 01702 352956
Website: raymondhousecarehomesltd.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Raymond House provides accommodation and personal care for up to 39 older people. The inspection took place on 2 September 2015 and 3 September 2015. Some people living at Raymond House had care needs associated with living with dementia. At the time of our inspection 33 people were living at the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of

Summary of findings

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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered Managers, 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. At Raymond House the registered manager is also the owner/Registered Manager of the service.

At our last inspection in March 2015 the service had an overall rating of 'Requires Improvement' as the views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their families were not fully involved in planning and making decisions about their care. The service was found not to be responsive in identifying and meeting people's individual occupational needs.

At this inspection we found that the overall quality of the service had not improved and in some areas it had deteriorated further. The Registered Manager could not demonstrate the service was being run in the best interests of people living there.

Arrangements in place to keep the registered Manager up to date with what was happening in the service were not effective. As a result there was a lack of positive leadership and managerial oversight. Systems in place to identify and monitor the safety and quality of the service were ineffective as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

Staff did not have the skills and experience and they were not deployed effectively to meet the needs of people. We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.

Medicines were not stored safely and the Registered Manager could not demonstrate that people received their medication as and when they needed it and/or as it had been prescribed. In addition medication was not always stored safety to ensure its quality and integrity.

People enjoyed the meals but arrangements were not robust in terms of meetings all the people's individual nutritional needs. As a result the Registered Manager was unable to demonstrate that people had enough to eat and drink to support their overall health and wellbeing.

Although people told us that staff treated them with kindness and were caring, we found the way the service was provided was not consistently caring. Staff did not always demonstrate a caring attitude towards the people they supported and some failed to promote people's dignity or show respect to individuals. The majority of interactions by staff were routine and task orientated and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. This also meant they were socially isolated as opportunities provided for people to engage in social activities were limited.

Whilst we were concerned that some staff did not always recognise poor practice, suitable arrangements were in place to respond appropriately where an allegation of abuse had been made. There was a system in place to deal with people's comments and complaints however we found the service needed to be more open and transparent in their responses.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not always protected against the risks associated with medicines because the Registered Manager did not have appropriate arrangements in place to manage medicines safely.

Although staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were not robust. Individual risks had not always been assessed and identified. There were not always effective systems in place to reduce the risk and spread of infection.

The recruitment process was robust which helped make sure staff were safe to work with vulnerable people. The deployment of staff was not appropriate to meet the needs of people who used the service.

Inadequate

Is the service effective?
The service was not effective.

Arrangements in place were not always appropriate to meet people's individual nutritional needs. However, the dining experience for people was positive.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service. Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Improvements were required to ensure that staff recognised people's deteriorating healthcare needs and made sure that appropriate healthcare professionals were contacted at the earliest opportunity.

Inadequate

Is the service caring?
The service was not always caring.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved in the planning of their care.

People were not always treated with dignity and respect.

Requires improvement

Is the service responsive?
The service was not responsive to people's needs.

Inadequate

Summary of findings

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs.

Effective arrangements were in place for the management of complaints.

Is the service well-led?

Inadequate 

The service was not well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified

the areas of concern found during our inspection and there were no plans in place to address them.

Raymond 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 Registered Manager 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 the 2 and 3 September 2015 and was unannounced. The inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the Registered Manager completed a Registered Manager Information Return (PIR). This is a form that asks the Registered Manager to give some key information about the service, what the service does well and what improvements they plan to make. We also reviewed other information that we hold about the service such as notifications, these are the events happening in the service that the Registered Manager is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with 15 people who used the service, four relatives and nine members of care and support staff, the registered manager who was also the owner of the service and the Registered Manager's operations manager. We spoke with one social work professional who was supporting people who lived in the service.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met.

We spent time observing care in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of this inspection we reviewed 12 people's care records. We looked at the recruitment and support records for three members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring and audit information and maintenance records.

Inadequate

Is the service safe?

Our findings

At our last inspection we had concerns about the amount of staff available to meet people's needs. At this inspection we found that improvements had not taken place and people remained at risk because of inadequate staffing levels.

There was not enough skilled staff to keep people safe and meet their needs at all times. Our observations over a 90 minute period at night showed that although there were three members of staff on duty, four people became anxious and distressed as they wished to go to bed but no staff were available when they were needed.

One person was seen to keep rubbing their forehead, had their eyes shut and rocked to and fro in their chair. They said, "Oh, I want to go to bed" and, "I just want to go to bed now. Are you going to take me? There must be someone who can take me upstairs-there must be." They told us, "If I knew my room and where it is, I'd go myself. Do you know where my room is?" However, they were repeatedly told by a senior member of staff that they would have to wait five or 10 minutes. On one occasion the person stated, "I don't like your five minutes." Another person who had also expressed a wish to go to bed and was waiting to be taken by staff told us, "They [staff] eventually listen but you have to wait so long. They [staff] just look at you and then you're none the wiser." We brought this to the attention of the night staff that were present at the time of our inspection.

Where people required close monitoring due to high risk of falls or becoming anxious and distressed towards other people, there was not always a member of staff to monitor or support people. One person informed us, "There is only three staff on duty at night." They went on to say, if a member of staff was busy attending to another's care needs it only left two staff members to support everyone else. One relative told us, "There are times when it's obvious they're [the service] running short of staff, especially at weekends, and also at a bank holiday." Some people said that staff were not always timely in responding to emergency bells.

We saw that two people repeatedly tried to stand and leave the communal lounge so as to take themselves to bed. Both people were unsteady on their feet and there were no staff available to provide support with their mobility needs. When we looked at their care plans we found that they were at high risk of falls.

One person told us, "It's good here but the staff seem to be rushed off their feet. This is because there are not enough of them working to support all of us." Another person told us that they sometimes had to wait for their call bell to be answered by staff. They told us that this could range from a few minutes to 10 or 15 minutes. Our observations showed that the deployment of staff throughout the day was not always appropriate to meet people's needs.

Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others told us that staffing levels were inadequate to meet people's needs and that this could be stressful. One member of staff told us, "There is not enough staff here and we have to rush things. I am concerned that the quality of care has dropped." Another member of staff told us, "There is definitely not enough staff, particularly at night." Staff told us that the impact of this was that people could not always go to bed at the time of their choosing and/or preference. We had concerns about how staff viewed there role and whilst some recognised the importance of interaction others were task orientated so their views may also be a concern.

The registered manager was unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required. Although people's level of dependency was assessed and recorded each month, there was no systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances.

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

Appropriate measures were not in place to ensure the safety of people using the service. We observed that two fire exit doors were not linked to the service's alarm system. We opened a fire exit, and waited for 10 minutes to see if staff would be alerted and respond accordingly; however none responded and were unaware of our actions. Given

Inadequate

Is the service safe?

that the service provides care for people who are frail and in some cases also live with dementia there was a significant risk of people accessing the fire escape, car park and exiting the service without staff's knowledge.

We discussed this with the Registered Manager and they gave us an assurance that although not alarmed during the day, the fire exit was alarmed at night. However, on the second day of the inspection at 8.45 pm we found the fire exit door was still not alarmed. We shared our concerns with the Registered Manager in writing and alerted the local authority to our concerns to this matter as they have responsibility for safeguarding people who using the service.

Registered Manager had requested an external company complete a fire alarm inspection in July 2015. This recommended that a number of fire detectors required replacing and one emergency light had failed the inspection. No information was available to indicate if the works had been completed or an action plan had been devised as to the actions to be taken.

In addition, the Registered Manager had requested that an external company undertake an asbestos survey in November 2014. The report made a number of recommendations but no information was available to indicate if the works had been completed or an action plan had been devised as to the actions to be taken.

On two occasions, inspectors were given access to the premises by staff and tenants living above the home without being questioned as to whom they were and their identification being checked.

Adequate measures for review and governance of the safety of the service were not in place to address to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

These failings were a breach of Regulation 17 of the health and Social care Act 2008 (Regulated Activities) Regulation 2014.

We found the risk to people was not well managed and staff did not have the skills or competence to deal with the situations safely. One person who used the service was pushing another person in their wheelchair. We had to intervene as the person sitting in the wheelchair caught their foot underneath the wheelchair. Although the person did not injure themselves on this occasion, staff present during this incident took no immediate action to ensure the person's safety. Staff told us that they did not intervened because that the person pushing the wheelchair could become distressed and harmful to staff and others living at the service.

Appropriate arrangements were not in place to manage risks to people's safety. Information relating to the specific nature of the risk to the person and the steps to be taken by staff to alleviate the risk were not robust or recorded. In most cases the information was generic with only a change of name of the person who used the service without relating to their personal circumstances or identified needs. In addition, where there had been changes to a person's health and wellbeing, the risk had not always been reviewed and updated. Information was contradictory and conflicting, for example, one person's pressure ulcer risk assessment recorded that they were at 'very high risk' of developing pressure ulcers. However the person's care plan relating to skin integrity recorded them at low risk.

We found that the arrangements for the management of medicines were not safe.

We found a number of discrepancies with the records. For example, unexplained gaps on the Medication Administration Record (MAR) forms for five people giving no indication of whether they had received their medicines or not, and if not, the reason why was not recorded. Not everyone had received their medication as it had been prescribed. One person did not receiving their medication used for the management of chronic pain until one day later than they should have. The person told us that they experienced pain on occasions and their care records confirmed this. No explanation was recorded as to why the medication had not been administered as per the prescription on the day required. Where people had not received their medication due to them being 'asleep', there was no information available to show that this had been discussed with the person's GP so staff knew what to do in these circumstances, for example considering if their medication could be given earlier and before they went to bed.

A MAR record for one person was not accurately completed and suggested that they had been administered more medication than prescribed. No rationale was provided by the management team as to the discrepancy. PRN 'as required' medication protocols were not in place for the majority of people A relative informed us that they had

Inadequate

Is the service safe?

approached the service and informed them that their relatives medication was not being correctly administered, despite regular conversations with the team leaders. We found that the information they had provided to the service had not been followed up with healthcare professionals as requested by the family and as a result their relative was admitted into hospital.

Staff involved in the administration of medication had received appropriate training but there was no evidence to show that they had had their competency assessed at regular intervals. Medication audits were completed twice monthly but were not robust enough and had not picked up the shortfalls identified at this inspection.

Despite the air conditioning unit not working properly, the temperature of the area where medicines were stored had been recorded over four month period and the temperature in the records were identical on every single day with no variations despite changes in the weather over this period. The temperature of the dedicated fridge used to keep medication cold was monitored and recorded each day. The temperature recorded each day over a two month period was identical with no variations and was below recommended guidelines. This indicated that the temperatures were not being monitored appropriately and only duplicated from one day to the next. This meant that there was a risk that people's medication was not always kept in a way which maintained its quality and effectiveness.

A cleaning cupboard which contained dangerous chemicals and was accessible to people who used the service. Given the vulnerability of many of the people, due to dementia or other needs, this posed a health and safety risk to their safety. In addition to this we had concerns about the cleanliness of the service including how infection control issues were managed. For example, a chair and pressure cushion for one person was soaked in urine and discharging a strong smell of urine. Several people's bedding was stained and required replacing. Hairbrush and hair curlers found in the hairdressing room were observed to be entangled and intertwined with hair.

All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff were able to demonstrate a good understanding and awareness of what they should do if they suspected that a person was at risk of abuse or harm. They had received appropriate safeguarding training and records confirmed this. Staff told us, "If I am worried about people living in the service I would speak to the team leader straight away."

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Inadequate

Is the service effective?

Our findings

At the last inspection we noted that most staff had received training to carry out they role and although staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, this was not embedded in their everyday practice.

Staff told us that the majority of the training provided was through e-learning or watching a video and staff did not feel that this was an appropriate method to aid their knowledge, understanding in their role or test their competency.

On the first day of our inspection we observed three members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. The person grimaced, started to shake, looked to be uncomfortable whilst this was being carried out and requested that staff stop what they were doing. Although records showed that each member of staff had received manual handling training, this showed that staff did not know how to apply their training and provide safe and effective care to the people they supported.

Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of understanding and application of the learning from training provided. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives; for example, some staff did not communicate effectively with individual people or provide positive interactions. One person asked for support and staff were dismissive and walked out of the room without responding to the person. The training did not equip staff to communicate effectively with people living with dementia or had communication difficulties.

Several medication errors also showed that although staff had received training in the management of medication, this training had not been effective or tested to ensure its ongoing impact and demonstrate staff had the appropriate level of skill in this task.

Staff informed us that when they commenced employment they went through an induction programme, had ongoing training, one to one support, team meetings and daily handovers. The majority of staff had not received regular supervision in the last 12 months. Staff confirmed that there was not enough time in the day for formal supervision to be undertaken. In addition, staff did not see the value of supervision as issues raised in previous supervisions had not been addressed or dealt with. This included issues relating to staff practices, relationships and communication, for example, completion of tasks and responsibilities between staff on different shifts.

These failings were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) is legislation which protects people when they are, at times or in specific circumstances unable to make decisions about their care. This helps to ensure that decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and they ensure where someone may have their freedom restricted, the least restrictive option is taken. The registered manager in place had a good knowledge and understanding of DoLS and had recently made applications to the Local Authority for their consideration and authorisation.

Information relating to people's ability to make decisions, or the decisions that they may need help with was not clearly recorded. For example two people had been assessed as lacking capacity in their daily lives. This was inaccurate as we found that both people were able to make some decisions and choices about their care, such as, what clothes they liked to wear, where they would like to eat their meal, choice of food, the time they got up in the morning and the time they retired to bed and how they liked to spend the rest of their day.

One person was receiving their medication covertly. Consent to administer their medication covertly had not been agreed in their best interest by the appropriate people involved in their lives or other professionals, for example, pharmacist and GP. Staff confirmed they had been covertly administering the person's medication without their consent or a best interest decision being in place.

Inadequate

Is the service effective?

The Registered Manager could not demonstrate if they had consulted people or their relatives as to what food and drink they would like to have or how it was prepared. Some people needed a specific diet linked to their religious belief. Whilst this was respected there was also no other choice available which meant everyone had the same meals. In addition the Registered Manager had not considered how to proactively support people to make choices about food and drink. For example there were no visual aids or other ideas to encourage people to make independent choices.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always being supported effectively when they required additional support with their nutritional and hydration needs. The service had not always sought additional support in relation to people's nutrition or fluid intake from other professionals, such as, the person's doctor or community nursing services. The service had recently appointed one of the senior care staff as a nutritional lead who was responsible for monitoring people's food and fluid intake, however the member of staff was still not clear on what the role involved and had not been trained in this specific area and this staff member being appointed to aid the monitoring of this part of people's care we found that food and fluid charts had not been completed effectively and were not accurate. The staff member was unable to explain how people were being monitored effectively to ensure they were not, or did not develop risk of malnutrition and dehydration.

The majority of people enjoyed the food provided at the service and made positive comments. One person told us, "I am not much of an eater, but the food here is good." Another person told us, "The lunch today was very nice." A visitor said there were always drinks and food available. At lunch time we observed staff with two people who needed support with eating. They did this is a respectful manner and made conversation with the person and engaged in social conversation with the other people around the table.

In general people had received effective support to care for their healthcare needs from the GP, District nurse and end of life care team who visited people requiring support on a regular basis, however, for those people living with dementia, the service had not sought support from the local dementia service or CPN (Community Psychiatric Nurse). Records highlighted that for some people additional support was required to manage their emotional wellbeing and anxieties. However, no external support had been sought and best practice guidelines were not readily available or being followed.

Improvements were required in the way the premises was maintained to meet people's individual needs met by the adaptation, design and decoration of the service. The premises was tired and worn and in need of redecoration and refurbishment throughout, for example, there were missing handles on drawers and wardrobes and some wardrobes did not close properly and could not be locked. Within the main lounge on the ground floor a number of comfortable chairs were noted to be dirty with food and drink stains.

Little thought had been put in place by the Registered Manager to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast and lighting was poor. There was limited signage available to help people to orientate themselves, for example, the names of previous people who no longer lived at the service were still in place on people's doors. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were very few memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

Requires improvement

Is the service caring?

Our findings

Some staff provided care that was intuitive and positive. However, others did not always display kindness and respect when supporting people and staff practices were poor at times. One member of staff talked about people as if they were not present instructing other staff that, "She needs a zimmer frame" and, "Ask him whether he wants to come to the dining room" and did not refer to people by name. One person told us that staff did not listen to them or seem to care. When asked why this was the case, the person informed us, "I have asked staff to stop using one particular piece of equipment to transfer me however they continue to use it and this causes me a great deal of pain." We shared our concerns with the registered manager after the inspection.

The Registered Manager's arrangements did not ensure that people's privacy and dignity was maintained Three toilet doors on the ground floor could not be locked to maintain people's privacy and dignity as they were electronically controlled and could be operated by anyone.

Staff did not support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people, at times, had to wait long periods before being supported and people were not being engaged and staff did not always spend time speaking with people or acknowledging them as individuals.

The Registered Manager informed us that due to an agreed contract during purchase of the service, they were only able to serve Kosher foods from their kitchens and people were not given any choices regarding whether they had Kosher meals. A further previously agreed arrangement meant that the communal dining room was being used for outside religious worship on a regular basis and there was no evidence that the Registered Manager had attempted to gain people's views about the continued use of their communal areas.

We found advocacy information displayed within the service. An advocate provides support and advice to people and is there to represent people's interests. However, when we spoke to people and relatives about who they would turn to should they need external support they had very little knowledge of who they would speak to.

Inadequate

Is the service responsive?

Our findings

At our last inspection we had concerns about person centred care and people's involvement in their care delivery and activities. At this inspection we found that improvements had not been made. People were not being supported as individuals and their individual social interests and well-being was not proactively considered or catered for?

Some records provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to individual needs.

Whilst others did not. For example where people were diagnosed with diabetes, the care plan did not contain sufficient information to guide staff on how to support the person to manage the condition. There was no information on how each person was effected or symptoms to look for if their blood sugars should become too low or too high. There were no instructions as when or if blood sugar checks should be made. The care records for one person showed that it was only when they attended the diabetic clinic that their blood sugars were found to be very high. This meant the Registered Manager had missed an opportunity to avoid this potential risk to the individual's health and wellbeing.

Staff told us that there were some people who could become anxious and distressed. The care plans did not provide sufficient information detailing people's reasons for becoming anxious and the steps staff should take to reassure them so as to ensure positive outcomes. Staff demonstrated only a basic understanding and awareness of how to support people during these times. Although specific incidents had been recorded where people could become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes. Staff had shared experiences where people had become frustrated and we witnessed an occasion where a person was at risk but staff failed to intervene because they were concerned about how the person would react. There was no support or guidance in place to support them to deescalate situations where people became angry or upset.

Records also lacked details about how people's dementia affected their day-to-day living and how they were to be supported by staff. They did not include detail about people's strengths, abilities and aspirations.

In addition, where people were at risk of developing pressure ulcers, appropriate arrangements were not in place to ensure that people were having their body repositioned at regular intervals in line with their care needs or that pressure relieving equipment was fixed at the correct setting. The care records for several people showed that they should have their body repositioned every two hours so as to relieve pressure on key areas of their body. However, repositioning charts showed that this was not always happening as frequently as they should and people remained in the same position for long periods of time. The records for one person indicated that they had remained placed on their back for up to 13 hours. This was not an isolated case.

The provider did not have adequate systems or processes in place to ensure that records relating to people's care were accurately maintained and complete, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided.

We found that some people had been involved the initial discussions and decisions about their care and any potential risks associated with their care needs, but this was not everyone's experience. One relative said, "I saw the care plans and I signed them. I was pleased with the care plans. I had the chance to talk to them about them." Another relative said that they had been heavily involved in their parents' care plan when they first arrived at the service and that they had had the opportunity to talk it through with staff and their relatives. They said, "I got given the plan to look at a couple of months ago." However, another relative informed us, "My relative has been here for a few months now and we have had to write a list for the service to aid them to meet our relative's needs however the service has not taken any of the information and we are still waiting to sit with the manager so they can go through the care plan." One person said, "I have never seen it neither have I signed it."

These failings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

A member of staff told us that the Registered Manager used to employ two people responsible for activities that shared the responsibility over a five day period. However, they confirmed that one person had recently left and this now meant that social activities were only provided twice a week. Another member of staff told us, "We no longer plan activities, as people don't want to do them." Staff advised that sometimes people used to go out shopping with staff on a one-to-one basis, however this has stopped. One person told us, "We used to have outings and other activities and it was good. Nothing happens now." Another person told us, "There is not a lot going on here. We sit here and if you are lucky staff come and talk to you."

There was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies. There were no opportunities for social engagement or activities for people on the first day of inspection. On the second day, staff informed us that activities had been planned however they were unable to tell us what these were and when these would take place. In addition people were not made aware of the planned activities. Activities we were told about did not linked to people's past hobbies or interests but involved 'everyday tasks' such as assisting staff to lay the table, help with laundry or dusting. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and 'life story work' was used to help trigger memories or enable people the opportunity to independently entertain themselves. This meant that people were not encouraged to keep active or to stay involved in their surroundings. Records confirmed our observations, for example, the activity log for one person showed that they had not participated in any social activities since 24 May 2015. This was not an isolated case.

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

Relatives told us that if they had a concern they would discuss these with the management team or staff on duty. Relatives confirmed that they felt able to talk freely to staff about any concerns or complaints and were assured that if required these would be effectively dealt with.

The Registered Manager had a complaints policy and procedure in place but no complaints log to provide clear monitoring or identify themes or trends which could assist in improving people's experience overall. Records showed that there had been five complaints since our last inspection in March 2015. However, the information recorded did not evidence openness and transparency or provide an opportunity for the Registered Manager and the complainant to establish a positive relationship and develop an understanding of the complainants concerns and needs. No outcomes were recorded and there was no evidence to assume that the complainant was happy with the outcome of the investigation.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Prior to the inspection stakeholders including the Local Authority shared with us their concerns which included poor care outcomes for people, medication management issues, poor maintenance of the building, a lack of meaningful activities for people and the Registered Manager's lack of response to issues raised to improve care for people which had been raised by the Local Authority earlier in the year. During our inspection we found that the Registered Manager had not addressed the majority of the identified concerns raised by the Local Authority and this was reflective in our evidence of this inspection. The Registered Manager acknowledged there were several areas within the home that needed improving and they told us with the recent action plan and input from the Local Authority the service should improve in the near future.

Although there was a system in place to monitor and provide numerical information relating to the incidence of complaints, accidents and incidents and pressure ulcers, no other arrangements were in place to assess and monitor the quality of the service provided. The Operations Manager informed us that this was due to the home being in the process of changing documentation and they used to carry out checks and monitor areas of improvement; however we found that in most cases no audits had been completed since the month of July 2015.

The Registered Manager did not have effective quality assurance systems to assess, monitor and improve the quality and safety of the services provided. Our identified concerns about people's safety, safe staffing arrangements, and people's activities of daily living, staff practice and suitability and competence and general cleanliness of the service had not been identified or addressed. The Registered Manager was unable to mitigate the risks relating to the health, safety and welfare of people and others who may be at risk because of the lack of quality monitoring and they failed to maintain accurate, complete and contemporaneous records in respect of each person's care and treatment.

During our inspection we spoke to the Operations Manager about the day to day running of the home. They had little insight into the service or how it was run and often referred us to the a supporting manager who had been deployed from a 'sister' home due to a number of concerns that had been raised by the Local authority.

There was a lack of managerial oversight and leadership within the service as a whole. The service had a registered manager in post however the registered Manager told us that oversight of the of the service had been primarily delegated to an Operations Manager, Deputy Manager and Care Team Manager who were responsible for looking after the service and keeping the registered manager up-dated of the day-to-day management of the service. The Deputy Manager was unclear about their role. Staff did not know what the aims and objectives were for the service and as a result this led to a poor culture, were best practice was not promoted or in some cases not recognised. There were no staff meetings and there was a general lack of supervision to support staff and ensure they understood the ethos of the service and what was expected from them.

Although some relatives we spoke informed us that they found the service to be well run upon asking, they identified the operations manager as the registered manager which is not the case. One relative said, "From a relative's point of view, I find the management team very approachable." People informed us that they were unsure of who the manager was. Staff views on who was responsible for the day-to-day management of the service varied. Some staff appeared to know who the registered manager was, whilst others told us that there had been a number of changes in the last few months and they were unsure as who they reported to should there be an issue that requires management to resolve these. Staff told us that communication between staff and management was not effective and that support from the management team was not very good and not consistent.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that risks were not fully assessed for the health and safety of people who used the service and the environmental risks had not been updated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing Staff training provided did not equip staff with the knowledge and skills to support people safely. There was no evidence staff knowledge and implementation was checked following completion of specific training courses. Staff did not have the opportunity to attend supervisions or annual appraisal meetings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Need for consent The care plans we looked at did not contain appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Safety and Suitability of Premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance The registered person did not have effective systems in place to monitor the quality of service delivery.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment Regulation 12(2)(g) We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance The registered person did not have effective systems in place to monitor the quality of service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Safety and Suitability of Premises.