Macari Homes Limited

Springfields Residential Home

Inspection report

Hengist Road
Westgate on Sea
Kent
CT8 8LP
Tel: 01843 831169

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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

Overall summary

This inspection took place on 11 and 12 March 2015 and was unannounced.

At our last inspection of 2 and 3 September 2014 we found breaches of seven regulations, most of these breaches had a major impact on the people at the home. We followed up these breaches at this inspection and found that most of the breaches continued and there were new breaches of other regulations.

The home provides accommodation and personal care to up to 20 older people. Bedrooms are on the ground floor and first floor, the first floor is accessed by a stair lift. There are communal lounges and a dining room. There were 14 people living at the home when we inspected.

There was no registered manager; there has been no registered manager since July 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found the home was not meeting the requirements of the Deprivation of Liberty Safeguards as the provider had not made the appropriate referrals. There were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice.

When people lacked the mental capacity to make decisions staff were not following the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

Potential risks to people were not recognised and assessed. Individual risk assessments were not in place to prevent or reduce the likelihood of harm. The provider had not assessed risks posed to people by the environment. There was a fire risk assessment that had not been reviewed, faulty fire equipment and a lack of fire training and practice drills. Some fire exits were locked and not all the staff had a key. There were environmental hazards including rucked and torn carpets that had not been assessed as safe.

The home was not clean and hygienic. Some bedrooms were dirty and smelled strongly of urine and had carpets that were sticky underfoot. The provider said that staff checked the bedrooms, but this was not recorded. Staff said they had not checked or had time to clean the bedrooms. A relative told us "(My relative's) room is filthy, the carpet is stained and it smells awful."

Staff knew what abuse was and said they would report to the manager. The manager did not understand her role in safeguarding and had not reported safeguarding concerns to the local authority or to the Care Quality Commission (CQC). People had suffered abuse.

There were usually enough staff on duty, there had been no cleaner for a while so care staff had to take on cleaning tasks. Recruitment checks were not thorough and not in line with the provider's recruitment policy. Medicines were not always given as prescribed.

Staff did not all have the skills and competencies needed to give safe, good quality care and support. Staff were not regularly supervised and had not had a yearly appraisal. The induction was not thorough and some staff had not completed it.

People did not have the support they needed to reduce the risk of malnutrition and dehydration. Staff did not always follow the instructions of doctors and nurses to support people's health needs.

Most of the staff were patient and kind but there had been occasions when staff were inconsiderate and disrespectful to people. People were not supported to be fully involved in their care and treatment. People's dignity was not always protected.

Care plans were not up to date. People's needs had changed but care plans had not been updated so staff were following out of date information. Care plans had not been reviewed and evaluated so staff could not be sure that the support they gave was right for the person.

People were not supported to take part in activities they enjoyed. Some people stayed in their rooms and had limited interactions with staff. Staff did not always follow the instructions of nurses and doctors to keep people well and healthy.

The complaints procedure was not meaningful to everyone, relatives told us they had made complaints but nothing had changed. A relative told us "There has been a tap dripping in (my relative's room) since before Christmas, we have told the staff and so has (our relative) but it hasn't been fixed."

The provider did not have an understanding of the key risks and challenges of the home. The provider had not carried out audits and checks to make sure the home was safe.

People and staff were not involved in developing and improving the service. Relatives told us that they did not have an opportunity to have their say. One relative said, "It's all about the fees. They go up but nothing gets done".

The provider had not assessed risks to people and did not monitor the quality of the service. The provider said they visited and carried out checks but this was not recorded so there were no actions recorded from these visits.

Summary of findings

The provider had not supported and supervised the staff team to make sure they displayed the right behaviours and values to people and to each other. The home was not well led and the staff lacked the direction and support they needed to provide safe care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took enforcement action and cancelled the provider's registration.

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?

Inadequate

The service was not safe.

People said they did not feel safe. There was a lack of fire procedures, staff had not had practice evacuations and the fire risk assessment had not been reviewed. People were not protected from harm if there was a fire or other emergency.

The provider and manager had limited knowledge about safeguarding procedures. They had not reported allegations of harm and abuse.

People said there were usually enough staff to meet their needs but the manager did not have a way to check this was the case. Recruitment checks were not thorough.

People did not always have their medicines as prescribed. Risks to people were not always recognised and assessed, leaving people at further risk.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the training and supervision needed to meet people's needs.

There were no arrangements in place to prevent people having unlawful restrictions placed on their liberty and freedom. Mental capacity assessments had not been completed. Decisions made on people's behalf were not always in their best interests.

People did not always have enough to eat and drink and had lost weight and were at risk of dehydration.

Staff did not always follow the instructions of nurses and doctors to keep people well and healthy.

Is the service caring?

Inadequate

The service was not always caring.

Staff did not always treat people with consideration and respect.

People were not involved in planning their care and did not have a say about their care.

People's dignity was not protected.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not up to date so staff did not have up to date information about people's needs. Care plans were not reviewed and evaluated to check that people were still receiving the right support.

The complaints procedure was not accessible to everyone. People's complaints were not listened to and resolved. People told us that they had made complaints but 'nothing had been done.'

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

People were not involved in developing and improving the service.

The provider had not assessed risks to people and did not monitor the quality of the service.

The provider had not supported and supervised the staff team to make sure they displayed the right behaviours and values to people and to each other.

Springfields Residential 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 was 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 11 and 12 March 2015 and was unannounced.

The inspection was conducted by an inspector and an inspection manager, an expert by experience and a specialist adviser. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We usually ask the provider to complete a provider Information return or PIR. Because we carried out this inspection at short notice we did not have a PIR.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority and safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with most people living at the home. We spoke with the provider, the manager and five staff. We spoke with four relatives or visitors; we had information from the local authority case managers, commissioning officers, visiting nurses and the safeguarding team.

We looked at records relating to three care staff, four care plans, audit and monitoring records, medication records, staff rota, policies and procedures and training records.

The last inspection was carried out on 2 and 3 September 2014 when we found breaches of seven regulations, most having a major impact on people at the home.

Inadequate

Is the service safe?

Our findings

People said they did not feel safe at the home. They said they felt at risk from some people's problem behaviour. A relative said they were concerned about their loved one's safety. They said "There is not enough staff, when it all kicks off the staff cannot cope." One person told us "It is run for the staff here, not for the residents." One person told us that they did not like their room and preferred to stay in the lounge. They said that they felt "Very bullied to go to my room because staff don't like me sleeping in the lounge."

Some people were at risk of harm and abuse. One person was sitting in their room throughout the first and second day of the inspection. They appeared to lack capacity and the provider confirmed the person had dementia. Their clothes were crumpled and stained and it appeared that their hair had not been brushed and they were unshaven. The carpet in their bedroom was very heavily stained and was sticky underfoot. The person could not get to their sink because a commode was in the way. They asked us to try to get to their sink, and we could not. Their toothbrush had hard dry toothpaste on it as if it had not been used. The commode bowl had dried heavy brown staining smeared around the bowl. The room smelled so strongly of urine that the inspector's eyes watered. The person spent most of the time in their room; there was no television or radio on. The wallpaper was torn and the radiator cover was broken. We pointed this out to the staff who said "We cleaned that carpet only two months ago." We took the provider to this room over two hours later and it was the same. The provider said that the staff were responsible for checking and cleaning rooms. We asked the manager if we could see the records of room checks. The manager said "It is pointless me showing you, I know they (staff) haven't done it." The last recorded check of bedrooms was 4 October 2014.

The provider's records showed that 10 out of 17 staff had not had training in how to safeguard people from abuse. The three staff on duty told us about different types of abuse and how they would report abuse. Staff said they would report concerns to the manager and knew who they could report to outside of the home. Staff had reported concerns of verbal abuse by staff twice to the manager. The manager had not reported these concerns to the safeguarding authority as she should have done. Instead, the manager investigated herself and interviewed the staff involved who denied parts of the allegation but admitted to others and carried on working at the home.

Two staff had raised concerns that some staff were 'nasty' and were 'bullies'. The manager said she had spoken with staff about this at a staff meeting. The manager could not find the record of this staff meeting. After these concerns were raised other staff raised concerns saying, 'I cannot cope with the nastiness, other staff are having a negative impact on how I feel'. There was no evidence of what the provider had done to address the concerns raised about some of the staff.

The provider had failed to protect people from possible harm and abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had not assessed the risks associated with fire. Providers must comply with the Regulatory Reform (Fire Safety) Order 2005. Under this order providers must provide people, staff and visitors with relevant information on the risks to them identified by the fire risk assessment, inform them about the measures the provider has taken to prevent fires, and how these measures will protect them if a fire breaks out. Providers must consult staff about fire precautions and protect people and visitors by providing information about fire procedures.

Providers are required to carry out a fire risk assessment, provide staff with training about what to do if there is a fire, hold practice evacuations and ensure safe fire detection and warning systems are in place. The fire risk assessment must be reviewed if there are any changes including a failure of any of the fire precautions including emergency lighting.

On the first day of our inspection the provider could not find the fire risk assessment. The provider found it on the second day we were there. The fire risk assessment was dated October 2009 and it had not been reviewed since then. A fault had been reported with two emergency lights in two corridors on 24 February 2015 as they were not working. The same fault was reported again on 5 March 2015. The fire risk assessment had not been reviewed following the report of the failure of the emergency lighting.

Inadequate

Is the service safe?

Some of the fire doors were ineffective. One fire door was propped open with a footstool and another was propped open with a book so if there was a fire these doors would not close as they should do. Other fire doors were held open by 'doorguards' which allowed the fire door to close if the fire alarm was activated. Some of these doorguards were beeping to indicate they needed new batteries to work properly. Staff said the maintenance man changed the batteries and he 'was on holiday this week.'

There had been an incident on 4 March 2015 when clothes were placed on a portable radiator creating 'smoke'. The manager said she was unaware of this incident. There were portable plug in radiators in many of the bedrooms. The provider had not assessed the risks posed by the use of the portable radiators. The fire risk assessment had not been reviewed following this incident.

Two fire drills had taken place in 2014, but this had only been for the staff on duty at the time so not all of the staff had been included. Two of the three staff on duty told us that they had never taken part in a practice evacuation. 12 out of 17 staff had not attended fire safety training according to the provider's records. Of the five staff that had attended the training, had not received any updates since August 2012. The manager said that she had booked fire training for June 2015.

There were personal emergency evacuation plans (PEEP's) for some people but not for everyone. The manager said "They (PEEP's) need updating as some people have passed on".

The front door was kept locked by a key. There was no other exit to the front of the building. The manager said that there were two keys to the front door, one held by the manager and the other held by the team leader. During the inspection staff came to the office to ask for the manager's key to the front door 'to let the nurse out' saying they 'could not find the team leader to get their key'. There was a spare key in a locked glass fronted box on the wall by the front door. Staff did not know where the key to this box was. The hammer that should be attached to the chain to break the glass was missing.

The provider had not assessed the risks to people from electrical installations and equipment. The Electricity at Work Regulations 1989 requires providers to check the safety of the electrical installations including the hard wiring of the service. The hard wiring should be checked in care homes every five years. The last check of the hard wiring was carried out on 7 September 2007 and was 'unsatisfactory' with a list 29 recommendations of 'urgent remedial work' needed. There was no further hard wire check and the provider could not provide evidence that the urgent work on the electrics had been carried out. The manager told us she thought the electrics were 'dodgy' as she had just purchased the fourth iron in a year because the 'irons keep shorting out.' Staff reported that when they turned the dining room lights on the power 'tripped'.

Some people were at risk of falling over. Several people used the first floor landing on leaving their bedrooms to use the stair lift to the ground floor. One person used a walking frame and walked across the landing with a shuffle to their gait. Parts of the landing were uneven. The carpet had dips and in places was rucked posing a trip hazard. The provider had not assessed the risks that this posed to people. The last environmental risk assessment was dated 2008 and did not cover all areas of the home. This risk assessment was difficult to read due to water damage. The manager had risk assessed the 'lounge' on 26 February 2015.

Risks were not always assessed and managed safely. There were records of incidents that had happened. These included situations between people, when one person was either physically and / or verbally abusive to another person. These incidents had not been reported to the appropriate authorities, there were no updated risk assessments or care plans about how to manage these situations or to reduce the risk of them happening again.

Staff used a hoist to move and transfer some people. We looked at the hoists. The last service had been carried out in May 2014 and the label stated that the next inspection was due in November 2014. There was no record that this had happened. The maintenance person told us that they checked the hoists; they said the last check they carried out was in July 2014.

There were two first aid kits for emergencies. One had two plasters in it. The other had opened bandages, so they were no longer sterile and out of date dressings.

The provider had failed to protect people from emergency situations that might arise. This was a breach of Regulation

Inadequate

Is the service safe?

9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On the first day of our inspection a person was in bed. When we walked past their room they were very upset and calling out for 'help' and said they wanted 'a drink'. Their call bell was out of reach and they told us that they didn't know where it was. One member of staff said this person could use their call bell, another member of staff said they couldn't and a third member of staff said that this person would not know what the call bell was for. There was no risk assessment and no guidance in the person's care plan to tell staff how often to check on the person and what support they needed to summon help. Staff told us that they would carry out two hourly checks at night, but could not tell us how often they checked on the person during the day if they stayed in bed. Staff told us that this person was 'often upset and needed more one to one support', but told us that they 'didn't have the time because there are other people to look after'.

People told us that they thought there was usually enough staff to meet their needs. People said there were occasions when the staff 'struggled' especially if there were incidents to deal with. There was no system being used to calculate how many staff were needed to meet people's assessed needs. The manager had not assessed and monitored the staffing levels to check the levels were suitable for people's needs.

The building had lots of rooms and corridors, some narrow and more than one staircase. There were occasions when staff were not present in communal areas and times when we could not find them. Staff said that they were 'kept busy' but said they thought there was enough staff. The provider said that staff followed a shift plan in an 'allocation book' so they knew what their duties were. Staff said that this was not the case, they said nothing was written down, they 'just did what they thought was needed.' The last shift plan record in the allocation book was dated 26 February 2015.

Recruitment procedures were not thorough and did not follow the provider's own recruitment policy. We checked the files of three staff who were on duty. There was no proof of the qualifications declared on application forms and they had not been checked and verified. One of the staff had only one written reference and not two, as required.

Gaps in employment had not been checked and some dates of employment did not tally with dates on employment references. This had not been questioned or checked. One staff member had been working unsupervised for a month before their criminal background check was received.

The home was not clean and some bedrooms and areas smelled of urine. A relative told us that they could not visit their loved one in their room because it 'smelled so bad'. Another relative told us "The rooms are disgusting." They said they had complained about it but nothing had changed. The manager said there had been a period of time without a cleaner. A cleaner was now in post but was 'off this week'.

Some carpets were very dirty and were sticky underfoot. Some surfaces were dusty and tables that people ate from were dirty. We found the same situation at our last inspection in September 2014. The provider told us that they would introduce new cleaning schedules. The provider showed us the new schedules; they were blank and had not been used yet.

The provider had failed to keep the home clean and free from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicine procedures were not safe. There was too much pain relief medicine in stock than there should have been suggesting a person did not have their pain relief medicine as prescribed. The manager said she had checked this and did not think the person had suffered any pain but could not be sure.

Staff were giving one person's prescribed medication to another person without the authority to do so. One person's medicine had run out and staff had used a tablet prescribed for another person instead. Staff were not sure whose tablet they had used although the manager assured us that they had asked for this tablet to be replaced.

A person had returned from hospital with two additional medicines. They had been given one medicine regularly, but had only received the other medicine for three of the six days since they had returned from hospital. No one

Inadequate

Is the service safe?

knew why this person hadn't been given their medicine for three days, no one had checked to see if there were any ill effects and no one had checked with the GP to make sure it was safe to stop giving this person their medicines.

There were gaps in the medicine administration record (MAR) charts with no explanations. Some people were recorded as not having their medicines, but no actions had been taken to check this would not cause any ill effects. No advice had been sought about why a person continually refused their medicines. Medicine records were disorganised and not readily available.

One person often refused to take their medicines. There was a letter from the GP stating that this person's medicines should be administered covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. One member of staff told us that it was 'usually the morning medicines' this person refused. They told us they didn't refuse often but when they did they said they crushed all the tablets and put them in this person's cereal. Crushing some medicines alters the way they work and can make them ineffective and staff should always ask for a pharmacist's advice before they crush any medicines. Staff had not asked for advice from a pharmacist and there was no guidance in the care plan about how to administer these medicines covertly and safely.

The provider had failed to protect people from the risk associated with medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service effective?

Our findings

Staff did not have the skills and competencies to meet people's needs safely. Visiting health and social care professionals told us that they had witnessed people being moved and handled in an unsafe way. One of the three staff on duty had not attended moving and handling training including a practical session in using a hoist. Moving and handling training had not been booked. The training plan for 2015 included 'moving and handling - date to be confirmed'. Staff had not been observed using moving equipment and signed off as competent in moving people by a qualified person. At least two people had to be moved with the help of the hoist. One person was hoisted from a wheelchair to an armchair in the lounge in front of several other people. The person's bottom and incontinence pad were exposed as staff hoisted them. Staff did not cover the person to protect their dignity.

Two staff we spoke with could tell us about different types of dementia. They told us how they supported people when they became upset or agitated. Staff gave a variety of accounts of how they supported people; this support was not written down in care plans leading to a risk of inconsistent support.

We looked at the induction of two staff members who joined the staff team in October and November 2014. They both had a Skills for Care workbook. Skills for Care is a recommended induction for care staff and has 8 'standards' for staff to complete. The manager said that staff completed the induction during their first 12 weeks of working at the home. The providers training policy said that staff completed their induction within 6 weeks of starting work at the home. One member of staff had started work at the home in early November 2014, standards 1-3 on their induction were signed by the manager as completed on 12 February 2015, over three months after they had started work. Standards 4-8 had not been completed, the staff member confirmed this. Another staff member had started work in October 2014; their induction booklet was signed across every page covering standards 1-6 by the manager 'competent in all these areas 28 October 2014'. Standards 7 and 8 were not signed as completed.

On each page of the induction booklet there were boxes to complete to show how competency in all areas was assessed including, by questioning, by observing or by answering written questions. These boxes were not completed on both booklets we checked. There was no record of how this staff member had been assessed as being competent. Standard 2 of the induction required staff to know about 'The aims and objectives' of the home. Standard 2.1 was 'Be aware of the Code of Practice'. We asked the staff about what this meant and they did not give us the right answers.

Staff should have regular one to one meetings or supervision with a more senior staff to talk about any issues, training needs and to gain support and coaching. The provider's policy was that staff had a supervision meeting at least six times a year and a yearly appraisal. The supervision plan for 2015 had six dates for each staff member. Four staff had more than six dates. We asked for the supervision records for the supervision meetings held in January and February 2015. The manager said that some of the meetings had not happened. The manager said "I plan it, they don't remind me and so it doesn't happen." We checked the records of three staff on duty. None of the three staff members had one to one supervision meetings in line with the provider's policy. One staff member had two supervision meetings in five months, a second member of staff had five meetings in 18 months, and the third staff member had one supervision meeting in five months. The manager said that no staff member had had an appraisal in the 14 months that the manager had been at the home. The manager could not find any previous appraisal records. The manager had not had a yearly appraisal and had been in post for 14 months.

The provider had failed to ensure that staff were suitably trained and supervised. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Communication between staff was not good. Staff were not always aware if a person's needs had changed as they were not told. Sometimes the manager said that staff were told but did not write things down. The manager said that she had told staff to complete records but they had not always done so. Visiting nurses told us they gave directions to staff and found the next time they visited, the directions had not been followed.

The provider did not have a system to assess people's ability to make specific decisions where it had been identified that they may lack capacity. In three of the care

plans there was a mental capacity assessment. The mental capacity assessments stated that people were confused. There was no decision specific assessment as stated in the Mental Capacity Act code of practice. One person was refusing personal care, but their capacity to be able to make this decision had not been assessed. There was no information in the care plan about how to help this person with their personal care. The manager told us that there was a 'Lasting Power of Attorney' in place for one person, but there was no information about how this affected the care and support provided to this person.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services 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.

Staff had taken a person out for a walk and they had refused to come back. Staff had to ask the manager to help them persuade the person to return to the home. Staff said that person was no longer going out for walks because staff felt this was too much of a risk. There had been two further incidents in November 2014 and January 2015 when the person had tried to leave the building. The last two reviews of the person's care plan said that 'they asked to open the front door to go out'. There was no risk assessment and no care plan that told staff how to support the person. The manager said that they had contacted the DoLS office in November 2014 and started to make a DoLS application in January 2015, but this had not been completed. The person continued to ask to go out and was prevented from doing so.

Another person had tried to leave the home by the front door saying they wanted to go out. There was no mental capacity assessment for this person and no DoLS application had been made even though his liberty was being restricted. There were no DoLS checklists in place for anyone using the service, so staff could not be assured that people's liberties were being restricted lawfully.

The provider had failed to assess and act in accordance with people's consent and had adhered to the Mental Capacity Act 2005. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Menus covering four weeks were framed and displayed in a small room that led to the kitchen. The menus were written and the frames were positioned so you had to stand to be able to read them. The written menus were not accessible to everyone. We asked the cook which menu was being used that week. The cook said "We don't go by them. Because we are small I just give people choices each day."

Some people were at risk of dehydration if they did not drink enough. We spoke with one person who was at risk of dehydration and staff were recording how much they drank. The person had a drink nearby but needed support to drink. Staff were recording how much the person drank but were not adding it up each day to make sure that it was enough. There was no record to say how much the person needed to drink each day.

One person had been assessed as a low risk of losing weight. The weight records for this person showed they had lost five kilograms in two months so the risk had increased. The provider had not updated the person's care plan or risk assessment following this change. The provider had not taken steps to refer this person to a dietician to see why their weight was decreasing. One person had not been weighed for three months so staff would not know if this person's weight had changed.

Some people had diabetes. Staff told us that there was no one who had special dietary needs as people's diabetes was controlled by tablets. One person's care plan said that they had a 'sweet tooth'. There was no guidance about how to support this person to maintain a healthy diet and to enjoy sweet treats safely. The care plan for another person said that they were prescribed an additional supplement to be offered when they did not have much of an appetite. Staff said that there were none of these food supplements in stock so they had not been giving them to the person. Some staff did not know that they should offer these prescribed supplements.

One person did not enjoy their meal. They had the chicken casserole and when they looked at their meal they said "There isn't much chicken in here it is all vegetables". They did not eat all of their meal. Other people told us they enjoyed the meals. One person said, "Lunch was very nice today" and another said "There is usually something I enjoy". One person wanted an early evening snack and a member of staff made them cheese and biscuits which they had with a small glass of wine.

Inadequate

Is the service effective?

Visiting health professionals told us that they had concerns about staff not recognising people's health needs. They said that they were worried that staff did not recognise and act on deteriorating health needs. Healthcare professionals such as G.P.'s and district nurses were contacted by staff if there were any concerns about people's health. Advice given by nurses and doctors was not always acted on quickly. Staff had contacted the GP about one person, who advised that this person needed to be checked out with the mental health team at their next appointment. There was no date for that appointment or check.

The district nurses had asked for one person to stay in bed until they had visited as they wanted to check a red mark on their skin. Staff had not handed this over to the next shift and the person was not in bed when the nurse arrived. They refused to go back to their room so the district nurses could not check their skin. This person had to wait until the next day which resulted in a delay to any potential treatment needed.

There were body maps in place that recorded any marks or bruises. We asked staff about two people who had been recorded as having red marks on their skin. Staff could not tell us if these had improved or not. Staff did not know that one person had red marks on their heels. Body maps were not updated to show if a person's skin had improved or deteriorated so staff could make sure that people were getting the right support. The relative of one person whose continence needs were not being managed told us they 'Get really sore on their bottom'. The person's care plan had no plan to reduce this soreness.

One person was cared for in bed and needed to be turned regularly to maintain healthy skin. The turn charts were not consistently completed. This person had a deep pressure sore and needed to stay in bed. Although there had not been any further deterioration to this pressure sore, without being turned regularly, the person was at risk of developing more pressure areas.

Some corridors were narrow and had tight corners. Visiting health professionals told us that staff were unable to get the hoist around corners to get to three bedrooms and the manager confirmed this. If the occupant of one of these bedrooms fell over and needed to be hoisted to their feet the manager said that they would have to dismantle the hoist to get it into any of these three bedrooms and then reassemble it. People who were at risk of falls had occupied these bedrooms recently.

The provider had failed to assess, plan and deliver care to meet individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service caring?

Our findings

Most people said good things about the staff although one person said "I am not happy here, it is not run for the residents, it is run for the staff." Other people told us that they thought the staff were kind and tried their best.

Staff did not always treat people with respect. Staff told us about one person who called out and sometimes screamed out. Staff were disrespectful when they said 'We call this one the 'ghost train' because of the way they scream."

Staff helped a person in the lounge area to move from their wheelchair to the chair. The staff used a hoist. As the staff hoisted the person, the person's trousers slipped. A member of staff said "Oh their bum is showing". A wet incontinence pad could be seen. Neither member of staff attempted to protect this person's dignity by shielding them from other people's view.

The manager showed us around the home. When the manager entered several rooms she did not knock on the doors before entering, she just walked in. One person was stood up and the manager felt this person's trousers and said "I am just checking you are not wet". This was carried out in front of the inspector and without the person's permission.

People were not always supported to maintain their dignity with regard to their personal care. One person was wearing trousers which were stained and wet. Other people had not had a shave. We noticed that four people in the lounge were sitting in wet clothes. We alerted staff to this and they took people to the toilet.

Care plans had very little information about people's likes, dislikes and personal preferences. None of the care plans had any information about people's life histories. This information was important because it helped staff to understand the backgrounds of the people they were supporting.

Some people told us that they did not need help from staff to dress. They told us that staff respected this and only helped them if they requested assistance. We observed that staff spoke kindly to people and gave them the time they needed to respond. Some staff were considerate towards people and helped them to find things they needed. One person wanted their earrings and staff went and got them.

There were no restrictions on visitors and they could visit at reasonable times. Relatives told us they could visit whenever they wanted and were always made welcome. People said that they often had visitors and could meet with people in private when they wanted to.

People were not involved in planning their care. Most of the care plans we looked at were not up to date, people had not been involved in updating their care plans even though their needs had changed. There was little opportunity for people to influence their care and support and to make any changes. Staff did not all have the skills or the time to talk to people to gain their views and opinions. The provider said she spoke with people occasionally but did not record this so there was no action to improve the service based on people's views.

Some people reported that their clothes were not looked after and they often did not get the right clothes back from the laundry. One person said "I often get the wrong clothes, even though names have been put in them. They think I don't notice because I'm blind." A relative told us that they had complained about clothing being lost. Other people and visitors told us that the wrong clothes had been returned to them. One person said "I haven't had some of my clothes back at all. I don't know how they get muddled". At our last inspection net underwear was being shared and not allocated to specific people. Staff told us that this was still happening.

The provider had failed to treat people with consideration and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service responsive?

Our findings

People did not know about their care plans. A visitor said that their relative did have an assessment before they moved into the service but they were not sure about a care plan. People told us they felt that staff looked after them although one person said, "I'm not sure they always listen to me".

Some people needed support to manage their continence. Care plans were not always up to date about people's continence needs. The review sheets in one care plan were blank even though the person's needs had changed. The provider said that this care plan had not been reviewed since 13 January 2015 because 'the person's key worker had left.' The provider had not arranged for another member of staff to review the care plan.

Staff told us that they had run out of continence pads and were 'using spare ones'. They said that these were not 'good enough' as they did not keep people dry. The manager said they had purchased some extra ones, but these had all been used. They told us that the provider had said that the family must now purchase any extra pads that were needed. A care plan stated that a person 'should be encouraged to use the W.C.' On one day of our inspection the person was not asked if they wanted to use the toilet for two hours. During this time their trousers looked wet. Their relative told us the person 'often got sore because they were wet'.

We spoke with one person who was being cared for in bed. They were in bed in their room with the television on. The control for the television was out of their reach as was their call bell which they needed to call for staff. They had been discharged from hospital recently; their care plan had not been updated following their admission to hospital even though their needs had changed.

The care plan for one person showed that they had formed an attachment to another person. The care plan had been reviewed and recorded that this no longer happened. During our inspection we observed the person trying to grab another person who was becoming visibly upset. The member of staff who was in the room tried to distract the person without success. We had to bring the incident to the attention of another member of staff who was able to diffuse the situation. There was no guidance recorded for staff to follow about how to diffuse or prevent this type of situation.

The care plan for a person had been written in November 2014 and stated that they 'could display moods of aggression and could pose a risk to themselves, staff and other residents'. There had been an incident in December 2014 where they had hit another person on their head. There was no evidence of what was done after the incident to establish why it might have happened. There was no guidance in the care plan for staff to follow if that type of incident happened again.

People did not have the opportunity to have regular baths. The bathing records showed that 7 out of 14 people had had a bath since the beginning of February 2015. Five of these people had only had one bath in six weeks. Staff said that some people did not like a bath. The care plans did not show staff what to do to encourage people to have a bath or body wash. One person told us they liked a bath, but didn't always get one.

Care plans did not give any guidance about how to help people with their oral care. One person had dentures. They were not wearing these on the day of our inspection and the dentures were stored in a small tub in their bedroom, there was no liquid in this tub or cleaning fluid, to clean the dentures. We looked in three bedrooms on the ground floor; all three had a toothbrush by the wash hand basin. Each toothbrush had hard and dried white toothpaste on it as if it had not been used. We checked the care plan of one of the people who had a hard dried toothbrush; the page entitled 'oral care' was blank. Visiting health professionals told us that they had concerns that people's oral health needs were not being met.

Activities were limited. Staff told us there were 'no activities at the weekends'. There was an activities coordinator who spent about three hours in the afternoon during the week arranging different activities. Some people did not want to join in with the activities. On one day staff told people that there was bingo that afternoon. Some people groaned and said, 'not again'. The game of bingo went ahead during the afternoon.

Most people spent their time in the main lounge. There were times when the television was on and music was being played on the organ at the same time. Two people

Inadequate

Is the service responsive?

told us that 'this always happened' and said they weren't asked if they wanted music to be played. One person told us they used to like knitting, but couldn't manage this anymore. Staff did not help this person to pursue their interest. One person told us "I don't go to the lounge. There isn't anything I am interested in and no one talks to you". One person stayed in bed, there was no evidence to show that staff spent time with the person to stop them being isolated. Staff said they tried to spend time with people and one member of staff spent time painting some people's nails.

The provider had failed to assess, plan and deliver care to meet individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was a written complaints procedure that was displayed on the manager's office door on the first floor landing. This was written so it was not accessible to everyone. The manager said that she had held two meetings in the last year for people and asked people at these meetings if they had any complaints. The minutes of the meetings showed that people did not have any complaints, but people told us about different things they were not satisfied with including not getting their own clothes back from the laundry and not being happy with their rooms.

Complaints were not always resolved to people's satisfaction. The manager told us that they had not had any complaints, but relatives told us they had complained about different things. One relative told us that they had made a complaint about their relative's room. They said 'nothing has changed'. Other relatives told us that they had also complained about the bedrooms. One visitor said "There has been a tap dripping in (my relatives) room since Christmas. We have told them but nothing has been done". Another relative said "We are not getting what we pay for. The provider doesn't listen and should be accountable but she's not".

The provider had failed to respond to and resolve complaints. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

Relatives told us that the provider was rarely at the home. They said they had raised concerns but nothing had changed. The manager had been in post since January 2014, they were not registered with the Care Quality Commission so they had not been judged as a 'fit person to manage a registered care home. There has been no registered manager at the home since July 2011. There were widespread and significant shortfalls, most of which had not been addressed since the last inspection.

Staff were not clear about the aims and objectives of the home. They were not clear about their role and responsibilities and what they were accountable for. Staff described a culture of bullying and nastiness by some staff. Some of these staff had left but some continued to work at the home. Staff had reported concerns to the manager but these had not been dealt with in the right way. The provider had not supported and supervised the staff team to make sure they displayed the right behaviours and values to people and to each other.

People were not involved in developing the service. The provider said she spoke with people when she was at the home but she did not record this. The provider said she reviewed records including care plans but she did not record this. With no records of the reviews and audits there was no action plan for improvement. Opportunities for people to give their view and opinions about the home were limited. When people did give their views, they were not recorded or analysed to lead to improvements. One person told us ""I have a very small room and I am claustrophobic. I have asked if there is a larger room but there isn't. I don't like going to bed as it is hard and uncomfortable". The manager had previously reported that there were spare rooms available.

The provider did not have an understanding of the challenges and key risks of the home. The provider had not assessed risks posed by the environment, the risks posed by fire and posed by fittings and the electrical installations. The provider lacked understanding about systems to keep people safe. The provider was not monitoring the quality of service provided at the home; they did not monitor and record staff practice, did not check records and had no improvement plan for the home. There were limited quality assurance procedures so no plan for continuous improvement. Health and social care professionals told us that they felt people's needs were only met due to their interventions. They felt that if they were not intervening staff would not have the skills to meet people's needs.

There was no clear vision for the home, the provider was not aware of the shortfalls and did not take responsibility for the shortfalls and continued breaches in regulations. The provider had written an action plan but most of the timescales had passed with little improvement achieved. Many of the home's policies and procedures had not been updated. Staff were not always following existing procedures, the manager was unaware of the content of some of the procedures including the recruitment procedure and the training policy.

The provider had failed to assess and monitor the quality of the service and identify and manage risks to people staff and visitors. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2009. This corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider and manager did not understand their responsibilities. They had not reported three safeguarding allegations at all. There had been a number of incidents including a fall resulting in a broken bone and a fall resulting in cuts to the face and body. These incidents should be reported, by law, to the Care Quality Commission (CQC). The provider had not reported these incidents and other incidents to the CQC.

The provider had failed to notify CQC of incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider could not find records when they were needed, the office had records strewn and piled up on each work surface. We waited for the manager to find records she said "It is hard for me to find things" referring to trying to find records in the office. Some care plans had not been updated when people's needs had changed and the review sheets were blank. This has not been picked up by the checks the provider said she carried out but did not record. Staff said they did not have the paperwork they needed to record people's care needs. The communication book recorded a number of requests for staff for the correct forms.

Inadequate

Is the service well-led?

The provider had failed to keep an accurate record on respect of each service users plan of care. This was a breach of Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2009. This corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had sent us an action plan. The action plan did not identify how all of the breaches found at our last visit in September 2014 would be addressed. The action plan stated that systems were in place and we found that they were not. The action plan said that weights would be recorded and staff would inform the manager of any concerns. Visiting social care professionals told us that recent weight records showed that 10 people had lost weight and another had not been weighed.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had failed to protect people from possible harm and abuse. Regulation: 11 (1)(a)(b) This corresponds with Regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had failed to assess, plan and deliver care to meet individual needs. Regulation 9 (1)(a)(b)(i)(ii) (2). This corresponds with Regulation 9 (1) (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The provider had failed to protect people from emergency situations that might arise. Regulation 9 (2). This corresponds to Regulation 12 (1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

This section is primarily information for the provider

Enforcement actions

The provider had failed to keep the home clean and free from the risk of infection.

Regulation: 12 (2)(a)(c)(i)(ii)

This corresponds with Regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The provider had failed to protect people from the risk associated with medicines.

Regulation: 13

This corresponds with Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The provider had failed to ensure that staff were suitably trained and supervised.

Regulation 23 (1)(a)(b)

This corresponds with Regulation 18 (2)(a)of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Enforcement actions

The provider had failed to assess and act in accordance with people's consent and had adhered to the Mental Capacity Act 2005.

Regulation: 18

This corresponds with Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider had failed to ensure that people were treated with consideration and respect. Regulation: 17 (1)(a)(b)(c)(i)(ii)(d)(e)(f)(g) This corresponds with Regulation 10 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider had failed to respond to and resolve complaints. Regulation: 19 (1)(2)(a)(b)(c)(d) This corresponds with Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider had failed to assess and monitor the quality of the service and identify and manage risks to people staff and visitors. This corresponds with Regulation 17 (1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider had failed to keep an accurate record on respect of each service users plan of care. Regulation 20 (1)(a)(b)(i)(ii) (2)(a)(b) This corresponds with Regulation 17 (2) (c)(d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to notify CQC of incidents. Regulation 18

The enforcement action we took:
Cancellation of registration