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Tordarrach Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 February 2018 and was unannounced.

At our first comprehensive inspection of the service in April 2016 we identified breach of regulations relating to depriving people of their liberty, good governance and staff training. We rated the service 'Requires improvement' overall. We carried out a focused inspection in October 2016 and found the provider was meeting the breaches of regulations we had identified previously. We did not change the rating at that inspection and the service remained 'Requires Improvement'.

At our comprehensive inspection in June 2017 we identified breaches of regulations relating to safe care and treatment, good governance, person-centred care and submitting notifications of significant incidents to CQC. We rated the service 'Requires Improvement' overall and 'Inadequate' in the key question 'Is the service well-led?' We served the provider with warning notices for the breaches relating to safe care and treatment and good governance and told the provider they must be compliant by July 2017. We carried out a focused inspection in October 2017 to check whether the provider was compliant with the warning notice and found they were. We did not change the rating because we needed to see sustained improvement over a greater period of time.

Tordarrach Nursing Home provides nursing care for up to 20 people. People presented with a complex range of needs. Most people were older people, many of whom were living with dementia. There were also two younger adults using the service, one with a mental health condition and the other a regular respite user of the service who had a brain injury. There were 11 people using the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the provider had not maintained systems to reduce risks relating to falls from height and water hygiene. In addition we found the provider had not assessed and managed risks relating to cold temperatures well. We identified two radiators in the communal lounge were broken which made parts of the lounge cold, and the provider was unaware of this. Staff did not always do all they could to mitigate risks relating to a person's care and we observed a person experienced pain when staff supported them to reposition their legs.

Medicines management was suitable although systems to ensure medicines outside the fridge were stored at safe temperatures were lacking. Our checks of medicines stocks and records indicated people received their medicines as prescribed.

The provider did not always obtain evidence staff had the right to work in the UK and we reported our

concerns about one staff member to UK Visas and Immigration. The provider had not always obtained two references for each staff member in accordance with their recruitment policy. There were not always enough staff deployed to support people promptly. People were safeguarded from abuse and improper treatment due to systems in place.

The provider had an improvement plan in place in relation to infection control after an inspection by the clinical commissioning group (CCG) identified concerns. We found most areas of the service were clean although some areas of the dining room such as curtains had food stains.

We found the provider had not fully followed the recommendation we made at our last comprehensive inspection regarding adapting the environment to cater for people with dementia. In addition the provider had not considered best practice in dementia care in other aspects of service delivery. The provider had also not considered best practice in occupying and stimulating people with dementia.

The provider had not ensured Mental Capacity Act (2005) assessments were decision specific in accordance with the Act. This meant the provider may have incorrectly determined people's capacity in relation to key decisions and so may have prevented people making their own decisions in relation to their care.

We observed people were sat in armchairs with tables in front of them for the whole day which may have deprived them of their liberty unnecessarily. We raised our concerns with the provider who informed us they would review this. Besides this the provider applied for authorisations to deprive people of their liberty appropriately.

Staff received a programme of support although training was lacking in some areas and records relating to staff training were not always clear. Staff attended key training in relation to their role but training in relation to people's individual needs, such as brain injury and mental health issues, were not provided.

People were not always supported to receive choice of food. The lunchtime meal was shop bought frozen food reheated on the day of our inspection which meant the quality of some meals could be improved. The chef had a good understanding of people's dietary needs and received updates from staff if people's needs changed. We observed people received the support they required from staff to eat. People received the necessary support in relation to their day to day health needs.

People did not always receive kind, compassionate, person-centred care. Staff did not engage well with people using the service and some staff required support to improve their communication skills. We observed some interactions which showed staff did not always show empathy in the way they cared for people and did not always ensure people felt they mattered. The provider lacked systems to check staff provided care to people in a compassionate and personal way.

People were not always treated with dignity and respect. Staff exposed parts of people's bodies in the communal lounge when carrying out tasks such as hoisting and clinical procedures. A screen was not used to maintain people's dignity. Staff had not always explored and maintained systems to help people express themselves. Information about people was not always stored in a way which ensured confidentiality.

Relatives were able to visit at any time besides mealtimes. We observed some people waited long periods to be served their meals while those around them ate. Relatives told us they were willing to support their family members to eat to reduce the burden on staff and increase the quality of care to people but the provider rejected their requests for this.

People lacked meaningful activities to stimulate and occupy them and staff heavily relied on the TV to entertain people on a day to day basis. This meant the provider had not improved in relation to this since our last comprehensive inspection. People were also not supported to maintain and improve their mobility on a daily basis with people seldom supported to move from their seats.

The provider's complaints policy remained suitable although the provider told us they had not received any complaints since our last comprehensive inspection so we did not look at complaints in depth.

The provider had poor systems to govern the service and had not sustained improvements we found at previous inspections. The auditing systems in place were not robust as these had been ineffective in alerting the provider to the concerns we identified during our inspection. Staff lacked the leadership and support they required to develop in their roles and the service was poorly managed. There were ineffective systems to observe the care of people who were unable to express themselves verbally to check it was delivered in a responsive, compassionate manner.

Systems to gather feedback and experiences from people using the service could be improved. Systems to gather feedback from relatives and staff were in place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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

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

During this inspection we found breaches relating to safe premises and equipment, consent, person-centred care, dignity and respect and good governance and we are taking enforcement action against the provider. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider had not improved their processes to mitigate risks to people. Medicines management was generally safe, although temperature monitoring to check medicines were stored safely was not always in place.

Although the provider carried out recruitment checks to identify whether staff were suitable to work with people we found one staff member may not have had the right to work in the UK. There may not have been enough staff deployed to work with people.

Systems were in place to safeguard people from abuse.

The provider had an improvement plan in place in relation to infection control concerns the CCG identified.

Is the service effective?

Requires Improvement

The service was not effective. The provider had ignored the recommendation we made previously regarding adapting the environment to cater for people with dementia.

The provider did not always follow the Mental Capacity Act 2005 in ensuring assessments were decision specific.

The service was not effective. The provider had ignored the recommendation we made previously regarding adapting the environment to cater for people with dementia.

The provider did not always follow the Mental Capacity Act 2005 in ensuring assessments were decision specific.

Staff were supported with supervision and a training programme, although some training was lacking.

People were not always provided with a choice of food although people received support to eat.

People were supported with their day to day health needs.

Is the service caring?

Inadequate

The service was not caring. Staff continued to work in a 'task-based way' and spent little time engaging with people.

We observed staff did not always care for people in a compassionate way.

Staff did not always know the best ways to communicate with people.

People's dignity was not always maintained.

Is the service responsive?

Requires Improvement

The service was not responsive. People still were not provided with sufficient activities to keep them occupied.

People did not always receive care that took into account their individual preferences and wishes.

A suitable complaints system remained in process.

Is the service well-led?

Inadequate

The service was not well-led. The governance systems in place remained poor and leadership was lacking.

Systems to gather feedback from people, including those who could not communicate verbally, and relatives could be improved.

Systems to communicate with staff remained suitable although staff did not always work well as a team.

Tordarrach Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place 5 February 2018 and was unannounced. The inspection was undertaken by an inspector 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 service.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications we received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also received feedback from the clinical commissioning group (CCG) and the local authority. The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. The registered manager informed us they experienced difficulties submitting the PIR and submitted this 17 days after our inspection after we raised this with them. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we spoke with three people, two relatives, one care worker, one nurse, the chef and the administrator. We spoke with the registered manager via telephone as they were abroad. We also spoke with a consultant who had been advising the registered manager on the running of the business. We reviewed five people's care records, five staff records and records relating to the management of the service. We looked at medicines management processes. Throughout the day we undertook general observations and used the short observation framework for inspection (SOFI) in the main lounge. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

After the inspection a person contacted us anonymously to relay their concerns about the service.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection in June 2017 we found a breach in relation to safe care and treatment. This was because the provider was not always managing risks relating to people's care and welfare and the health and safety of the premises. We served a warning notice to the provider and told them they must be compliant with the regulation by July 2017. At our inspection in October 2017 we found the provider had taken the necessary action in respect of our warning notice to improve safety. However, we did not improve the rating for the key question 'Is the service safe?' as we needed to see improvements sustained over a greater period of time.

At this inspection we found the provider had not sustained all the improvements. We found a window restrictor in a first floor communal bathroom was broken and the provider had not identified and repaired this as part of managing risks to people. This meant people may be at risk of from falls from height. We identified a lock on a communal toilet was broken which may have impacted on people's privacy and dignity. The lock on the sluice was also broken which meant people may have been at risk of harm from accessing machinery inappropriately and contaminated waste products. The provider informed us the window restrictor and locks were fixed after our inspection.

We identified the provider had not assessed and managed risks relating to cold temperatures well. A relative told us, "When I kissed [my family member] goodbye [their] nose was really cold." Our inspection fell during a very cold spell with outside temperatures of two degrees Celsius. Two radiators in the communal lounge and in some communal bathrooms were not producing any heat. There were no radiators in the top floor communal hallways and we found this area felt very cold. We placed thermometers in the communal lounge and found parts of the lounge were between 11 and 19 degrees Celsius. People living with dementia can have difficulty regulating their body temperature and recognising that they are cold and some people were unable to express if they felt cold. When we raised our concerns the administrator told us they were unaware of these issues and they had not been identified previously. We then observed staff asked people if they felt cold and placed additional layers on people who they identified were cold. The provider also contacted a gas engineer to fix the issue and they arrived around six hours later. After our inspection the provider told us the gas engineer identified a boiler had been switched off and the provider could not explain why. The provider confirmed they were monitoring temperatures across the home and all areas were a suitable temperature.

These issues were a repeat breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Besides the concerns identified above, the provider had a range of checks in place to check the fire systems, gas safety and electrical items. The registered manager confirmed checks of the electrical installation, lifting equipment such as hoists and the lift had been carried and sent us some certificates after our inspection.

The provider had systems to check pressure-relieving mattresses were at a safe setting for people. However, these systems were not robust as we identified the air mattress for a person whose weight was 80kg was adjusted for a person of 110kg. This meant the person's air mattress was not providing adequate support to

protect them from the risk of pressure ulcers. When we raised our concerns with the nurse the informed us staff must have changed the setting by knocking the dial in error while supporting the person and readjusted the dial. This meant staff had carried out insufficient checks to ensure this equipment was used safely at all times.

We found the provider had suitable systems to manage people's medicines. However, the provider did not have systems to monitor the temperature of the medicines storage room. This meant the provider may be unaware if the temperature reached levels which were unsafe for medicines storage the provider may not identify and respond to this appropriately. The provider confirmed checks were in place after our inspection. We found other aspects of medicines management were safe, including ordering and disposal. We carried out stock checks of medicines and our findings indicated people were administered medicines as prescribed.

People were not protected from being cared for by unsuitable staff because there were not robust recruitment was in place. Some staff had not had full reference checks completed. For one member of staff there was no evidence they were able to work in the UK. We referred this to the Home Office and after the inspection the provider confirmed the person was no longer working until they supplied evidence of their right to work in the UK.

There were not enough staff deployed to support people safely at all times. One relative told us, "Some days it's hard to find any staff and plenty of times when there's no one in the lounge. I've seen two staff in here at times today, that's very unusual." After our inspection a person contacted us to inform us staffing levels were poor. During the lunchtime we observed people had to wait long periods to eat their meals, with one person in the lounge waiting 43 minutes while others ate around them. This was because there were not enough staff deployed to promptly support those who required assistance. Staffing levels were consistent with the levels the provider had identified as necessary according to the rota. However, the provider told us they would review whether staffing levels were sufficient after we raised our concerns with them.

Systems were in place to reduce the risks of abuse to people. Staff understood the signs people may be being abused and how to respond to keep people safe. The provider had responded to concerns of a safeguarding nature raised in the last year. This including investigating concerns and attending meetings chaired by the local authority. Staff received regular safeguarding training to keep their knowledge current. The provider had an improvement plan in place to reduce infection control risks to people. The CCG carried out an infection control audit of the service in August 2017 and identified some concerns. These issues were mainly related to the laundry. The provider confirmed they were working with the CCG to improve in the identified areas. We observed staff followed suitable infection control procedures during our inspection such as using personal protective equipment (PPE). In April 2017 the provider was awarded the highest food hygiene rating from the food standards agency. We found infection control processes and cleanliness in the kitchen remained high. We found most areas of the service were clean although some areas of the dining room such as curtains had food stains.

Information about people was not always stored in a way which ensured confidentiality. People's care folders were stored in a filing cabinet in a communal corridor which was unlocked. Staff told us it was always kept unlocked to allow ease of access for staff. However, this meant confidential information about people was not held securely and could potentially be accessed inappropriately. After our inspection the provider told us the filing cabinet should always be kept locked and they had spoken with staff to reinforce this. At our last inspection we found people were not adequately protected against the risks associated with the management of records because the provider did not have appropriate systems in place to ensure records kept within the service were comprehensive and contemporaneous. At this inspection we found the

provider had improved in this respect after transferring people's care plans to a new format and information about people was up to date.

Systems were in place to reduce the risks to people of receiving care. The provider assessed risk relating to people's care including clinical risks such as pressure ulcers, malnutrition and dehydration and moving and handling. The provider put risk management plans in place for staff to follow which included guidance from professionals such as tissue viability nurses (TVNs). We saw clear records were made of treatment people received in relation to pressure ulcers and regular correspondence from a TVN showed pressure ulcers were being managed appropriately by staff.

Requires Improvement

Is the service effective?

Our findings

We found the provider had partially acted on the recommendation we made at our last comprehensive inspection regarding adapting the environment to cater for people living with dementia. The provider had ensured pictures of people were placed on bedroom doors to help people recognise their rooms. The provider had some pictorial signage in place across the service to help people navigate around the home. However, the provider had not considered using contrasting colours to enable people who were disorientated to place to navigate more easily around the home, for example to more easily identify toilets and bathrooms. The provider had also not considered the impact of patterns on carpets on people with dementia. Some people were provided with sensory lights in their rooms to help stimulate and occupy them. However, the provider had not considered other adaptations such as sensory and reminiscence stations around the home to occupy people and trigger memories. During our inspection we observed staff did not follow best practice in dementia care in relation to colour contrasted mats and crockery to help people with dementia identify their plates. After our inspection the provider informed us colour contrasted mats and crockery were usually used by staff and could not explain why they were not used during our inspection.

Staff were supported by a provider who had did not always follow best practice guidance in relation to dementia and antipsychotics. For one person we identified the provider used an antipsychotic medicine 'as required' ten times in December and nine times in January. Staff told us this was to help them manage their agitation. However, the National Institute for Health and Care Excellence (NICE) guideline on dementia advises against the use of any antipsychotics for this reason unless the person is severely distressed or there is an immediate risk of harm. The guidelines recommend other approaches are considered to help a person manage their anxiety including aromatherapy, multisensory stimulation, therapeutic use of music or dancing, animal-assisted therapy and massage. The provider informed us this medicine was used because the person was very aggressive. Although the provider informed us staff recorded the reasons they administered the antipsychotic to the person each time and what approaches they had tried to help the person beforehand they did not provide us with this evidence as agreed. The provider told us staff used diversion tactics before administering the antipsychotic to the person. Our findings relating to poor staff interaction with people and poor provision of activities indicated it was unlikely staff used any of these alternative approaches to support the person before administering the antipsychotic to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found the provider had recently carried out MCA assessments in relation to people's care as part of transferring care plans into a new format. However, the provider had not ensured MCA assessments were decision specific in accordance with the Act. The provider had assessed people's capacity to consent to support with washing, nutrition, continence and dressing in one assessment in the records we viewed. This

meant the provider may have incorrectly determined people's capacity in relation to key decisions and so may have prevented people making their own decisions in relation to their care. When we raised our concerns with the nurse they told us they would review their procedures as soon as possible to ensure care was always provided in line with the MCA.

One person was administered medicines covertly. We viewed the decision to do this was made through consulting their GP, the pharmacist, relatives and the registered manager and the decision making process was recorded in line with the MCA. However, there was no record of a capacity assessment carried out to check the person lacked capacity in relation to this decision. When we queried this with staff they did not understand why it was important to ensure a capacity assessment was carried out and recorded. After our inspection the provider told us they had a copy of the capacity assessment although they did not send this to us as agreed. Instead the provider sent us a copy of the court of protection order appointing a deputy for property and affairs. This did not relate to the capacity issue we were querying. Our findings meant the decision to administer medicines covertly to the person may have been made without consideration of the person's mental capacity to make the decision themselves.

These issues relating to the MCA were a repeat breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the provider continued to apply for DoLS authorisations appropriately and kept authorisations under review. However, we observed people in the lounge sat in chairs with tables in front of them for the whole day which could restrict their movement. There was room for these tables to be placed in a less restrictive way to the side of people but staff had not considered the best ways to arrange them. After the inspection the provider told us tables should not have been positioned in this way through the day and confirmed they had reinforced this with staff.

People were supported by staff who received support in relation to their role although training was lacking in some areas. Staff received regular supervision with their line manager to review their work. Staff also received an annual appraisal to review their performance and set goals for the coming year. Each staff member had a personal development plan in place detailing their training needs and individual training programme. Staff confirmed they had attended key training in key areas including dementia care, safeguarding, the MCA and DoLS and moving and handling. However, records of training staff had received were unclear. The provider produced a training matrix showing the training staff received, although this showed significant gaps. The provider told us they did not record training staff received on this matrix until they received certificates, which meant this matrix was not a true reflection of the training staff received. The provider told us they would update the matrix with training staff had received and mark on if they were awaiting a certificate and send this to us. However, we had not received this at the time of writing. We also found the provider had also not provided training to staff to help them understand the best ways to care for some people's individual needs. This included needs relating to mental health conditions and brain injury. The provider told us they would book staff on this training as soon as possible. Some staff had received training in dementia and the provider had booked training for all staff to take place soon after our inspection.

People were not always supported to receive choice of food and the quality of meals could be improved. People made positive comments to us about the breakfast, but were less positive about lunch. One person told us, "I was disappointed in [my meal] and the vegetables were cold." We observed the food served was reheated shop-made frozen food such as pies and veggie-burgers which meant the quality of food could be

improved by making it from scratch. The provider told us usually people were provided with food made from scratch and were only served shop-made food such as this around one day each week. The chef told us they prepared two main meals for lunchtime, one for those who required soft foods and one for those who did not and there was no choice of meal provided at the point of serving. An additional meal was made for a person who was vegetarian and a person's relatives provided cultural food for a person on respite. People were required to state if they wanted an alternative meal and we found many people would have been unable to express this clearly. The provider monitored people's weights and usually took action to refer people to a dietician if there were concerns. We identified one person was underweight and lost over 2kg between December and January. The provider told us they were aware of these concerns and were in the process of referring the person for dietitian support.

Staff told us people were supported to understand the meal being served in advance through pictorial cards. The chef had a good understanding of people's dietary needs and received updates from staff if people's needs changed. We observed people received the support they required from staff to eat. The provider received support from the CCG to reduce the use of supplements by providing alternatives such as smoothies.

People continued to be supported by staff to maintain their day to day health. Staff monitored people's general health, including their risk of malnutrition and dehydration. Records confirmed people regularly saw the healthcare professionals they needed such as GPs, tissue viability nurses, dietitians and speech and language therapists. A chiropodist visited the home regularly. The provider received guidance from speech and language therapists (SALTs), dietitians and tissue viability nurses (TVNs) and incorporated this into people's care plans.

People were supported to transition between healthcare services including transitioning into the service. A relative told us, "When [my family member] has to go to hospital they send an ambulance and a carer goes." The provider was involved in the Vanguard Scheme run by the local authority. This meant the provider had information about people which was readily available to pass to hospital staff should a person be admitted in an emergency. The provider carried out an assessment of people's needs before they came to live at the service which included meeting with the person and their relatives and reviewing professional reports.

Inadequate

Is the service caring?

Our findings

At our last inspection we rated this key question 'Requires Improvement' as care was provided to people in a task-based way with little interaction between people and staff. At this inspection we found the service had not improved in relation to this. One person received one on one care during the day from an agency staff member sourced and employed directly by the CCG. This was because the CCG were concerned the service were not meeting the person's needs. The agency staff member read the person their favourite poems, stories and music and interacted well with them. Although this person received good quality person-centred care from the agency staff member, this was in contrast to our findings for other people. Our observations showed staff did not provide care to people in a person-centred way which indicated staff did not understand people's preferences well and how to tailor care to individuals. We fed our findings back to the nurse and asked them to look closely at the issues to improve the quality of care for people.

People did not always receive kind, compassionate, person-centred care. One relative told us about one care worker who, "…can be very off and doesn't seem to like being with the residents. Her manner is very abrupt, awful." The relative also told us, "When staff are in the lounge they are usually writing up their notes and paying no attention to the residents."

During our inspection we observed staff in the lounge seldom interacting with people. We observed two people eagerly engage with anybody who passed by but staff did not spend time engaging with them, or with others. We observed a staff member supporting a person to paint their nails but this was done with minimal conversation. In the afternoon one staff member ignored calls from people for interaction or assistance and focused on recording their notes. We observed some interactions which showed not all staff were caring. We observed a person request staff provide a small cushion as they were uncomfortable. The staff member responded, "No" and continued other tasks in the lounge. A person asked staff to help them reposition their feet and the same staff member told the person, "They are supposed to be like that." A different staff member heard the request and came to offer support instead. When a person became anxious about the location of items they liked to keep with them a staff member told them to stop asking for assistance and the person lapsed into silence. We observed the items were in the seat next the person yet staff offered no reassurance or assistance to the person.

Staff did not always understand the best ways to support people. We observed staff helping a person to readjust their seating position. The repositioning caused the person to scream out due to pain in their knees. Staff were unaware of the best ways to reposition the person without causing pain to them. After the inspection the provider told us they had spoken with the staff involved and were monitoring them closely. People were supported by staff who did not always understand the best ways to communicate with them and people were not always involved in decisions about their care. A relative told us, "The [named nurse] is the best communicator, works very hard and is attentive." We observed staff preparing to hoist a person and staff did not explain what they were doing to the person as they positioned the straps on them. We observed the person looked anxious at what was happening to them and a different person commented, "That lady looks frightened!" When the person being hoisted asked what was happening to them staff responded with, "Going up!" with no further explanation or reassurance. A relative told us, "[My family member] has very little

that she can make a choice about or express an opinion."

Staff had not noticed the communal lounge was cold in some areas during our inspection and only provided extra layers to people when we raised our concerns.

People were not always treated with dignity and respect. People received support from a hairdresser who attended every two weeks to help people maintain their hairstyles. We observed a person being hoisted with no screening in the lounge, although staff did attempt to rearrange clothing as it rode up exposing their body. We observed another staff member lift a person's clothing to expose their body to carry out a clinical procedure in the lounge with no screen used to maintain the person's dignity. We observed staff placed aprons on people before lunch without gaining their consent first or explaining what they were doing. During lunch a person's chair was too low in relation to their table which made it more difficult for them to eat independently. The person was not provided with a plate-guard and we observed they were unable to prevent food falling onto the table. Staff did not notice these difficulties the person was experiencing.

People were also not supported to go out into the community. A relative told us, "[We take our family member] out for lunch at the local and she loves it but nobody here does anything like that so for people who don't have anyone. They are just stuck." A person told us, "The carer who used to take me to church isn't here so I don't go now." When we raised our concerns about this with staff we were informed people lacked the mobility to go on day trips. However we found this not to be the case as wheelchairs and transport would make day trips accessible to people. Some people were supported to visit local places by family members and the provider told us they encouraged this. The provider also told us they sometimes took a person to their favourite eatery on occasion.

People were not supported to maintain and improve their mobility on a daily basis as part of maintaining their independence. We observed people were seldom supported to move from their seats and lunch was served to people in their armchairs. When we raised our concerns with staff we were informed people were usually supported to eat at the dining tables in the lounge but our presence meant they had not done this during our inspection. However there was no reason why this would be the case.

Staff implemented a communication book for a person who had severe hearing loss but this was no longer in use as the book had run out of sheets around Christmas time. Staff had not found an alternative way to aid communication with the person and we observed staff communication with them was limited. Staff did not know the best ways to communicate with a person who was unable to communicate verbally and did not use any aids or adaptations to help the person express themselves. Information for people living with dementia or with a visual impairment was not easily accessible. There were pictures of the meals for the day being displayed on a board but this was positioned too high for people to see.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People lacked meaningful activities on a day to day basis to stimulate and occupy them which impacted negatively on their quality of life. This was in line with our findings at our last comprehensive inspection. Although people's care plans were sufficiently detailed staff did not use these details to tailor care individually. Staff relied heavily on the television as a source of entertainment for people. Meaningful activities were not provided that took into account people's preferences and interests. One person told us, "There's only the telly to look at." Another person commented, "Why do we have to see these horrible people [on TV] and it was on this morning as well?" in relation to a television programme repeated during our inspection. Staff did not choose programmes according to people's interests. In addition staff did not always position people to ensure they could see the television if they were interested in this.

People's social needs were not met. A relative told us in the recent relative's questionnaire, "I commented on the lack of activities, the lack of staff in the lounge and the poor staff and that they don't do anything to stimulate and engage with my relative." A person explained they had a keen interest in a particular sport. When we asked the person whether staff were aware of their interest and had supported them to follow the sport they responded, "I don't think they even know or are bothered." One relative told us, "I always presume they do something in the morning because there's never anything when I'm here in the afternoon."

During our inspection one staff member passed a drawing book to a person who told us, "[Staff] gave me a drawing book but I'm no good at drawing and don't like that." We requested a copy of the activity programme and staff informed us there was no structured programme in place. Staff told us one member of staff visited each week to lead activities and the provider told us they were recruiting for a full time activities role. However we found on a day to day basis the level of activities was poor. During the afternoon staff put a music CD on in the lounge which was turned up loud while two televisions in the same room continued to play. One staff member went around the room with a musical shaker for a short time. People were not provided with instruments or included in the activity in a meaningful way. Staff told us the provider had invested in resources for activities such as games and these were visible in the lounge. However staff did not make full use of these resources to engage people. During our inspection we observed people seated in a way which did not promote social interaction, around the edges of the communal lounge.

These issues form part of the continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had professional entertainers visit the service on occasion but these visits were not always popular. One relative told us, "The Christmas entertainer wasn't traditional as it should have been but modern and loud. We endured it." People also had access to a massage therapist who visited the service weekly. People were also visited by a reverend from a local church and a priest to allow those who wished to take part in communion. After the inspection the registered manager emailed us several photos of people taking part in activities to evidence that some social activities took place at the service. The photos included people celebrating their birthdays with cake, the summer BBQ and the June entertainer who visited people. This aside our findings indicated on a day to day basis activities for people were lacking.

At our last comprehensive inspection we found people's care plans contained information about their backgrounds, preferences, preferred methods of communication and healthcare needs to help staff understand the people they supported. However we found some people's care plans were handwritten and were illegible. This meant staff may have been unable to obtain the necessary information from people's care plans to follow in caring for people. At this inspection we found the provider had reviewed all people's care plans and transferred them to a new format and they were now legible. Care plans continued to reflect people's needs and preferences appropriately.

People were supported to plan how they received care at the end of their lives. People were supported to prepare advanced care plan with their families. Staff also received some training in how to provide end of life care including how to ensure people's wishes were respected.

At our last comprehensive inspection we found the provider's complaints process was suitable. At this inspection the administrator told us they had received no complaints since our last comprehensive inspection. However we were informed the complaints process had not altered and complaints would be dealt with in the same way we found suitable at our last inspection. After our inspection the provider told us no concerns had been raised with them regarding the service although they would address any concerns immediately if any were raised.

Inadequate

Is the service well-led?

Our findings

At this inspection we found the provider's governance had deteriorated since our last inspection where we rated the service 'Inadequate' in this key question. We found further breaches of regulations including ones that had been identified previously.

The provider continued to have poor systems to govern the service. The provider submitted an action plan to us after our comprehensive inspection setting out how they would become compliant with the regulations. However, our findings showed the provider had been unable to follow their own action plan to improve the service fully and sustain the improvements. The auditing systems in place were not robust as these had been ineffective in alerting the provider to the concerns and breaches we identified during our inspection.

At our last comprehensive inspection we were unable to evidence how the provider assessed the quality of interactions between staff and people, as well as the quality of the activities programme in place and whether this met people's needs. In their action plan the provider told us they had held meetings with staff to 'stress the importance of identifying resident's preferences and wishes regarding the types of activities they wish to take partake in.' The provider also told us activities would be planned in advance and a dedicated activity coordinator had been employed. At this inspection we found the provider had not improved in relation to this as the activities on offer on a day to day basis remained poor. The provider told us the activity officer employed remained in post for a short time and they had been unsuccessful in recruiting to the post in the meantime. The quality of some interactions between staff and people remained poor. We found the provider did not have systems to check staff provided care to people in a compassionate and personal way and training was not provided to all staff regularly in relation to these skills. The provider also lacked systems to support staff to develop and improve their caring skills.

The provider's systems to gather feedback from people as part of monitoring and improving the service were not robust. The provider sent questionnaires to people each year and staff supported some people to complete them, although this was carried out too infrequently too keep the provider abreast of people's experiences. People were assigned a member of staff to be their keyworker. In a keyworking system keyworkers work closely with people to ensure their care needs are met. However it was not clear how keyworkers worked closely with people to gather their views and hear their experiences as part of improving their care. For example, there was no evidence keyworkers met with people regularly as part of the provider's quality assurance processes. The provider lacked systems to check staff were responsive and compassionate towards those who were unable to express themselves verbally.

Relatives did not all have confidence their feedback would be used to improve the service and events to encourage relative's involvement in the service could be improved. A relative told us, "I filled in the recent survey but I don't expect much to come of it. I did it because it is anonymous. When I have mentioned things to staff in the past they have been very defensive and then stand offish so I don't say anything now." Another relative told us, "There was a BBQ but it was a lot of friends of the owners and they 'wheeled' [my family member] out for some photographs. She was very confused." The provider had a cheese and wine evening

planned for February 2018 to encourage relatives' involvement in the service.

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

There was a lack of leadership and the registered manager, who was also the owner, was often absent which meant that they had insufficient oversight of the day to day running of the service. During our inspection a consultant who had been advising the provider in relation to the business called the service. We asked them how they were helping to improve the service and they told us their focus had been on persuading the registered manager to 'step back' from managing the service and they had now done that. The provider had tried to recruit a new registered manager but the administrator confirmed this had been unsuccessful, although they would continue their attempts. Staff told us the registered manager visited a few times a week to carry out tasks such as food shopping.

Staff told us nurses had been asked to take on a managerial role and minutes of staff meetings confirmed this. We found the arrangement for the registered manager to take a back-seat in managing the service was inappropriate and unsuitable. Staff lacked the support they required from the registered manager to develop in their role. In addition, we requested documents relating to training be sent to us as soon as possible after the inspection. When the provider did not send these promptly we called the service to question this. The nurse told us they were unable to send the documents to us, only the administrator could in the managers' absence. However, the administrator worked only one day a week which meant we would have to wait almost a week to receive the requested documents which we found unhelpful. Our findings showed the registered manager lacked understanding of their pivotal role in overseeing all aspects of the service and guiding staff to ensure people received good quality care.
The CQC had not received a completed provider information (PIR) return to help us monitor the service and plan the inspection. We request providers now complete PIRs each year. We contacted the provider prior to our inspection to request they submit their PIR. The registered manager informed us they had difficulties submitting the PIR and submitted this 17 days after our inspection after we requested this again.

People were not always supported by staff who worked well together. Even though staff told us they worked well as a team we found this was not always the case. A relative told us, "I was very uncomfortable when one of the carers was verbally aggressive to the nurse when she was asked to do something. She shouted, 'It's not my job' and [my family member] seemed scared." The provider told us they were unaware of this incident when we raised it with them and confirmed they would look into it.

Systems to openly communicate with staff remained suitable. The registered manager continued to hold regular staff meetings and nurses meetings. Staff felt shifts were well organised and led by the nurse in charge. Staff were assigned responsibilities each shift which were agreed at handover. Staff were positive about the registered manager.

The provider had also introduced a system to monitor the frequency of staff supervision and training which was up to date.

At our last inspection we found the registered manager did not always submit statutory notifications to the CQC about the outcomes of applications for authorisations to deprive people of their liberty under DoLS as required by law. This meant CQC was not able to monitor the volume and nature of these applications to deprive people of their liberty. At this inspection we found the provider had improved and was sending notifications to us appropriately.

The provider attended meetings held by the local authority and cooperated with providing information when there were concerns about the service in the previous year.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate and did not always meet their needs and preferences. Care and treatment was not always designed with a view to achieving people's preferences and ensuring their needs were met. Regulation 9(1)(2)(3)(b)

The enforcement action we took:

We served notice to remove the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Staff did not always ensure people's privacy and did not always support people's independence of involvement of people in the community. Regulation 10(1)(2)(a)(b)

The enforcement action we took:

We served notice to remove the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided to people with their consent and in accordance with the MCA 2005. Regulation 11(1)(2)(3)

The enforcement action we took:

We served notice to remove the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always properly maintained. Regulation 15(1)(e)

The enforcement action we took:

We served notice to remove the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established systems or processes which operated effectively to ensure compliance with this regulation. The registered person had not ensured effective processes to assess, monitor and improve the quality and safety of the service and evaluate and improve their practice in respect of the processing of the information relating to all of the above. Regulation 17(1)(2)(a)(f)

The enforcement action we took:

We served a notice to remove the registration of the provider.