Healthcare Homes (LSC) Limited

The Chase Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out a comprehensive unannounced inspection at The Chase Care Centre on 24 April and 3 May 2018.

At our last inspection on 6 June 2017 the service was rated Requires Improvement (RI). We found breaches of regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of activities coupled with a lack of interaction, engagement and personhood for people which impacted on people's wellbeing. We also found that people's safety was not always sufficiently mitigated due to the unsafe management of medicines. At this inspection we found the service continued to be in breach of regulations 9 and 12 and we also found breaches with regulations 10, 11,13,14,17 and 18. We found that there were serious failings from both management and staff to ensure people received care and support in a safe and effective way.

The Chase Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Chase Care Centre is registered to provide personal and nursing care for up to 110 people aged 18 and over with a range of complex health and care needs. At the time of our inspection 86 people were using the service.

The Chase Care Centre is divided over three floors and accommodates people within six separate units, some of which have adapted facilities. The service supports people with complex nursing and residential needs which included supporting young people with brain acquired injuries, people with mental health needs, physical needs and people who are living with dementia.

During our inspection, we were informed that the registered manager had tendered their resignation in April 2018 and therefore a temporary operations manager was providing the management support whilst recruitment takes place for a new manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People who lived at the home gave mixed views about feeling safe. Five people and four relatives felt there were not enough staff to meet their needs in a timely way. We were told that agency staff working in the home were not always knowledgeable about their needs which had impacted on their dignity, care and general well-being. Staff were observed to be rushing from one task to another with little time to spend talking or engaging with people. This was particularly apparent during mealtimes.

Risks to people`s well-being and health were not always identified, assessed or mitigated in a way to reduce

them. Where people were assessed as requiring a fortified diet to help reduce the risk of malnutrition they were not provided this by the kitchen staff who were not aware of people's needs.

Where people had pressure relieving equipment in place to help prevent the development of pressure ulcers, checks carried out by staff did not effectively identify incorrect settings on air mattresses. There was a risk that this shortfall had contributed to people developing pressure ulcers.

People who lived with specific health conditions had no care plans in place to address this area of their needs and staff had no guidance on how to maximise and improve people`s health. People`s end of life care needs were not always assessed and people`s wishes, likes and dislikes were not always considered when staff developed or reviewed care plans.

People were not always protected from the risk of infections due to staff not adhering to safe infection control techniques.

People's medicines were not managed or administered safely, which placed people at risk of harm.

People who had complex health care needs had not been properly assessed and care plans had not been developed regarding their health needs to offer guidance to staff on how to maximise people`s health and keep them safe.

People told us they did not know about their care plans. Care plans we reviewed were not up to date and did not reflect people`s current needs.

People were not always asked for their consent to the day-to-day care and support they received from staff. We observed staff assisting people without communicating with them and walking into people's bedrooms without knocking. Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). Staff were not aware if people had Deprivation of Liberty Safeguards (DoLS) authorisations or Do Not Resuscitate (DNR's) in place which could restrict their freedom unlawfully and place people at risk of harm.

Staff received support through induction and a training programme with a mixture of distance learning and face to face training. However training was not consistently effective in providing staff with the appropriate skills and knowledge to help them meet the needs of the people who lived at the service. We could not be assured that staff were competent following the completion of their training, especially for people whom English was their second language. Staff were unable to explain the procedure to follow in relation to how they safeguarded people from harm and the correct fire evacuation procedures for the home.

Recruitment processes were robust and ensured that the staff employed were suitable to work in this type of care setting.

People had mixed views on the food provided to them. People who had to maintain a healthy diet and lose weight were appropriately supported by staff; however the needs of the people at risk of malnutrition or requiring special diets were not always met effectively.

The atmosphere at The Chase Care Centre was subdued and unreceptive, with several people left for long periods of time without any stimulation or engagement from staff. Over both days of the inspection there were only two activity staff providing activities to 86 people. People who spent time in their bedrooms were at risk of social isolation.

Some staff and people who lived at The Chase Care Centre told us they did not know who the registered manager was. They gave us mixed views about if they felt confident to raise concerns or complaints to the managers. Relatives told us that they did not always feel listened to.

Although there were systems in place to provide an overview of the service we found that these audits were not consistent and at times only provided limited information about the issues found.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always kept safe from harm.

Staff were not always aware of risks to people`s well-being and health and how to effectively mitigate these.

There were not sufficient staff deployed to meet people`s needs in a timely way.

Incidents identified and reported to managers were not always escalated and reported to external safeguarding authorities.

People`s specific health conditions were not always assessed and guidance was not in place for staff to know how to maximise their health.

People were not always protected from the risk of infections.

People who were identified at risk of malnutrition and at risk of developing pressure ulcers had not had these risks sufficiently mitigated by staff who had limited guidance on how to keep people safe.

People were at risk of harm from unsafe medicine administration.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always seek people's consent before providing care and support.

The principles of MCA, DoLS and DNAR's were not known to staff. Where DoLS authorisations were in place with conditions attached these were not met.

People`s dietary needs were not always known to staff and they were not always met. People had mixed views about the meals provided.

People were supported to access health care professionals as needed to help ensure that their health and well-being was maintained.

Is the service caring?

Inadequate

The service was not always caring.

People did not always receive care and support from staff in a kind way.

People`s dignity was not always maintained.

Staff had limited knowledge about people`s likes, dislikes and preferences.

Some people told us that they had not been involved in their care planning and had no review meetings to discuss their care needs.

Confidentiality was maintained.

People`s records were kept locked and secure.

Is the service responsive?

Requires Improvement

The service was not responsive.

People not received personalised care. Care plans were not reflective of people`s likes and dislikes and staff were not knowledgeable about these.

Care and support was delivered to people in a task orientated way.

People`s care plans were not detailed around people`s needs to give staff sufficient guidance to meet their needs effectively.

Opportunities were not provided to help people pursue social interests and take part in meaningful activities relevant to their needs;

People who lived with life limiting conditions did not always have plans in place for staff to know their wishes and preferences about the care they should receive nearing the end of their life.

People told us they were not confident that their complaints would be dealt with appropriately and not everyone knew who the manager was.

Is the service well-led?

Inadequate

The service was not well led.

The systems and processes used by the operations manager to quality assure the service were not comprehensive and did not identify the concerns we found in this inspection.

The management team was not able to provide us with evidence of an effective monitoring system they used to ensure the service was safe.

People`s care records were not up to date and did not provide sufficient detail for staff in how to deliver care and support to people in a safe way.

Some people told us they were not always confident that complaints made would be addressed or resolved effectively.

The Chase Care Centre

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 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out to follow up the breaches of regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 found at the last inspection and to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We received information about eight safeguarding concerns that had been reported and that are currently under investigation by the local authority safeguarding team regarding allegations of poor care, neglect and physical abuse.

The information shared with CQC about these incidents indicated potential concerns about the management of risk of falls, nutrition, staff not recognising signs and symptoms when people`s health needs changed and that people received care and support which did not meet their nursing needs. This inspection examined those risks.

Due to these concerns, we took the decision to bring forward this comprehensive inspection.

The inspection was carried out on 24 April and 3 May 2018. On the first day of the inspection, there were three inspectors, a specialist advisor and an expert by 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. Our specialist advisor was a registered general nurse with 20 years' experience in the field of nursing care. The inspection was unannounced. On the second day of the inspection, there were two inspectors, a specialist advisor and assistant inspector.

Before the inspection, we reviewed information we held about the service including statutory notifications.

Statutory notifications include information about important events which the provider is required to send us.

As part of the inspection we spoke with 12 people who used the service, seven relatives, eight staff members including, care staff, staff working in the kitchen, nursing staff, team leaders and members of the management team. We also talked to three members of the provider's senior management team. We looked at care plans relating to six people and five staff files.

We used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us. We also looked at other care records such as turning charts, food and fluid charts, monitoring charts and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

When we last inspected this service, we found that people were not provided with safe care and treatment. At this inspection, we found the service continued to fail to provide safe care and treatment to people.

There were mixed views from people with regard to if they felt safe at the home. One person told us, "I feel safe most of the time. Not night time." Another person told us "I'm not safe. I've lost my glasses. I'm frightened without them, I can't see". We asked the staff member in the room if [name] glasses could be found but they did not know [name] very well and told us "I didn't think they wore glasses". They then asked another staff member, who fetched the glasses. We saw that this person was visibly happy and more relaxed, once they were able to wear their glasses. One person who we spoke with said "Yes, always safe. I would like to be able to lock the door.

People told that generally staff responded to them using their call bells. One person said "Yes I have a call bell and they always come to see me, usually come straight away. Sometimes if the carers are busy I might have to wait ten minutes." Another person we spoke with said "It doesn't always work. They did see to it but then it went again. I'm not sure if it's working now. There's always someone about, so I can always ask someone if the buzzer's not working." In the night [staff] come in straight away and see what is needed. They say 'I'll be back in five minutes'. They do come back."
We asked one person if they used the call bell when they needed help, they said they were not sure what that was. We found their buzzer under a towel on the small chest of drawers at the foot of the bed. However we found several cords had been removed from people's call bells.

When we asked why this was we were told that some people were unable to use their call bells due to their cognitive impairment or at risk of strangulation. A nurse informed us that for these people hourly checks were carried out to maintain people's safety and to ensure people's needs were met in a timely and prompt way. The records for three people we looked at failed to confirm these people had been consistently checked every hour. For example, we saw one person's record dated 30 March 2018 stated that they were checked at 02.00 but the next recorded check was at 06.10. Another record dated 5 April 2018 showed this person was checked at 06 .00 but not checked again until 09.00 on the same day. The care records stated clearly that the frequency of these checks should be hourly.

There were 46 safeguarding referrals regarding the service since the last inspection took place in June 2017. 10 of these had been investigated and had been substantiated, nine had been partially substantiated and 10 had been unsubstantiated. In addition to this there were five safeguarding investigations that were found to be inconclusive and four referrals that did not meet the criteria for a safeguarding investigation. There are currently eight safeguarding referrals that are being investigated by the local authority and these are related to poor care and neglect. Three further safeguarding referrals were made as a result of this inspection.

There was safeguarding information displayed around the home and staff had received training in relation to identifying and reporting abuse. However when we asked staff if they could tell us how to report their concerns internally and externally to local safeguarding authorities we found that they had a very limited

understanding. Staff told us they had received safeguarding training. However, three staff we spoke with were unable to tell us how to identify possible abuse or about different types of abuse. For example one staff member we spoke with told us "It is not a problem here we wash them and check their skin to make sure its ok". Another staff member told us "You must be kind to everyone. I tell other staff to speak nicely to the people". When asked about the process for reporting concerns one staff member told us "I would speak to the staff and tell them to be kind, if they carried on I would tell the person in charge". Another staff member told us "We do not have any problems like this here". None of the staff spoken with told us they would immediately report concerns to the person in charge to elevate the concerns if they needed to.

Staff were unable to confidently describe how they helped to ensure people were kept safe. This meant that people we placed at risk from staff who had a limited knowledge and understanding about how to safeguard people from harm.

We found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We asked staff the procedure to follow in relation to fire. One staff member told us that "If there was a fire I would run and would not use the lift, I would follow the rest of them". When asked about the people who lived at the home they responded "They stay in bed". Another staff member told us "I would check the board to see where the fire was". The fire alarm sounded during the inspection and we observed staff spill a drink on the floor and then went to get a cloth and proceeded to clean the spillage and took no notice of the fire bells ringing or followed the home's fire procedure. None of the three staff we spoke with were aware of how to ensure people were kept safe or how people would be evacuated. Furthermore, none of the staff mentioned people's individual evacuation plans. We asked a staff member what about evacuation of the people, they told us "Someone else would do that it's not my responsibility I am only part time".

We asked the operations manager for a copy of each person's personal evacuation plan (PEEP). We found the information within these documents was limited and failed to fully describe how the person would be supported if they had to be evacuated from the home in the case of a fire. One plan was dated 20 September 2017 however we had been told that all these documents had been fully updated in April 2018. We looked at another PEEP where the person was visually impaired and was living with dementia. The plan gave no information on how their additional needs may affect their ability to evacuate the home or the level of support they required. The 'external evacuation point' was recorded on this document as 'Reception Area'.

People medicines were not always managed safely. We found there was an appropriate system in place for the ordering and disposal of medicines and found that medicines were stored correctly in suitable lockable storage facilities on each of the units. The stock balances we checked corresponded to the records. Staff had received training in the safe administration of medicines and had their competencies checked. The rooms had room for storage and a number of additional cupboards were secured. Temperatures were monitored and recorded and fell within the expected range. However, we found that covert medication was being administered without safe and proper processes being followed. A covert medication assessment for one person was last completed in September 2015 and had not been reviewed or updated since. We also found that this assessment did not reflect what medication that was currently being prescribed and administered to this person. We found that this issue had only recently been followed up with a letter to the GP dated 25 April 2018.

We saw from one person's medicine administration record (MAR) they had been prescribed an anti-psychotic medicine and also medicines to help reduce anxiety. However we saw that this prescription had been changed by the GP on 16 April 2018 and one of these medicines was now 'administered when

necessary' (PRN) and another medicine had been stopped completely. However, we found there was no PRN protocol record in place for this medicine and no guidance for staff on when to administer this medicine, or signs or symptoms to look for.

We noted that where people required their food and medicines to be administered via percutaneous enteral gastrostomy (PEG) the details included on MAR`s were not consistent. We noted from one person's medicine administration record that they had been prescribed a tablet that was 'Gastro-Resistant' and the prescriber's instructions stated clearly 'Swallow whole, do not chew or crush.' When we asked the nurse about this direction they stated, "We have a best interest decision for that." When we explained that we were not questioning the covert administration of the medicine but the actual administration of this medicine, they said, "It'll be in the care plan then." But when we informed the nurse it was not they stated, "Ok, I don't know then." This practice could have placed this person at risk of unnecessary harm and discomfort.

Some people were identified being at risk of developing pressure ulcers. We found that these people had specialist equipment in place to mitigate this risk. Records showed that people required to be checked at regular intervals. This included staff checking to ensure that the pressure relieving mattresses were set at the correct setting for their weight, in order to help prevent pressure ulcers. However, we carried out a check of 20 mattress settings over the two day inspection and found ten of these were set incorrectly. For example one person's mattress setting was set at '3' for their weight of 55 kilograms however we found that their setting was at '2' therefore the incorrectly set mattress increased the risk of people developing more pressure ulcers.

We reviewed the wound care records for one person, which evidenced that the advice and instructions given by the Tissue Viability Nurse (TVN) were not always followed. During our inspection, we found that that there was not always a full complement of registered nurses on duty.

During the second day of the inspection we found that on Mayger Unit, there was a senior carer in charge and not a registered nurse. They told us "Only registered nurses carry out changes to people's dressings." We found that there were gaps in this person's records that related to the frequency of when these dressings were changed. The tissue viability nurse stated these dressing needed to be changed daily, however, there were gaps of between two and three days where there was no evidence that these dressings had been changed in line with the instructions from the tissue viability nurse. We also saw from this person's records that despite staff having documented an offensive smell from this wound there was no evidence within the care records that a swab had been taken and sent for analysis. This placed this person at risk of further deterioration of their wound and could cause them unnecessary discomfort and pain.

People who had been at risk of falls or sustained falls had not had their care plans reviewed. We saw from one person's care plan that they had experienced falls every month from January 2018 to April 2018. We found that staff had failed to identify or review the falls risks assessment following these falls, which placed them at risk of continued harm.

We found that not all moving and handling assessments were up to date. One assessment we saw had last been reviewed on 2 December 2017 and it stated that a hoist should be used for all transfers for this person. However when we spoke to one staff member with regard to this and they told us "[name] is self-caring and transfers themselves." We reviewed another person's care plan where we found it stated that the person was mobile, however the moving and handling assessment conflicted with this information and it stated that the person required an 'Oxford hoist' for all transfers and this person was now a wheelchair user.

Some people who lived in the home had swallowing difficulties and were assessed by the speech and

language therapists (SALT) to ensure they were on the correct diet and the risk of choking was sufficiently mitigated. We observed that staff did not always follow these assessments. For example, we saw from one person's care plan that they had suffered a recent suspected chest infection, which indicated there was a concern in relation to aspiration. Their relative told us that staff had said that [name] had not been taking fluids safely. The agency nurse on duty advised the relative "I think [name] may need some thickener in their fluid. " The nurse informed the relative that they would get some thickener from another person for now then get [name] assessed by the GP and speech and language therapist (SALT). We found no evidence within this person's care plan that they had been assessed with regard to the risk of choking. This practice placed this person at risks from not receiving a specialist diet and at risk of choking.

We saw one person had been identified at risk of choking and required a pureed diet. However, their lunchtime meal was found to contain shards of onion, which had the potential to cause them harm by choking. We had to intervene and prevent this person from eating this meal in order to safeguard them from risks to their safety and well-being.

We saw from four people's care plans that they required a thickener to be added to their drinks to reduce the risk of aspiration. We found that the guidance for this was inconsistent, and no information was readily available for care staff with regard to the quantity of thickener to be added to fluids. We observed staff administered varied quantities into people's drinks and failed to measure the amount of liquid required before adding the thickener. This ranged from between two scoops, three and a half scoops and four scoops. Staff spoken to gave conflicting answers when we asked them to confirm the correct quantities for individual people. There were also various size drinking cups used throughout the home and no written or pictorial guidance for staff to ensure the correct measures were given. This demonstrated that staff were not aware of the risks to people which put people at significant risk of choking or having other adverse reactions as a result.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people`s well-being were not sufficiently mitigated to protected them from harm.

People gave us mixed views when we asked if there were enough staff to meet their needs in a timely way. One person said, "There's only two carers here in the afternoons now, it used to be three or four with five or six in the morning. The past 18 months it's really gone down. One person told us "There are only two night staff I feel confident with. There are lots of agency staff. I only allow a few of them to hoist me; the ones who listen to me. I'm not confident with the others. They run around like headless chickens but don't listen. The nights worry me. If something went wrong they wouldn't have a clue, something would hit the fan."

Another person told us "Yes I do think that there are enough staff for the basics but when it comes to providing more complex tasks they are not very confident, especially the agency staff." We spoke with four staff about the staffing levels and all stated that they only have time to carry out the basic support and care to people. One staff member told us "It would be nice to have time to sit and chat with people, but there is never time and always too much paperwork to do." One visiting relative told us "I have been waiting for assistance for [name] for over an hour and only got the attention [name] needed from staff when she made a 'fuss'." Another relative we spoke with said "Changes of staff disconcerting, particularly having to explain from the beginning again about our relative and what they need."

One person who lived at the home told us "They don't have enough staff. The carer ratio is two carers in morning and in the afternoon, however some afternoons there is only one carer. So sometimes I have has to wait for between one and two hours to be cleaned. Staff are not allocated properly. It takes one hour twenty

five minutes to do my personal care from beginning to end with a less experienced member of staff. With a more experienced member of staff it takes 45 minutes."

A representative of the management team told us the staffing ratios' were calculated on people's individual dependency levels. We asked how the service monitors and evaluates people's dependency levels but we were told that there is currently no system that provided this oversight and they were not able to evidence how people`s changing needs influenced staffing numbers on each unit.

On both days of this inspection we were told that there were six registered nurses rota'd on duty, one nurse per unit. However, on the second day of the inspection we were told by the operational manager that six registered nurses were on duty for the morning shift. However, we found that on Mayger Unit there was a senior carer co-ordinating the shift, which included the administration of medication. This person told us they were a 'Nurse Practitioner'. However, we found that there is no such qualification and that in fact this person was employed as a senior carer and not a nurse. This meant that the service was not providing the appropriate mix of skilled, competent and qualified staff.

We found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not always adequate levels of suitably trained, competent or qualified staff.

We found that people's nutritional records were inaccurate. One care plan we reviewed stated that the person had a body mass index [BMI] score of 30, however this score was determined by a recorded height of 1.47cm and as a consequence rated as 'Morbidly obese'. We checked with the operations manager and asked if this record was correct and found that this person's height had been incorrectly recorded. This placed the person at risk of not receiving the appropriate support and care in relation to the weight management of their weight.

We spoke to the chef on the first day of the inspection and asked them to tell us how many people were on fortified diets and what additional foods and drinks were provided. They were unable to tell us or comprehend this request and also failed to locate any guidance or confirm the names of the people in the home who required fortified diets. This meant that people were at risk of harm by not having their individual and identified nutritional needs met because of the lack of effective knowledge and communication.

Systems to promote infection control were not always effective. During both days of this inspection, we witnessed staff members not adhering to the proper use of personal protective equipment (PPE). We saw on four occasion's staff took unclean incontinence products to the utility room without the use of gloves or aprons. We also observed poor hand washing techniques with two staff who were observed to enter and come out of a utility room and then enter another room without washing their hands or using the anti-bacterial wash provided.

Safe and effective recruitment practices were followed to help make sure that all staff were of good character, physically and mentally fit for the roles they performed and relevant checks were in place such as verifying references. Staff told us before they started working at the service they went through a thorough recruitment process where their employment history was explored, references were requested from their previous employers and a criminal records check was done to help ensure they were suitable for the roles they had to perform.

Inadequate

Is the service effective?

Our findings

People had mixed views on the staff who worked at the home, in relation to their skills and abilities. One person told us, "They vary. I don't think anyone is actually unkind. They're well trained." Another person said "Being honest, some of the staff are not the staff I would employ myself." Some people we spoke with told us that there was a high use of agency staff which made consistency of care difficult. One staff member we spoke with told us "I've been here about four months. I don't usually work on this unit so I don't really know the people. One nurse was asked to provide information about a person in their unit and they replied that they were "A bank nurse and did not know the person well." Another staff member we spoke told us "My induction and training are good and on-going." One relative we spoke with stated "No continuity of care. The place is rife with agency staff who do not know the needs of the residents."

Training included safe administration of medicines, health and safety, infection control, first aid, safeguarding. Staff had also received training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS). However we found that there was limited evidence that staff competency checks were completed following people's training.

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. 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 that people had restrictions applied to their freedom without having the up to date DoLS authorisations in place for these. For example during the first day of our inspection we observed one person had become anxious and distressed near to the main entrance of the home and indicated that they wanted to leave. We checked with a senior staff member to confirm if this person had a DoLS in place with regard to restricting their liberty and freedom to leave the home. The deputy manager told us there were no restrictions in place. However we observed two staff members, on two separate occasions re-direct this person away from the front door and back into the main area of the home. We saw this person was led back into the home through a connecting door that had a key code fitted. This meant this person was then prevented from re-entering the reception area and leaving the home independently. When we checked this person's care plan we found there was no guidance for staff on how to support this person through periods of distress, no guidance with regard to any legal restrictions in place and no evidence of a best interest decisions or DoLs application. This was an unlawful restriction of this person's liberty.

Although staff had received training we found that not all the staff we spoke with had clear knowledge in relation to MCA and DoLS. Not all staff were able to give any examples of where a person`s liberty may be restricted although they confirmed they had completed the training. One staff member said when we asked them about DoLS, "Sorry I don't know what that means, can you explain it to me." We also spoke with one of

the nurses on duty to assess their understanding of DoLS and they told us "It's about stopping people going out of the home." However one staff member was able to tell us that "You have to assume that residents have capacity, when talking to person and they can retain that information, but if not use necessary tools to establish whether someone lacks capacity". One Staff member talked about unwise decisions. "Sometimes when an unwise decision has been made it does not mean they lack capacity."

We checked the current DoLS register with the operations manager who informed us that this was currently being updated. We found multiple errors with the information provided. This included 13 people were still on the register but had left the service. Seven people were logged down as being in the wrong units and five people's authorisations had expired with no evidence that new applications had been made. This meant that people's liberty could be unlawfully restricted due to inaccurate and out of date records

During our inspection, we found there was conflicting information with regard to another person's capacity who was standing by the main door of the home, appearing anxious and unsettled. We attracted the attention of the nurse (agency staff) working on the ground floor. However, they were unable to provide any assistance and shrugged their shoulders and told us they did not know this person. We reviewed this person's care plan but could find no evidence of a best interest decision or DoLS application and no management guidelines in place on how to best support this person in times of distress or anxiety.

We observed several examples during this inspection where staff failed to obtain people's consent before they provided support or care to them. The daily notes for one person dated 3 May 2018 stated '(name) was in bed asleep. I tried to wash them but they were very deeply asleep. I just washed their face & legs & changed their pad and then I left them asleep in bed.' We raised this with the operations manager as a concern and they confirmed that (name) had been given personal care whilst they were sleeping, with no consideration of seeking their consent. Throughout our inspection, we observed several examples where people were moved without staff speaking or explaining what was happening when providing care, staff walking into people's bedrooms without knocking and putting their bedroom lights on when they were still asleep.

We looked at three care plans with regard to mental capacity assessments and found two out of three of these consent forms had been left blank. The mental capacity assessment for a fourth person was completed on 3 August 2017 but this had not been reviewed or updated since. This person had a registered Lasting Power of Attorney (LPA) document in their care plan folder, but the name on the document did not match the name in the care plan. This was raised with the operations manager and although the manager confirmed the care plan was for the correct person, their full name was incorrect which could have placed them at risk of not receiving the appropriate care and support. The correct name was confirmed from their medication administration records.

Mental Capacity assessments were completed for some people evidencing that they lacked capacity to make certain decisions. However best interest decisions had not always been undertaken following the right process. For example, one person had been the subject of a best interest decision, which related to the specialist care provided. One of the requirements was that all staff should be provided with the specialist training in order to support and care for this person effectively and to have a better understanding of the person's complex illness. We asked the operation manager if this specialist training had been provided but were informed that it had not. This meant the person could have been placed at risk of harm from not receiving the care and support they required to maintain their health and wellbeing and could have also contributed to a deterioration in their condition.

We looked at one care plan in relation to the person's consent records and found the following documents

had been left blank. The name of the home, the consent to care and treatment was blank, the record for consent to checks was blank and the Best Interest Decision, consultation document pages three and four were missing. This meant that this person may have been receiving care that they or their representative had not consented to.

We found conflicting information in people's care plans with regard to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation. We reviewed one person's end of life care plan that stated that they did not want to be resuscitated. However, the DNAR document had only been completed by the staff of the care home, with no evidence of the involvement of (name) and was unsigned by a GP or a clinician. The date recorded on the form was 2 May 2017. This may have exposed this person to serious risk of harm. We saw a note within the care plan that advised the 'GP should be asked to sign the form'. To date this form remained incomplete and (name) was therefore recorded for active resuscitation. This inconsistency put the person at serious risk of not receiving appropriate care and treatment.

We found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the decisions taken in people`s best interest could not be evidenced that there were made following the best interest process and staff carried out care and support without asking people for their consent.

People told us the food was generally good and they had enough. Comments from people included, "The food is lovely". "I'm kosher and it took a little while to get it right but they've gone out of their way to get it right. It's good now, except the portions, too much." Another person told us "Every meal is like a west end restaurant." However, other people we spoke with told us they were not happy with the food provided. For example one person said, "The food has always been a problem and has got worse. No beans or tomatoes this morning, the eggs are like plastic. The kitchens do what they want. I've complained and spoken to the chefs."

Another person said "They [staff] seem to only want to give me vegetarian meals all the time, they never listen. One person told us "The food was 'ok', but it was not as hot as they would like it and as they were in their room they felt they had to wait a long time for her food to arrive." A relative we spoke with commented on the meal served to their family member and said "How can people remain strong and well when they are served this slop". They then pointed to the plate. They went on to say that (name) isn't even told what it is supposed to be. The carers haven't even told me why (name) needs this soft food'.

We observed the lunchtime meal being served in the respective units and found this to be a functional occasion. There were no menus displayed on the individual tables, no napkins or condiments. There were only two choices of refreshments which were orange or blackcurrant squash. We observed staff approach each table in one unit and simply poured out a glass of orange juice for each person without a choice being given or communicating with people.

On one unit we saw the menu displayed was dated 14 February 2018. We were told that there were two choices for the main meal which was salmon and beef lasagne. The meal served to each person on one unit was only sausages, potato and vegetables. One person was given an omelette. The Chef told us this was because nobody had requested either the salmon or the beef lasagne. On one unit we saw the food pictorials on display did not correspond with the actual menus for the day. Two further dining rooms we visited also had the previous day's menu displayed along with food pictorials, which also failed to match with the day's menu but displayed the menu for the previous day.

We reviewed a meal time and nutrition audit that was completed in April 2018 that stated 'Tables nicely

presented, with table cloths, napkins and correct menus displayed. However, this was not seen when we carried out our inspection.

We saw that people were assisted into the dining room by staff at 12.30 p.m. but did not receive their meal until 1 p.m. People who had their meal in their room were not served until 1.30 p.m. One person had a meal left on their bed table at 1.25pm but was not eating. The meal was still there, untouched, at 1.40pm. We also observed some undignified and disrespectful behaviours from staff during this time. This included one staff member assisting two people with their lunch at the same time.

Another person who had a vegetarian diet was about to be given sausages until we intervened. One staff member said "Put you're hands down so I can put the bib round you." This language is both degrading and disrespectful. We saw one person had been waiting for a long period of time for their lunch reach over and attempt to take another person's meal who they were sitting next to. The staff member was heard to shout at the person and grab the plate. The pureed meals provided to people consisted of three scoops of food which were difficult for people to recognise what they were being given and we found none of the staff went on to describe what the person was eating.

We saw a bowl of fruit in one of the dining rooms that had perished, with flies on it and was no longer edible. We found that none of the staff had noticed this and disposed of the fruit. This was a concern especially as this this was a dining room where people lived with dementia and they may have consumed the out of date fruit.

Not all people in the home were supported to receive a healthy and balanced diet. We found that people who were at risk of malnutrition did not receive fortified foods. Although this information was detailed in people's care plans when we spoke with the chef they told us that they did not fortify people's meals. We found that where people who had lost significant amount of weight they were not always referred for specialist advice and support. We reviewed one person's care plan that recorded a weight loss of loss from 60.1kg dated 2 December 2017 to 56.8kg 6 April 2018. Although there was evidence of the speech and language support there was no evidence that confirmed this person had been referred to the dietetic services or that they were receiving a fortified diet. The last record of dietetic involvement was on 21 December 2015.

Records for people's food and fluid consumption were not always accurate. For example, we reviewed fluid charts for three people in one unit and none of these had an optimum fluid intake figure recorded. One chart dated 18 April 2018 recorded a total of 950 mls for a 24 hour period and another record dated 23 April 2018 only had 800 mls recorded for a 24 hour period. We saw no action had been taken with regard to reviewing these low intake levels of fluids in order to ensure people had receive adequate amounts of fluid to maintain their health and well-being.

We found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people`s nutrition and hydration needs were not always met.

The design and layout of the building enabled people who were physically able to move around the home. There were several communal areas on each unit for people to access and socialise in. We found that although the service provided care and support to people who lived with dementia the environment lacked stimulation. The colour of the walls were bland and did not reflect the current good practice guidelines in relation to complimentary colours that enhance the environment. There were no aids to assist people with locating their own bedrooms. No memory boxes or photographs on each person's door. All the bedroom doors were painted the same colour. There were no memorabilia areas in which people could access

objects and reminiscence.

We saw in one person's bedroom that the carpet was heavily stained and their walls were blank. Throughout the home there were items of furniture that were badly soiled and stained. We found four arm chairs on the ground floor that were soiled and stained and in a quiet lounge on the third floor the scatter cushions were heavily stained. We found bedding had been placed on people's beds that were also heavily stained. The standard of the linen through the home was poor and some people had been provided with lumpy pillows and threadbare sheets and bed clothes. This issue was immediately addressed with the operations manager for their attention. We were informed that replacement bedding had been ordered for each person in the home.

People told us that they received good support with their health care needs from their GP and professionals outside of the home. However, one person told us that they had not been able to have a shower for a period of two years due to the service not having the necessary equipment in place. This was also confirmed by the operations manager. We were informed that although this person had been able to attend two hospital appointments with the support of external specialist equipment, the specialist equipment within the service was still inadequate and unsuitable for this person to be able to access the local community or to socialise outside of the home.'. The home's statement of purpose states 'We regularly review the needs of every resident and adjust their level of care accordingly. We do this with the resident, and, if appropriate, their family.' The home has failed to adhere to this statement and as a result placed this person's health and wellbeing was placed at risk of harm and also failed to maintain their dignity.

People told us they had support from the provider`s physiotherapy team was good and they were able to see their GP when necessary.

Inadequate

Is the service caring?

Our findings

People had mixed views about staff and if they were kind and respectful towards them. One person told us "The staff look after me well". Another person told us "The nurses and carers attitude is exceptionally good, very much a personal relationship, all fine with them." Another person we spoke with confirmed that "Staff knock and respect my privacy. Staff cover me up when they do my personal care and treat me with respect. Staff help me brush my teeth in my bathroom." However, we also received some negative feedback from relatives and people who lived at the home. One relative told us" The home was good once, but now it's a terrible place and I have been unhappy with the care of (name) since Christmas." Another person told us "Staff are being rude to me and are insulting me. Management say that they will look into it. I'm getting upset and not sleeping." They went on to say "One of the male carers said to me "You can do that, you're quite capable, you don't need a night bag you're quite capable of going to the bathroom." They also told us that "They made me feel degraded and I felt like I was being treated like a child." A relative who we spoke with told us "I don't like complaining, but there are 'too many excuses, nobody really knows what's going on, people just don't care. What the hell are we paying for."

We saw several examples where staff ignored people and failed to respect people's privacy and dignity during our inspection. For example, we were talking to a person in their bedroom when a staff member walked into the person's room without knocking or asking permission to come in. Another person we spoke with described an incident where a male carer walked into their bedroom and started looking through their drawers without asking or gaining permission to look through their personal items of clothing.

We observed a group of nine people who were seated in a communal lounge. There was one staff member present. The television was on. People were disengaged. Three people were asleep, two people were speaking but no one was responding. The staff member did not attempt to talk to people or engage with anyone in the room.

We saw one person who was walking around the unit wearing trousers that were several sizes too big for them with the waistband folded over numerous times. They had to hold them up whilst walking. We asked (name) about this and they said "I think they are mine. They are too big, look. I have lost weight." We observed a staff member enter a person's room without knocking. They proceeded to sit opposite the person and did some paperwork without speaking. The person became agitated and kicked their covers off. The staff member did not speak or reassure the person but just threw the cover back over the person and left the room. This was reported to the operations manager for their immediate attention.

During the lunchtime observation we witnessed a staff member call out to another member of staff who was in the kitchen "Can I have another soft please." They then continued in a loud voice to ask another staff member "Who is done. Can you do her?" This behaviour demonstrated a complete lack of respect towards people and failed to uphold people's dignity and self-worth.

We observed that all the bedroom doors were open which meant that from the corridors people`s catheter bags and PEG feeds were fully visible to anyone who passed by. This failed to provide any dignity or privacy

people being cared for in bed.

During the inspection, we observed staff moved people in their mobile chairs, with no thought shown to the protection of the person's feet. We saw that people's feet were being 'pushed' along with the chair without the use of the footplates. One person had bilateral pressure sores to their feet and were seated in one of these chairs, which could place them at risk of further harm.

We found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not treated with dignity and respect.

Some people told us they felt staff listened to their views. One person told us "I'm always quite impressed how respectful the staff are. How do they manage to do that, the way they communicate and show patience and are good at judging. They have a level of respect and kindness". However, some people felt that staff had not listened to them. One person told us "One female carer doesn't always concentrate. On one occasion they didn't put the night bag on properly because they were talking too much. I had an accident and was covered in urine, and then had to wait one and a half hours to be cleaned up. I pushed the call bell when this happened and the staff kept cancelling it. I pushed it four times and on the 5th time they came after approximately forty minutes". This meant that people's preferences were not always respected by staff.

We asked people if they had seen their care plan or were involved in its development. One person told us "No, staff have not talked to me about my care plan. I have been here for four years. No conversation about it recently." Another person told us that they knew that they had a care plan. They told us that staff asks them if there is anything they would like to do. However, they also told us that they have not seen it or read it. We spoke to a relative who told us that they have never been asked to be involved with the care planning process, despite holding a Lasting power of attorney for their family member and they have never been asked to sign a consent form. They went on to tell us that "It's a very sad place to be in."

People told us that they could have visitors when they wished and there were no restrictions in place. One person told us "Friends come and visit once a month and staff make them feel very welcome."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection carried out 6 June 2017 we found that people did not receive consistent person centred care, sufficient engagement and interaction. At this inspection, we found that the service still failed to provide care that was person centred and staff continued to provide task orientated care. We found that people continued to be left for long periods of time without any stimulation, engagement or meaningful activities from staff.

Not everyone at the home was able to tell us if they were happy with the support they received. However, two family members raised concerns about how responsive the service was in meeting their relative's needs. We asked one person we met if they felt the home was responsive to their needs. They told us "No, for instance, the food. Relatives have complained as well but it does not change. The kitchen is a law unto themselves." Regarding residents meetings the person said "There was a meeting a couple of weeks ago. I was not even notified this time, another resident told us. "If I don't want to attend, it would be nice to be able to ask a care worker to mention something for me".

We reviewed the summary in one care plan that listed the persons' diagnosis; this included dementia, hypertension, a depressive disorder, bi-polar disorder and emphysema. However, we saw no evidence that a risk assessment or management plan was in place in order for staff to provide the necessary support and guidance with regard to the person's mental health need or their wellbeing. We also found no reflection of this persons' emphysema and how to support and care for them within the care plan. This meant we could not be assured that staff would provide the correct. support and care to this person.

We reviewed a person who had a complex wound. This person had grade four bilateral pressure sores on their feet. A senior carer told us that the wound on the left foot was an on-going issue and the right foot wound was a 'new' problem. The left foot wound was reviewed by the tissue viability nurse (TVN) on 7 March 2018 and they advised that dressings should be changed on alternate days. However, the photographic log sheet evidenced that this advice was not being followed and dressings were often changed on a daily basis. This practice has the potential to cause harm and effect wound from healing.

One person's care plan was incomplete with vital information missing and inconsistent information being provided. For example, the notes within the care plan stated that this person had 'good eyesight' but the personal evacuation plan (PEEP) stated that they had a visual Impairment. The records also stated that this person's height was 1.67m and their weight was 81.2kg however the recorded height on the Malnutrition universal score (MUST) was 1.47 cm. This person's score was therefore calculated using the incorrect height measurement. These inconsistencies could have placed this person at risk of harm from not receiving the appropriate care and support.

Some care plans we reviewed had not addressed all the health conditions people were diagnosed with and did not provide staff with sufficient guidance on how to meet people`s needs and staff had not been offered training with regard to understanding this specific condition and three staff spoken with were unable to explain the common symptoms of this condition or knew how best to support the person. For example one

person who had a life limiting condition that required staff to support them in a specific way, this included an understanding of the involuntary movements the person made and how to interpret these, in order to provide the best possible care. The records seen demonstrated staff did not fully comprehend this condition. This person was described as being 'agitated and restless' and was regularly administered PRN medicines. However this behaviour was very 'typical' of this person's condition and did not always require medicine but staff should offer support and comfort to the person.

We found that staff had not been offered training with regard to understanding this specific condition and three staff spoken with were unable to explain the common symptoms of this condition or knew how best to support the person.

Staff were not always able to tell us what people liked, disliked and their needs were. We noted that some staff had a language barrier and did not always understand what we were asking them. This would have had an impact on communication with people who were less able, had limited communication skills or had a cognitive impairment.

Some care plans contained information about how people needed to be supported. However, care and support was not always provided in accordance with these plans. Some care plans were more detailed than others. Three out of six care plans we looked at failed to contain specific information about people's preferred times for getting up and going to bed and whether people preferred their bedroom door left open or preferred it closed.

Care plans were not up to date and were not reflective of people`s current needs. For example, 'wound care plans' were not kept in the people's folders but were kept in a separate folder. We found this folder to be disorganised and inconsistent. We found that if wounds had healed it was not always marked as 'healed' but remained in the folder and was not archived. This made it difficult to find the most up to date information of the person and accurate information with regard to the current condition of the wound.

People's care plans lacked detailed or accurate information that related to people's care and were not subject to regular review, no background or social history to support staff to understand the person better in four out of the six we reviewed. Each care plan contained a basic list of the tasks that care staff would follow when providing support, and some information in relation to continence, mobility, communication and diet. However, this information was not person-centred and did not provide enough detail to enable staff to carry out tasks consistently and safely. From our observations, we saw that staff often provided only basic and functional care and this was not always in accordance with their care plans or preferences.

The home currently has eight fulltime nurse vacancies and therefore has a high use of agency staff and given the lack of detail and specific guidance for supporting people in care plans it would be difficult to see how an agency nurse would know what care to provide to people. From our observations, we saw that staff often provided only basic and functional care and this was not always in accordance with their care plans.

We were told that there was an activity programme provided six days of the week and that the home was in the process of recruiting another activity person in order to provide a seven day a week programme. On 24 April 2018, we observed an activity in a lounge area on Churchill Unit. 10 residents were present and more joined in later, making 14 people in total. The two activity co-ordinators were present, with one leading the activity. Other staff brought teas and coffees during the activity, which included showing people pictures of fruit and vegetable and asking them what these were and what benefits we get from them. We saw that people were engaged with the activity, and appeared to enjoy it. Music was introduced with maracas and tambourines, while the lead Activity Co-ordinator played the guitar and sang. We saw that people joined in

and when one person became distressed, they were offered the guitar to strum. Recent activities included a prize giving activity for Easter hats made by people.

However, on 3 May 2018 we found that there was only one activity worker on duty for 86 people. We were told that this person would provide a morning and afternoon activity. However, we observed several people sat in communal lounges for long periods of time without any engagement or stimulation from activity staff or care staff. We saw no activities offered to people who lived with dementia and no visual prompts or objects available that could stimulate and engage people. We also found no evidence from the individual activity records that any room visits had taken place. We saw from the training records that there were no specific training courses provided for activity staff in order to further develop their skills. One person told us "Major gripe, I need to go out, they cannot provide any transport. There is no real entertainment here, just bingo. There is an activities coordinator. They have not had a chat with me but came and handed a programme of activities to me. There are no activities on a daily basis. I have requested a pianist and singer. There is not much stimulation for someone like me."

One relative told us, "There are not enough activities and not much at all at the weekends. One staff member told us "This rarely happened, as staff are always too busy." Another staff member told us, "We would like time to be able to just sit and chat with people but there never is time."

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people`s needs and preferences were not always assessed and care plans were not developed to meet all their needs in a personalised way.

Although care plans contained an end of life plan we found that some of the records were not completed and did not provide evidence that confirmed the person's family had been involved in providing information that ensured the person's time would be as comfortable as possible during their final days. This was an area that required improvement.

People gave us mixed views about complaints made about the service. One person told us "I have complained many times but nothing ever gets done or changes." However we spoke with another person who told us "I have made complaints. They took my complaints seriously." A relative told us, "My [family member] made a complaint because their clothes were lost in the laundry and this complaint was dealt with." There was a process in place for the recording and investigation of complaints. We reviewed the complaints log and saw that complaints were investigated and responded to in accordance with the complaints policy.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service on 6 June 2017, we found that the service was meeting the required standard. At this inspection, we found that not all the people living in The Chase Care Centre received care and support in a safe and effective way. The quality audit systems in place were not effective and had not identified and or resolved the issues found at the inspection.

The service is currently without a registered manager and the interim management arrangements were provided by an operations manager at this inspection. The service operated a management on-call system for staff to have this support any time they needed including nights and weekends. Each of the six units were managed by a team leader. Staff gave us mixed views about the support provided by the manager. Some staff were unable to confirm who the current manager was although one staff member thought the previous manager was still working at the home but had in fact left the service in April 2018.

The management of the service lacked leadership and was not transparent. We found during our inspection that people had been placed at risk of harm due to unsafe practices and ineffective systems that monitored people's health and safety. For example, people who were on pressure relieving equipment had their mattresses set incorrectly.

People's care plans were incomplete and failed to provide evidence that people had consented to their care. Medicines were not administered safely and covert medicines were being provided without the correct documentation or authorisation from the GP. We found that people's nutritional and dietary needs were not monitored which placed people at risk of harm from consuming food that was both inadequate and against their wishes or preferences and people were not treated with dignity or respect by staff.

We saw from records that staff had received safeguarding training, fire training and deprivation of liberty safeguards (DoLS) training however three staff we spoke with were unable to explain the procedure to follow in the event of a fire, they were also unable to describe how they would safeguard people against harm and were unable to describe the different types of abuse. They were also unable to explain or give examples of when a person may be lawfully deprived of their liberty. This meant that the standard of training provided had not ensured that all staff were competent or aware of practices that constitute abuse, in the fire evacuation procedures or understood their responsibilities with regard to deprivation of people liberties.

We found that people`s care plans were not up to date and contained conflicting information about people`s needs and were not effective and had not been regularly reviewed. Care plans had not addressed all identified needs for people. We found examples where people`s care plans had not changed since they moved in the home and updates suggested there were no changes to note for people.

There was no system in place that audited call bell response times and some people told us that often when they rang their bells staff turned them off without delivering care and they had to wait until staff returned to them.

We also found fluid balance charts had failed to identify gaps in these records, which placed people at risk of harm from pressure ulcers and from dehydration.

We found concerns in relation to communication with some staff and we could not be assured that they were trained effectively as their understanding of English was very limited. We found that some staff we spoke with were unable to answer basic questions that related to the care and support of people who they provided care to. For example when we asked one staff member to explain the moving and handling procedure for one person they were unable to comprehend the question and went for the assistance of another staff member in order to interpret what we had asked.
When we discussed this with the management team they informed us that they were intending to offer additional support to those staff members where English was not their first language. However they were unable to describe in what form this support would be provided.

Staff gave us mixed feedback about the support they received from the senior staff. We asked one of the permanent nurses if they felt supported by the management team. They told us that they were 'ok'. They went on to tell us that historically nurses were nobodies in this place. They told us that they had shared their concerns with the management, but nothing was ever done. They told us that there is too much unnecessary paperwork and not enough time to nurse."

We were told by the operations manager that there was a range of staff meetings held and that staff also met on an informal basis as part of the daily handover sessions. We were also informed that relatives meetings were held periodically and the minutes seen from the most recent meeting held in April 2018.

Feedback was obtained through the completion of an annual survey. One person told us "Sometimes the manager talks to us in the morning, not every morning." They told us that they had never been asked to fill out a questionnaire or any forms. We asked for the results of the most recent satisfaction survey. A copy of the most up to date action plan and satisfaction survey was not available at the time of the inspection but was later sent to the Commission on 9 May 2018.

Feedback from staff did not always demonstrate that they were being given the appropriate training or supervision to carry out their role effectively. For example, the most recent supervision records provided were dated December 2017. We spoke with four staff about supervision and three people told us that they had supervision every three to four months and one person told us "I don't think I have ever sat down and had a face to face meeting.

The quality monitoring systems in place had not been effectively used in identifying concerns and areas of risk. The provider had not identified the concerns that we found during our inspection and had therefore not taken action to mitigate risks or ensure people received safe and effective care. The provider shared with us an action plan they put in place in March 2018. Actions listed were signed off as completed however, we found that these issues were still present at the time of the inspection and improvements had not been made. For example risk assessments and care plans were not up to date. This meant that the quality monitoring had not led to sufficient improvement.

Therefore, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as their governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

Following this inspection, we received an immediate action plan from the provider, which addressed some of the concerns we had raised with the operations manager in feedback following the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People`s needs and preferences were not always assessed and care plans were not developed to meet all their needs in a personalised way.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People`s best interest could not be evidenced that there were made following the best interest process and staff carried out care and support without asking people for their consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people`s well-being were not sufficiently mitigated to protected them from harm.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from harm due to staff not fully understanding abuse and how to protect people from harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People`s nutrition and hydration needs were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always adequate levels of suitably trained, competent or qualified staff.