

Lincs Healthcare Limited

Bank House Care Home

Inspection report

Gosberton Bank
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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires Improvement



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

This inspection took place on 13 April 2015. This was an unannounced inspection.

The last inspection took place on 3 September 2014.

The home provides residential care for up to 30 people. The care provided is mainly for older people, some of whom experience memory loss and have needs associated with conditions such as dementia. At the time of our inspection there were 17 people living at the home.

At the last inspection on 3 September 2014 we found that the provider was not meeting the standards of care we expect in relation to ensuring people's care was planned and delivered to meet their individual needs, maintaining appropriate standards of cleanliness and hygiene and did not have appropriate arrangements for the management of medicines. We also found that the provider did not ensure staff were appropriately supported with training and supervision and did not have effective systems to

Summary of findings

asses and monitor the quality of service provided to people. At our inspection on the 13 April 2015 we found the provider had not made improvements in the areas we had identified.

There was a registered manager in place at this home who was also the provider of the service. 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.

Staffing levels were not adequate to ensure people's needs were met in a timely fashion. There were not always enough staff on shift to provide care for people or to maintain clean and hygienic conditions in the home.

In addition, staff had not received training in how to support people and did not receive adequate support from the provider to improve the standard of care they gave to people. Staff had not received adequate training in order to be able to understand people's needs and how care could be delivered to be more responsive to people's needs. In particular staff were unable to tell us how they would ensure people were protected from harm as they did not fully understand the types of harm people may be exposed to. Staff did not receive adequate support from the provider to identify areas in their practice where they would benefit from further training.

While staff were polite and respectful to people, they had not always taken the time to get to know people and how they liked their care delivered. In addition, people were not supported to make choices about their individual care needs and care plans did not record people's communication needs so that they could be consulted over their care. No aids to communication were available.

Care was not tailored to meet people's individual needs and people's care plans did not include information on how to keep people safe from avoidable harm. Care plans were basic and did not fully record people's needs. Risk assessments did not identify all the risks people were exposed to and were lacking in detail of the care needed to mitigate the risk. Care was not reviewed after accidents to identify if people's care needs had changed and more support was needed. Care and support provided by staff

was task rather than person centred and did not take account of people's preferences. We were concerned that people did not have access to meaningful activities either individually or as a group.

The provider did not have effective systems in place to manage medicines. We found that not all medicines could be accounted for and we found widespread inaccuracies between records and medicines prescribed and available to administer. Therefore, we could not be assured people's medicines were being administered as intended by their prescribers.

The provider had not complied with laws which protect people when they were unable to make decisions for themselves. The provider had not fully understood their responsibilities under the Mental Capacity Act 2005 and consequently and not ensured people's human rights were protected. Care plans did not record if people were able to make decisions for themselves. For people unable to make decisions for themselves there was no recording if best interest meetings were needed or if a Power of Attorney existed.

People were supported to have adequate hot and cold drinks. Where people needed help to eat this was offered appropriately, however, where people could be more independent this was not always supported by offering appropriate food.

The standard of cleanliness and hygiene did not reduce the risk of infection. The home was not maintained to adequate levels of cleanliness and infection control. The policies in place did not support staff to follow appropriate procedures to reduce the risk of infection. In addition, the provider did not identify infection control risks and therefore audits to improve the quality of infection control were inadequate. Furthermore, processes in place to monitor the cleanliness of the home did not identify on-going issues.

The quality of the decoration in the home was of a low standard and did not support people's well-being. The provider had not made any improvements to the environment since our last visit. Wall paper was coming off the walls in places and skirting boards and windowsills were cracked. In addition, furniture used was old and had not been maintained to a useable standard, with handles missing.

Summary of findings

People living at the home and staff were not activity involved in running the service and no staff or residents' meetings had taken place since our last inspection. While at our last inspection the provider had asked people to completed a quality assurance survey, at our inspection on 13 April 2015 we saw they had made not improvements to the service in areas where people had identified the service was not meeting their needs.

Systems to monitor the quality of service provided had not identified shortfalls in care.

There was no effective system in place for monitoring the quality of the service provided to people. The provider had undertaken a course in monitoring quality in February 2015 however, they had failed to implement any of their learning in the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Staff were not always available to ensure people would be safe from harm. People's care records did not identify all risks and were not kept up to date. Care delivered did not always ensure risks to people were minimised and medicines were not managed in a way to protect people from medicine errors.

There were not always enough staff to meet people's needs.

Appropriate levels of cleanliness were not maintained and infection control processes were not effective.

Inadequate



Is the service effective?

The service was not effective.

Staff did not always have access to the training they needed in order to meet the needs of all the people who lived at the service.

People's human rights were not protected as the provider did not understand their obligations under the Mental Capacity act 2005.

The building was not maintained to an appropriate standard and decoration did not support people to retain their independence.

Inadequate



Is the service caring?

The service was not caring.

Staff did not know people's preferences and personal histories and did not always show concern for people's well-being.

People were not always treated with respect. Staff did not always support people to maintain their privacy and dignity.

Requires Improvement



Is the service responsive?

The service was not responsive.

People's care plans did not reflect their personal preferences in the way they received care and did not support people to communicate their individual needs.

People were not supported to take part in activities or maintain their hobbies. They had little to entertain them during each day.

Inadequate



Is the service well-led?

The service was not well led.

Inadequate



Summary of findings

The provider was not proactive and had not responded to concerns raised about the home. They had not kept people or staff updated with issues and had not consulted with them to improve the home.

The providers systems to monitor the quality of service people received were ineffective.

Bank House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 April 2015 and was unannounced.

The inspection team consisted of three inspectors and a medicines management inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the

service, what the service does well and improvements they plan to make. However, the provider did not return a PIR and we took this into account when we made the judgements in this report.

As part of the inspection we spent time observing how care and support was provided for people who lived at the service. This was because some people had difficulties with their memory and were unable to tell us about their experiences of living at the home. In order to do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not speak with us.

As part of the inspection we spoke with the provider, a senior care worker, three care workers, the cook, the housekeeper and six people who lived at the service. We looked at the care plans for five people living at the home. We also looked at medicine administration records, staff training and supervision records and management paperwork related to the running of the home.

Is the service safe?

Our findings

At our inspection on 3 September 2014 we identified that people were not adequately protected against the risks associated with the unsafe use and management of medicine. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 management of medicines.

At our inspection on 13 April 2015 we found there were no systems in place to record when medicines were received by the home or to record when medicines which had not been taken were disposed of. This meant that it was impossible to complete an audit as it was unclear what medicines should be in the home. A person living at the service who we spoke with during the inspection told us their medicines were often not given to them on time. For example, they should take some medicine half an hour before breakfast. This meant the person may not get the full benefit of their medicine.

Medicines were inaccurately recorded. We found medicines administration records did not contain the correct name for medicines and other medicines which were being administered were not on the chart. We found a duplicate record where there was a risk of the medicine being incorrectly administered twice. We found two medicines that were recorded for administration but the provider did not have them in stock. This meant the medicine was not available for people if they needed it. There were body charts in place showing where on the body pain-killing skin patches were to be applied. However, there were no records for the administration of creams or other medicines prescribed for external application.

Guidance for medicine prescribed to be given as required was incomplete and did not always support staff to administer medicines appropriately.

We observed part of the morning medicine round. We noted that medicines were kept securely during medicine administration. The senior carer on duty prepared medicines for administration by reference to medicine administration record charts but completed records of medicine administration before they were actually administered to individual people. This was unsafe practice.

Medicine was not always stored appropriately. We found that medicines for oral administration were stored safely.

However, we found that the maximum daily temperatures significantly exceeded the accepted temperature range for the refrigeration of medicines. This meant we could not be satisfied that medicines requiring refrigeration maintained their quality and were safe to use.

We noted records showing that five members of staff authorised to handle and administer people's medicines had received training in January 2015. We saw records of monthly medicine audits carried out at the home. However, our findings showed the audits did not identify or resolve issues of concern in relation to people's medicines and did not protect people against the unsafe use of medicines.

At our inspection on 3 September 2014 we identified that the provider was not maintaining an acceptable level of cleanliness and hygiene. This meant people's risk of infection was increased. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 cleanliness and infection control.

At our inspection on 13 April 2015 we found people were not living in a clean hygienic environment. We saw there had been a slight improvement in the cleanliness of the home in the communal areas. However, people's bedrooms and equipment were not clean or well maintained. In addition, some parts of the home had an unpleasant odour. In one bedroom we found an aerosol can of a product used to clean skin had faecal matter encrusted on it. Rotas showed there was not enough housekeeping staff on duty. For example, there was no cleaner for six days and on six further days the cleaner was scheduled to care as well as complete the cleaning. Cleaning schedules showed cleaning was never fully completed and for 43% of the time no cleaning was completed.

Hand wash sinks in communal toilets and in people's bedrooms were ingrained with lime scale around the taps and plughole areas. The housekeeper said that it was difficult to clean the lime scale off as the taps. This showed that housekeeping staff were unable to clean effectively.

Commodes were not maintained to prevent them spreading infection. We found that commodes in people's rooms were not always clean. For example, one commode had faeces dried on the lid and seat. In addition, commodes were not maintained to enable cleaning to be effective. For example, one commode seat was ripped and the foam filling was on display. Systems to clean

Is the service safe?

commodes did not reduce the risk of infection as staff washed them where there was a risk of contaminating clean laundry. Staff also used the same sink to wash their hands.

Equipment used to clean the environment was not well maintained. For example, a carpet shampooer was stained and dirty. Dusters were covered in thick dust and had not been cleaned. We saw people were put at risk and allowed access to cleaning products which may be harmful to them. We found the cleaner's trolley had been left in an unlocked toilet and we were also able to access the cleaner's cupboard as it had not been locked.

Staff were not supported to maintain appropriate levels of hand hygiene as there was a lack of available hand wash, paper towels and waste bins in bedrooms. We saw used equipment such as gloves had been disposed of in open bins in people's bedrooms. This increased the risk of infection and meant they were not properly disposed of with the clinical waste.

We found the provider did not have effective procedures to prevent and control infection. We looked at the infection control and decontamination policies and it did not contain clear guidance for staff. This meant processes needed to reduce the risk of infection may not be followed. An infection control audit had been completed by the deputy manager in November 2014. However, we saw that it had not identified infection control issues. We saw an external infection control had been completed by Lincolnshire County Council in December 2014. The provider had a copy of the report and areas which required action. The provider's action plan was not complete and would not ensure people were protected against the risk of infection.

At our inspection on 3 September 2014 we identified that care plans did not contain accurate or up to date risk assessments. This meant people were at risk of receiving care which did not protect them from harm. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 13 April 2015 we saw some people's care plans had not identified the risks to people. The provider told us that one person had an area of skin damage due to pressure. They were put on bed rest for the afternoon as they had a sore area due to sitting in one position. There was no recording in the person's care plan

of the skin damage, the need for bed rest and what pressure relieving equipment was to be used. Where care plans did include risk assessments for pressure care, falls, personal safety and mobility and nutrition, risk assessments had not been updated and did not reflect the current care needed. Risk assessments had not been reviewed when accidents such as falls indicated people's needs may have changed. This meant that staff did not have relevant information about the care that people required and there was a risk inappropriate care could be given.

The fire evacuation plan had not been updated since our last visit and included people who were no longer living at the home. It did not include some people who were currently living at the home and so would have been meaningless to emergency services attending an incident at the home. The evacuation list recorded people's mobility but did not record people cognitive abilities and how they may react in an emergency.

At our inspection on 13 April 2015 we found the provider did not have effective systems in place to keep people safe from harm. People told us they felt safe living at the home. One person said, "The home is friendly and staff look after our safety." Staff said they would raise any concerns immediately with the staff member in charge or the provider and we saw the contact details for the local authority safeguarding team was on display near the provider's office.. However, despite staff telling us they had received training in keeping people safe from harm, staff were unable to tell us about the different types of situation which may put people at risk of harm.

Records showed on 27 February 2014 the provider and 12 out of 17 staff had completed training to help them recognise when people may be at risk of being harmed. No further training had been provided to update staff in this area. This meant some existing and new staff had not received this training and no further training had been scheduled.

We found through observations and discussions with people that there were not enough staff to meet the needs of the people living in the home. One person said, "I regularly wait for staff in the morning. I ring my bell to be told to wait for ten minutes. I ring again and generally it takes around 45 minutes before I get any help. There are definitely not enough of them, especially at night when there is one member of staff for us all." We also observed a

Is the service safe?

15 minute period in a communal area where people were sat and noted that no staff were available. One person was very unsteady on their feet and unable to communicate for help or assistance. An inspector alerted staff that this person required help.

Staff told us they felt there were currently enough staff to provide safe care for people but that at times they had to work long hours in order to ensure there were the right levels of support available. However, the dependency tool used by the provider to calculate the number of care staff needed had not been updated since September 2014. We found that the numbers of people living at the home and

the needs of people had changed since the calculation was made. Therefore the provider could not be sure the right numbers of staff were always available to support people safely. We found that that improvements made in staffing in 2013 had not been sustained.

The provider had recruitment processes in place and completed appropriate checks before new members of staff started work. A member of staff who had recently started to work at the service told us and records showed how they were required to have a DBS check and two suitable references before they started work.

Is the service effective?

Our findings

At our inspection on 3 September 2014 we found that the provider had not managed the environment to ensure it had been maintained to an appropriate standard. Rooms were in need of decoration and furniture was also old and worn hence was unable to be cleaned effectively. This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision

At our inspection on 13 April 2015 we found the provider had not improved the decoration of the home or the quality of the fixtures and fittings. The provider acknowledged a lack of action pertaining to the decoration of the home and told us we would find, "Much of the same things as last time." This meant the provider had not met the needs of people to be able to live in a pleasant well maintained environment.

There was significant environmental damage throughout the home and a lack of attention to detail. No decoration or maintenance had been carried out since our last inspection in September 2014. For example, wallpaper in people's bedrooms was peeling off and the walls were bare in patches. There were water marks on walls and ceilings where they had been water leaks. There were cracks in walls and skirting boards and window sills were scuffed and in need of re-painting.

People did not live in a safe environment. We saw a hole in a toilet wall approximately 2 cm across which had been plugged with plastic gloves. There were also holes in walls from previous fixtures and fittings which had not been filled. We noted nails protruding from walls in most people's bedrooms, there was a risk people could hurt themselves on the nails. In another room we saw an area of the wall had been covered with duct tape to prevent access to an electrical fitting.

People were not able to take pride in their environment. Furniture in people's bedrooms was old and in need of replacement. We saw drawer handles were missing, which meant people may not be able to access their belongings. We saw that people's armchairs had rips on the arms and were not made of a material which was easily washable.

Two wooden commodes were worn to bare wood and were unable to be cleaned effectively. We saw the light bulbs in people's bedside lights had not been replaced. Curtains had not been hung correctly and looked untidy.

Toilet frames in communal areas were rusty and therefore unable to be cleaned effectively. Carpets were stained in areas and worn. Three rooms had new vinyl flooring, however, the flooring had not been properly finished and there was a gap between the bedroom and hallway floorings which was a trip hazard.

We saw there had been no adaptation of the building to support people with dementia to retain their independence. For example, there was not signage or support to help people who may suffer from memory loss to find their way around the home.

At our inspection on 3 September 2014 we identified that staff had not received adequate monitoring or support to ensure the care they provided to people was safe and effective. This was a breach of regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 supporting workers.

At our inspection on 13 April 2015 we found the provider did not appropriately support staff to enable them to care for people effectively. One person said that staff did not have the skills to care for them. They said, "Some of the staff have no idea. I have to explain to them how to use the equipment. Some staff are very good, others appear new and don't have a clue."

We found that training and support for new staff and for staff who returned after a prolonged period of time was not effective or fully recorded. A new member of staff told us they had completed an induction and some of the training they needed, they had also spent time shadowing an experienced staff member. However, records had not been completed about the training needed or completed. One staff member who had recently returned to work told us they had not received any supervision or had a return to work meeting with the provider to review their training needs. This meant it was not possible to know if they all staff had the skills needed to provide care unsupervised.

Training for established staff did not ensure they had the skills required to care for the people at the home. The provider showed us the training plan which recorded the training completed between January 2014 and January 2015. However, we found the provider and staff had not received appropriate training in order to care for people in

Is the service effective?

the home. For example, training for dementia related needs, how to respond when people got distressed, nutrition and hydration and equality and diversity had not been completed.

The provider told us staff should receive formal supervision six times a year and an annual appraisal. Staff told us and records showed staff were not regularly supported with supervision. Actions identified during supervision had not been followed up. For example, one record showed a staff member had not completed the training the provider had identified as mandatory for all staff, but no actions had been set to address the incomplete training. Records showed that some staff had not received an appraisal in the last 12 months. This meant the provider did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver effective care.

At our inspection on 13 April 2015 we found that the provider did not ensure people's human rights were protected. Records showed that training had been provided in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These are laws which ensure people's human rights are respected when they do not have the ability to make choices for themselves about where they live and the care they need. However, the training was not effective as provider told us no one living at the home needed to be referred for a DoLS assessment, but we identified two people who had their freedom restricted as they constant supervision to ensure their safety which may be a deprivation of their liberty. No applications to the DoLS authority had been completed to determine whether this level of supervision was lawful and in their best interests

People's ability to make decisions was not recorded in their care plans. It was not always clear, when decisions were being made on behalf of people, whether they lacked the capacity to make these decisions themselves. For example, we saw one care plan which stated that the family had agreed to the way care was provided for the person.

However, there was no clear evidence that the person lacked capacity. An assessment had been started by the provider in 2013 but not completed and there was no outcome to show if the person could make a decision or not. No one had signed the care plan to show their agreement.

Before lunchtime we heard one person asked for egg custard for the pudding and that they really liked it. A staff member responded saying this would be provided. However, when the meal was served the cook told people egg custard wasn't available. This meant people did not have a choice regarding their meals.

Most people said they enjoyed the food at the home and we saw breakfast was tailored to meet people's individual needs. One person said, "I like my meals here the food is always nice." However, we could find no evidence to show people were asked about what they wanted to eat for either meal. Staff told us they knew what people liked and that they adjusted the menus based on the food they thought people would want.

The provider told us that the menus were changed three or four times a year, this was done by the cook and the assistant manager. The provider said they would ask people living at the home if there was anything they wanted adding to the menu. However, there was no record that people had been involved in developing new menus.

We found people were supported to have access to hot and cold drinks. Staff provided drinks for people during the day and we saw that there was a mid-morning tea and drinks trolley and people were offered a hot or cold drink between breakfast and lunch.

We saw and staff told us that people who lived at the home were supported by visiting community nurses. However, there was no recording of visits or care instructions from other health care professionals in people's care plans. This meant it was not possible to see if all appropriate healthcare professionals had been involved in people's care.

Is the service caring?

Our findings

At our inspection on the 13 April 2015 we found that people received an inconsistent level of compassion, dignity and respect from staff. We saw that positive caring relationships were not always developed between staff and people living at the home. The relationship between staff and people living at the home was polite and respectful. However, we identified that staff did not ensure they really knew the person they were caring for and interactions were based on tasks to be completed. For example, a staff member approached one person and said, "I have brought you a cup of coffee." The person smiled and thanked the staff member. After tasting the coffee the person shouted for sugar and the same staff member fetched some for them. The person told us, "They [staff] know I have sugar but they always forget."

One staff member told us they had provided support to a person who had lived at the home for about eight months and that they spoke with the person every day in order to motivate them to eat and to build themselves up towards a planned return home. However, when we asked the staff member to tell us the person's name they could not be sure of their first name and did not know their last name. Instead they referred to the person in a way we found to be discriminatory and which may have caused psychological harm. The staff member did not recognise this may be abusive and said that was what they called the person and that the person had not raised any concerns about the use of the reference.

Staff did not always ensure people were comfortable. A person was eating their meal sitting in a wheelchair. The chair had no footplates so the person needed to hold their legs up when they were both still and when the chair was moved. Staff told us the person needed a hoist to move from the chair to another place, for example, their bed. The sling used for the hoist was still underneath the person when they sat in their chair and they looked uncomfortable. The person's top was partly unbuttoned because of the way they were sitting and they indicated to us they were uncomfortable and that they may be in pain. This also meant their dignity was not being supported.

When people became upset staff did not always provide comfort and reassurance in a positive way. We saw one person was anxious and upset and not settled, they

continually shouted out for help. After some time a staff member responded by taking the person a drink but didn't stop to check if there was anything else the person needed or provide any reassurance for the person.

The provider told us that no one who lived in the home currently had an advocate. An advocate is an independent person who can represent the views of the person receiving care when they are unable to speak for themselves. There was no information on display so that people or relatives could find out about advocacy. This meant people may not be aware of advocacy services which were available to them. We saw care plans indicated that family members had agreed to the plan of care, however, care plans had not been signed and there was no evidence that the people involved in making the decisions had the right to do so.

People's ability to make choices about their care was effected by the task orientated way the care was delivered. We observed the main routines were set around specific tasks. For example, meal times were set and there was no flexibility for people to choose to eat at a different time. Once meals had been completed the kitchen area was closed until the next meal time.

People's privacy when they received care was not always supported. We observed a bedroom door had to be left open when one person was hoisted onto their bed. This was because the room was not big enough to accommodate the hoist.

People were not supported to maintain their dignity. We saw one person had been drinking from a beaker and that their drink had spilled down their jumper. The drink had dried and there was a large stain on the person's clothing. As the person drank some of their drink they kept re-staining the same area so it had become permanently damp. Staff took no action to help the person to change their clothing or support their dignity through the use of a protective apron.

We observed some positive examples of staff caring for people and some people told us the staff were caring. One person said, "The staff know my needs well and I think they are very caring." At breakfast time we spent time observing the interactions between staff and people. We saw one person was supported to eat their meal by a staff member

Is the service caring?

who took the time that was needed to make sure they ate and drank enough. The person could not communicate verbally but responded positively by smiling and gesturing to the staff member.

We also observed staff encouraging people to eat by sitting with them or getting down to the person's level to help

them to eat or drink. We saw one person was singing happily in advance of their breakfast and when a staff member took their food to them they sang together. The person looked very happy with the interactions and we saw they enjoyed their food.

Is the service responsive?

Our findings

At our inspection on 3 September 2014 we identified that people's care plans did not accurately record each person's care needs or how those needs could be met in a person centred way. Care plans had not been reviewed routinely or after incidents which may indicate a change in care was needed. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 13 April 2015 we found the provider had made no improvements to ensure care was person centred and met people's current needs. People's care plans did not fully identify their care needs or contain information on how care could be provided to meet those needs. For example, we saw one person's care plan indicated that they required support to eat meals but could eat finger food independently. There was no planning to offer this person alternative meals with finger foods so they could maintain their independence for longer. We also saw an assessment which indicated a person was restless between one and three times a day. However, we saw that this person was restless for the whole time of our inspection. Care workers told us that this was normal for the person. This showed the assessment had not been properly completed and there were no plans in place to support the person when they were feeling this way.

Where people displayed behaviour which may be challenging to others, this was not recorded in the care plan and plans did not contain any information on how staff should respond to this behaviour. For example, during our inspection we observed one person who was living with a dementia was very active and agitated. The person had socks on but no shoes or slippers to protect their feet. Supervision and support provided by staff was minimal.

We also saw that people's care plans did not support people to communicate their care needs. For example, one person was unable to communicate verbally. Staff told us the person communicated through gestures. We looked at the information about how the person preferred to communicate. The record stated, "[The person] will benefit from staff understanding [The persons] mannerisms as [The person] does not communicate well." However, staff could not tell us what gestures the person used or what they meant. One staff member said, "When they [the person] stands up it means they are hungry." However, we

saw the person stand up on two occasions and staff did not respond by bringing food or checking if the person wanted to drink. Instead staff responded by helping the person to sit back down.

The atmosphere in the home was very quiet. There were no meaningful interactions between the people who lived in the home and no attempt by the registered provider to create an environment which stimulated people. Staff were focussed on the care tasks they were undertaking and did not have time to support people in activities. In addition, people's care plans had not been written to encourage hobbies and meaningful activity. For example, we saw one person's care plan recorded, "Unable to take part in social activities."

People told us there was a lack of activities to keep them entertained. One person told us there was nothing to do at the home except sit and watch the television. They added, "I'm getting no physical or mental stimulation." Another person said, "We have a weekly church service which is great but not much else is going on here." A third person told us, "I have my breakfast and then sit in here. If I get tired I go and have a sleep in my room. No, there is nothing to do, but I have got used to that. It's what I expect now. There is not much going on."

However, people we spoke with were interested in taking part in activities and told us about activities they would like to see. One person said, "I think it would be a good idea if they did an art class here, could you suggest it?" Another person told us that people liked to sing and it would be good to have a sing along outside of the church service.

People with dementia were not always supported to undertake activities in a way they met their needs. One person who had dementia walked purposefully around the home throughout our inspection. Although staff held their hand at times and guided them to sit down, they did not engage with them or listen to what they had to say. There was no care plan in place for staff refer to and provide suitable activities to engage the person and help them to be more settled.

People were not always supported to make choices in relation to their food. One person said, "Oh no there is no choice around food. You get what's on the menu and it's

Is the service responsive?

just bought into me.” We observed that a menu was on display in the dining area, however, there were no pictorial aids for staff to use to show people the options available to them.

The provider had a formal procedure for receiving and handling concerns which was on display in the main foyer

of the home. Complaints could be made to the provider. There had not been any formal complaints since our last inspection in September 2013. One person we spoke with told us they had raised some issues with the manager but had not raised a formal complaint.

Is the service well-led?

Our findings

At our inspection on 3 September 2014 we identified that the quality assurance processes in the home were inadequate and the provider was not aware of the changes needed to provide an adequate service to people. This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision.

At our inspection on 13 April 2015 we found the provider had failed to make the required improvements to monitor and improve the quality of service people received. We found that the provider had not responded to the actions we had identified in our previous reports. The provider told us that they had not made the required improvements in care planning or decoration.

Despite continually failing to meet the regulations, the provider had not reflected on previous inspection findings and identified a clear vision about the quality of the service they wanted to provide for people and how to implement changes.

The provider did not ensure staff had strong and consistent leadership as they had failed to ensure their own skills were sufficient to recognise and develop a quality service. For example, they were unable to identify poor practice in relation to infection control, training and supporting staff and medicines management. This meant staff were not inspired to recognise and provide a quality service to people.

The atmosphere in the home was subdued with staff focussed on completing their next task. The general feeling of the environment was fatigue and this was reflected in staff attitude. Staff had not been supported to display the right values and behaviours to people. For example, staff were not upbeat when supporting people and did not encourage people to be independent.

The provider did not encourage an open culture. They had not discussed our previous inspection reports with staff or explored with them if they had any ideas on how to improve the quality of service provided to people. The provider had not held any staff meetings since our last inspection in September 2014. The last staff meeting had been on 13 May 2014. Information we looked at showed

further meetings had been scheduled by the provider for September 2014, November 2014 and March 2015 but the provider and staff told us none of the meetings had taken place.

At our inspection on 3 September 2014 the provider showed that a quality assurance survey had been completed and analysed to show where improvements to the service could be made. At our inspection on 13 April 2015 the provider was unable to show us that any action had been taken in response to the quality assurance survey and there was no action plan in place to show future improvements were planned.

The provider told us they had not discussed the findings of our last report with people living at the home or their relatives. People were not given the opportunity to influence the service they received as residents' meetings were not held on a regular basis to gather people's views and concerns. The last meeting had been held in May 2014. This showed that people were not kept informed of important information about the home and did not have a chance to express their views. However, people and staff said the provider was always available and that they were friendly and easy to speak with.

There had been three expected deaths which the provider was required to notify us of, however they had not submitted any notifications.

We saw that the provider recorded accidents in the accident book. However, we found they did not analyse accidents, monitor for trends or review care plans after accidents had occurred. Incidents were not recorded. One person told us that a member of staff had caught themselves on a medicine delivery device which had a needle. They said that the member of staff had asked them if they had any communicable diseases. However, there was no record of the needle stick injury or actions taken to reassure and support the member of staff. This meant that the provider did not take appropriate action to stop incidents re-occurring in the future.

We spoke with the provider about any improvements that had been made or were planned for the home. They informed us that quotes had been secured for re-decoration, however, this work had not yet commenced.

The provider showed us confirmation that they and a senior staff member had attended a training workshop

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related to the assessment of service quality on 11 February 2015. However, the provider was unable to tell us about the outcome of their learning or any plans they had to improve the quality of the services they provided.

We saw the provider was on the rota as a member of the care team for the majority of time they were available in the home. Rotas showed they were only scheduled to spend one day a week in the office. However, this was not enough to manage the home and the provider told us that they were unable to keep up to date with the paperwork needed to safely run the establishment. This meant the provider did not ensure there were appropriate resources to develop the home and staff team and to drive improvement.

We saw that the provider had taken some actions to manage the quality of the service provided. For example, we saw taps were run in empty bedrooms to protect against legionella and some audits were carried out. However, we saw attention to detail was lacking and hence the audits did not drive required improvements. For example, there was no evidence that taps and toilets had water flushed through them regularly and the infection control audit indicated that furniture was free from rips and tears, but we found furniture which was ripped. This showed that audits were not completed appropriately and could not be relied on to drive improvements.