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The Old Rectory

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 well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced focused inspection was carried out on 2 June 2016.

We carried out an unannounced comprehensive inspection on 21 and 22 March 2016. After that inspection we received concerns in relation to the safe care and treatment of people living at The Old Rectory. As a result we undertook a focused inspection to look into those concerns and to follow up on our previous enforcement action of three warning notices.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Rectory on our website at 'www.cqc.org.uk'.

The provider had made some changes. However, the provider had not met the requirements of the warning notices served following the last inspection.

The Old Rectory provides accommodation and personal care for up to 40 people who have physical disabilities and learning disabilities. People's needs varied and included sensory impairments, epilepsy, reduced mobility and communication difficulties. Accommodation is set out over three floors. On the day of our inspection there were 38 people living at the service.

People's medicines were not managed safely. Fridge and room temperatures were not taken and recorded so staff did not know if medicines were being stored at a safe temperature. Some people stored medicines in their rooms or took them out for the day. Staff had not undertaken any form of risk assessment to ensure that this was safe and that appropriate support was in place to check people's personal stocks of medicines and to ensure they were not taking too much medicine. There were no guidelines in place for when 'as and when' medicines (PRN) should be administered for some people. One person had not received the correct amount of their medicine used to thin their blood. Two medicines with specific storage requirements were missing. We informed the local safeguarding authority about this.

One person was at high risk of choking and did not have any risk assessments in place relating to this. They were regularly eating foods they had been advised not to, by a speech and language therapist. A speech and language therapist told staff to encourage the person to eat similar, less high risk foods and put in place a risk assessment and choking policy around this. This had not been done. We informed the local safeguarding authority about this.

Staff did not consistently manage people's behaviours safely. We saw one person become distressed and push another person over. There were known triggers identified for these behaviours and staff did not intervene to de-escalate the situation effectively. People had suffered a negative impact of other people's problem behaviour.

People were not asked about what they wanted to eat. Information about meals was not presented in a format which people understood so they were not able to make informed choices about what they wanted to eat. One person said that they did not want to eat their lunch and they were not offered or given an alternative meal.

People's guidelines from speech and language therapists were not consistently followed or shared with staff. People with diabetes did not receive support to manage their diets appropriately. People's weights had not been monitored consistently when they were at risk of losing weight.

The environment was not always safe. Flooring in some bedrooms was not suitable for people's needs and smelt of urine. People were using a bathroom that the provider had deemed unsafe.

The provider said that the maintenance schedule had 'slipped' due to staff sickness. Some jobs had not been completed within the timeframe the provider had given us. There were loose and cracked tiles in the entrance hall and a hole in the wall in the hall way.

The kitchen had been redecorated, the cupboards had been painted and the insides of the cupboards were in the process of being lined with easier to clean material. Mop heads were cleaner and suitable for use. The cellar had been cleaned, redecorated and all food stored was in date.

People were supported and helped to maintain their health and to access health services when they needed them, however staff had not always followed advice from health professionals.

Staff had received safeguarding training and knew how to recognise and respond to most types of abuse. However, staff and the provider did not recognise the issues we found during our inspection as safeguarding concerns. People were at risk of harm from improper treatment.

Staff received supervisions and appraisals and their competency was assessed with regards to administering medication. Staff did not receive all the training they needed to support people effectively. There were sufficient numbers of staff on duty to respond to people's needs.

Two people had Deprivation of Liberty Safeguards (DoLS) in place. Staff had followed the process with regards to these. Three people had moved to the service since our last inspection and no consideration had been given to their capacity. People could make day to day choices about their lives, such as declining meals.

People knew who the provider was and they were at the service most days. Staff and the deputy manager said they felt well supported by the provider. The provider told us they had made changes after our last inspection, these changes had not happened as they described.

Records were missing, incomplete and inaccurate. Two people that had moved in since our last inspection did not have care plans and staff did not fully know their care and support needs. Food and fluid charts had not been consistently completed, daily records were incomplete, some had gaps and others were not signed by the staff member making entries. Medicines information in health action plans did not tally with prescribed medicines found in stock. Some medicines records conflicted with others. Some audits were carried out by the provider and deputy manager but they had not identified these issues.

We found that the provider had exceeded the maximum amount of people that could live at the service between the 31 March 2016 and the 4 April 2016. We spoke with the deputy manager about this and they

confirmed that this had happened.

The provider had not displayed their rating, as required, following our previous inspection, which meant people, relatives and visitors were not aware of the service's rating.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

This focused inspection has been carried out within six months of a comprehensive inspection. In line with CQC methodology the rating has been reviewed.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not well managed and appropriately recorded.

People were not safeguarded from harm and improper treatment.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm. Some people did not have care plans to detail what their care and support needs were.

Some repairs and redecoration had taken place, however, not all parts of the environment were safe.

There were enough staff deployed to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

People did not have choices of food at each meal time which met their likes, needs and expectations. Food did not meet everyone's dietary requirements to maintain good health.

Staff had not followed people's guidance on how to safely support people to eat.

Three new people had moved to the service and no consideration had been given to their capacity or ability to make decisions, in line with The Mental Capacity Act.

People received medical assistance from health and social care professionals when they needed it, but staff did not always follow advice given by health care professionals.

Staff had not received all of the training they needed to support people effectively.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to assess the quality of the service were ineffective. These did not pick up the concerns relating to risk and people's safety, medicines and records.

Issues that the provider said had been resolved had not been.

The provider had exceeded the maximum amount of people that could live at the service between the 31 March 2016 and the 04 April 2016. This was a breach of the provider's conditions of registration.

The provider had not displayed their rating following our previous inspection, which meant people, relatives and visitors were not aware of the homes rating of 'Requires Improvement'.

The Old Rectory

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 2 June 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we reviewed previous inspection reports and notifications. A notification is information about important events which the home is required to send us by law. We received information of concern from the local authority that we looked into.

We did not ask the provider to complete a Provider Information Return (PIR) because we do not request a PIR before a focused inspection. 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.

We spoke with seven people. Some people were not able to verbally express their experiences of living in the service. 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 talk with us. We observed staff interactions with people and observed care and support in communal areas. We spoke with a district nurse and a physiotherapist. We spoke with 13 staff including the cook, the deputy manager and the provider.

We received feedback from the local authority commissioning team and the local authority safeguarding team. After the inspection we spoke with a speech and language therapist and two care managers.

We looked at records held by the provider and care records held in the home. These included 18 people's care records, medicines records, training records, risk assessments, four weeks of staff rotas, policies and procedures and other management records.

We asked the provider to send additional information after the inspection visit, including emails, people's

support plans, risk assessments and policies. The information we requested was sent to us except for one policy relating to choking and one person's risk assessment.

We last inspected this service in March 2016when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and we took enforcement action.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 21 and 22 March 2016, the provider had not managed medicines safely. The provider had failed to assess and mitigate risks to people and staff. The provider had failed to ensure that the premises were safe for use, failed to assess the risk of and prevent, detect and control the spread of infections. The provider had failed to operate effective recruitment processes. We took enforcement action and served a warning notice.

This focused inspection was carried out at short notice after CQC were made aware of concerns about the service. We looked into those concerns and followed up on some of the previous breaches of regulations.

At the last inspection medicines had not been stored or recorded correctly. At this inspection we found people were not always protected from the risks of unsafe medicines management.

Medicines were not always stored securely. Some people managed their own medicines with support from staff and stored their medicines and associated equipment, including a sharps box for used needles, in their bedroom. The provider's Medicines Management Policy stated, 'a secure area is provided in the service user's room for the storage of self-administered medication'. This policy had not been followed and medicines and equipment were not locked away and were accessible to other people.

Previously we found that checks had not been completed to make sure people's medicines were stored at the correct temperature. Since our last inspection action had not been taken to put temperature checks in place. The provider's Medicines Management Policy stated; 'A lockable fridge is also provided for medication that needs to be kept cool. The temperature in this fridge is regularly monitored as are the temperatures of the rooms where medicines are kept'. This policy had not been followed. The fridge thermometer was still broken and the temperature of rooms where medicines were stored were not checked. There was a continued risk that high or very low temperatures would reduce the effectiveness of people's medicines.

We checked the storage and records of medicines liable to abuse. Two tablets could not be accounted for. Staff did not know what action was required and who to report the missing medicines to. Guidance was not available to staff about the action they needed to take when medicines liable to abuse could not be accounted for. We raised our concerns with the local authority safeguarding team.

Some people took blood thinning medicines called Warfarin. The dose of these medicines changed from time to time. One person's prescribed dose had changed and this was recorded in their records stored with their medicines. The person had not received enough medicine on one occasion before our inspection. The provider's Warfarin and Anticoagulant Therapy Policy stated: 'Care staff administering medication should always double check the most recent INR report when giving a dose of warfarin'. An INR report looks at the effect of taking warfarin and how long it takes blood to clot. The policy had not been followed and the staff member told us they had not checked the record before they administered the person's medicine. Staff contacted the person's GP during our inspection who confirmed that one reduced dose would not put the person at risk, but too much medicine or a reduced amount on more than one occasion would put the

person at risk. The person needed regular blood tests to check their medicine was at the correct dose. They had not been supported by staff to attend the latest check and staff had not made arrangements for them to have another test.

Accurate records in relation to people's medicines were not maintained. We looked at the medicines administration records (MAR) for everyone taking prescribed medicines. On occasions, the MAR had not been signed. Staff were not able to tell us if people had been given their medicine or not. Some entries on people's MAR's had been handwritten. These had not been checked to reduce the risk of mistakes. The records were not accurate and were incomplete so effective checks could not be made on medicines records to identify any concerns that may put people at risk. Medicines that required two staff to check and sign their administration had been recorded correctly.

When people visited family and friends they took any medicines they needed with them. The provider had a 'Medication when the Service User is Away from the Home Policy' in place but this had not been followed. Records of medicines leaving and returning to the service and any medicines people were offered while away from the service had not been kept. Checks could not be made to make sure people had always been offered their medicines and if stocks of medicines were correct.

Effective systems were not in operation to manage the stocks of medicines. One person had received a reduced dose of one medicine on five occasions in the two weeks before our inspection due to low stocks. The last dose of the medicine had been administered the day before our inspection and action had not been taken to obtain any more stock of the medicine.

The date bottles and tubes of medicines were opened was not always recorded. The instructions of one person's medicine stated, 'Discard four weeks after first opening'. The date the medicine was opened was not recorded and staff did not know when it had been opened. This was important to ensure medicines are used safely within a given shelf life.

Creams had been prescribed to some people to keep their skin as healthy as possible. These were applied by care staff. Records of when and where prescribed creams had been applied were not kept. Checks could not be made to make sure that people were given the right creams at the right time or that creams had been applied to the correct area of the body.

Guidance to staff about people's medicines was not always correct. One person's care plan stated: 'Care staff to apply … and E45 on my face as per instructions on my MAR sheet'. E45 cream was not detailed on the person's MAR. Staff contacted the person's doctor who confirmed that their prescription of this medicine had stopped in January 2013. The staff member who wrote the person's care plan did not know that the prescription had changed. Another person's care plan and risk assessment stated, 'Care staff to only administer Diazepam if [person's name] is extremely agitated'. The person was not prescribed Diazepam. The staff member who wrote the care plan told us that the care plan was not correct and the person was not prescribed Diazepam. There was a risk that staff would administer medicines to people that they were not prescribed.

The provider's 'Medication to be 'Taken as Required' Policy' was not being followed. The policy stated: 'To ensure the medication is given as intended, a specific plan for administration is recorded in the service user's care plan and kept with their MAR charts. This will state clearly what the medication is for and the circumstances in which it might be given'. Clear guidance had not been provided to staff about when to offer people 'as required' medicines. One person was prescribed medicine to help calm them when they were anxious or upset. Their 'as required', medicine guidance stated the medicine was for 'behaviours' and

instructed staff to offer the person the medicine, 'If I show signs of agitation'. Clear information had not been provided to staff about what the 'signs of agitation' were for this person and when they should offer the person the medicine. Staff told us the person had not needed the medicine for several months but there had been no medicine or care plan review.

We observed people receiving their medicines. People were not able to choose when or where to take their medicines and most medicines were offered to people at meal times. Staff interrupted people while they were eating their meals to administer their medicines. People were not told about the medicines they were taking and what they were for to help them make a decision about taking the medicine or to understand what is was for.

At our last inspection we found that locked medicines trolleys were kept in an activities room to which everyone had access, which contained a pool table. Action had been taken to keep the medicines trolleys in a room not used by people, which was kept locked at all times. Systems were in place to manage keys to medicines storage areas to reduce the risk of them being used by unauthorised people.

Arrangements were in place to obtain medicines that might be needed urgently in addition to people's usual requirements, such as antibiotics. Medicines that were surplus, unwanted or expired were returned to the pharmacy.

The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, administration and recording of medicines. This was a continued breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and wellbeing were not well managed. Risks to people choking had not been managed safely. One person had been assessed by a speech and language therapist as being at high risk of choking. There was guidance in place stating what food the person should not eat as this may cause them to choke. However, the person was still eating this food which could cause them to choke. There were no risk assessments in their care file relating to the person choking or eating foods which could cause them to choke. Three staff members confirmed they did not fully understand the person's care and support needs. We spoke with a speech and language therapist who told us they had met with staff and told them they should encourage the person to eat similar but less high risk foods. They had also told staff they needed to write a choking policy and put a risk assessment in place regarding the person eating these foods. We asked the deputy manager by email to provide us with these. We received a basic risk assessment after the inspection that stated the person should not have certain foods as they were at risk of choking. We did not receive the choking policy. We told the local authority safeguarding team about our concerns.

People's behaviours were not managed safely. One person indicated that they wanted to go out with staff and several other people, they did this by pointing at the door. They were told they could not go out. Their risk assessment stated, 'Can become agitated and shows this by kicking out…They also grab others around them and can cry. This can happen if there is a change in [the person's] routine, not going on an outing or if they feel unwell'. The staff member who told the person they could not go out said, "You, that way" and put their hands on the person to redirect them away from the entrance hall. The person became distressed and pushed another person to the ground. Staff then pulled the person's top to move them away from the other person. Staff did not intervene effectively to de-escalate the situation when they knew the person was likely to become agitated as they were not going out. We told the local authority safeguarding team about our concerns.

Three new people had moved into the service since we last inspected. Two of these people did not have a

care plan in place to provide guidance to staff about how to safely provide their care and support. One person who moved in recently did not have any risk assessments to keep them safe from risks such as fire, moving and handling and dangers from the environment.

The provider had not ensured that care was provided in a safe way. Risks to the health and safety of people were not being managed and when possible, mitigated. This was a continued breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection two people living at the service were diagnosed with epilepsy. There were no risk assessments or care plans detailing what action staff should take if they had a seizure, when to call for emergency assistance and what each person's seizure looked like. At this inspection we found that the care plans and risk assessments for these people were now more detailed. A new person, who also had a diagnosis of epilepsy, had a risk assessment in place which accurately described their seizures and what care and support they required should they have a seizure.

Previously The Old Rectory was not suitably clean and infection control procedures had not been followed. We found that some improvements to the cleanliness of the home had been made, however there were still concerns. At the last inspection some bedrooms had inappropriate flooring and there was a strong odour of stale urine. The provider sent us details of what action had been taken to address this. They detailed, '[Person] has moved to a more suitable bedroom with suitable flooring for their needs'. This had not happened. The person was still in the same bedroom with the same flooring. The provider told us during this inspection that the person was going to be moving rooms. We noted that the smell was still apparent. We spoke with a housekeeping staff who explained they cleaning the carpet regularly to remove the smell of stale urine.

The bathroom on the middle floor was dirty and stained. After the last inspection the provider sent us an action plan which stated, 'The middle bathroom is being renovated at the end of this month and is currently out of use to residents'. During this inspection the bathroom was unlocked and it was in use. The bath was wet and remnants of bubble bath were in the bottom of the bath. We spoke with the provider about this who agreed that the bathroom had been used. They contacted the handyperson and arranged for the bathroom to be sealed off. The handyperson locked the bathroom door before we left.

There were cracked loose tiles in the entrance hall and a hole in the wall in the hallway at the last inspection. The provider sent us an action plan which stated, 'The one cracked tile has been replaced'. We found that the tiles were still loose and cracked in the entrance hall and hole in the wall was still there. The provider explained that the schedule of works originally planned to complete the works to the home had slipped due to staff sickness within the maintenance team. People were at continued risk of scalds. At the last inspection radiators on the second and third floors were not covered with radiator covers and this had still not been addressed.

At the last inspection the cellar was dirty, dusty and mouldy and there was poor stock rotation and storage of foods. The cellar had been cleared out, cleaned, redecorated and all food stored was in date. The broken freezers had been removed. Some furniture had been removed or repaired; the doors to the conservatory had been repaired.

The kitchen had been redecorated, the cupboards had been painted and the insides of the cupboards were in the process of being lined with easier to clean material. A new sealed floor covering had been ordered and this was due to be fitted on the 14 June 2016. New mops had been provided.

People told us they felt safe living at the service. One person said, "I feel safe. I'd speak to [staff member] if I was worried or [another staff member]." Another person said, "I've lived here a long time, I'm safe." Although people said they felt safe they were not always safeguarded from the risk of harm and improper treatment. Potential risks to people had not been assessed and managed to eliminate the risks, including the risk of choking and from epilepsy. Some people had not received the medicines they were prescribed to keep them well.

Staff had training on safeguarding adults. Staff knew the procedures in place to report any obvious suspicions of abuse or allegations and records showed that the provider had reported safeguarding concerns to the local authority and to the Care Quality Commission (CQC) previously. However, they did not recognise the issues we found regarding medication practice or people's support as safeguarding concerns. One person had choked in May 2016 and although this person had been referred to a Speech and Language Therapist it had not been reported to the person's care manager or local safeguarding authority. Staff had physically intervened, and the person's daily notes stated that they, 'may have bruises on their body from the procedure.' We spoke with the person's care manager after the inspection and they said, "I would expect a full report as he is very high risk and is 1-1 for eating."

We checked that the provider had suitable systems in place to safeguard people's money. We spoke with a member of staff who explained the systems in place, they showed us receipts and records and they explained that people's finances were dealt with by local authority appointees or by family members. The provider was not available during the afternoon of the inspection to talk to us about how people's money was protected.

At the previous inspection staff records showed some staff had started working at the service before a check from the Disclosure and Barring Service (DBS) had been fully completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider told us that these staff had not been working directly with people until their DBS had come back. After the inspection the provider told us, "In the staff files which appears to show they started work before their DBS was obtained these have been updated to show what they were doing before their DBS arrived."

People told us that they felt there was enough staff to support them. One person said, "I like living here, the carers come and check on you at night and supervise your shower." There were suitable numbers of staff on duty to meet people's needs. Staff were visably present throughout the inspection to support people when they needed it. Staff assisted people to eat their meals and came when called. Many staff had dual roles which meant they carried out other roles as well as care tasks, such as cleaning, entertainment, driving, and grounds maintenance. These duties took them away from giving care and support to people.

Inadequate

Is the service effective?

Our findings

At the previous inspection on 21 and 22 March 2016 the provider was failing to ensure that people had suitable food and drink to keep them well and healthy. We took enforcement action and served a warning notice.

People were not offered a choice of meals on a daily basis. People told us they were not asked about what they wanted to eat. One person said, "They don't ask what we want to eat…Here, they just bring it out" and, "I'd like to be able to tell them what I want to eat." Another person said, "At home they ask me what I want to eat but not here. I stay in my bedroom if I don't like the food".

Information about meals was not presented in a format which people understood so they were not able to make informed choices about what they wanted to eat. When we were talking to two people about food they said they did not know what was for lunch. One person asked a member of staff what was for lunch and they said, "It is on the board." Meals were written on a whiteboard in the conservatory. The person then said, "I can't read." The staff member went and checked and told the person that there was salad for lunch. Few people living at the Old Rectory were able to read so could not understand what was written on the board.

During lunchtime one person told a member of staff that they did not want to eat their lunch. The staff member told a senior member of staff and they said loudly to the person, "Seriously, you were asked this morning what you wanted, what is the point in that? You can't do this". The person was not offered or given an alternative meal.

One person needed assistance with eating and drinking. Their food and drink needed to be served at a particular texture. They had experienced a choking episode recently which caused their guidelines to change. The updated guidelines were not in the person's support plan but were displayed in the kitchen, alongside the out of date guidelines. The newer guidelines were not dated so it was not clear which guidelines were the correct ones. Staff were not clear about which guidelines to follow. We asked one member of staff which was the correct one and they said they did not know. Another member of staff told us the undated ones were the correct ones. A third staff member confirmed the undated ones were correct.

At lunch we saw staff following the new guidelines and repositioning the person before sitting and before eating. However, during their meal the person was having difficulty sitting upright and staff had to get an additional cushion to support the person in their chair. The person's new guidelines stated, 'If [name of person] is having difficulty achieving upright position you may need to thicken drinks to a custard thickness and give from a spoon'. This did not happen. The person was at risk of choking or aspirating as their guidelines had not been followed.

Another person had specific guidelines in place which had been reviewed by a speech and language therapist; however, records of the revised guidance had not been written down and shared with staff. This person was at high risk of choking especially as staff were not following the revised guidance. We told the local authority safeguarding team about our concerns as this person was at risk of harm.

At the previous inspection one person had been advised by their GP not to have any sugar and to have smaller portions of meals. Clear information had been recorded to state that if they continued to eat sugar and inappropriate foods it would result in them being prescribed insulin to control their diabetes. Food had not been prepared and cooked that met their nutritional needs. The person was regularly eating sugar and their portion sizes had not been reduced.

At this inspection the person's support plan still stated, 'Staff encourage [name of person] with healthy eating' and 'discourage from buying sweets and chocolate'. There was also a folder in the kitchen which stated, 'I am a diet and medication controlled diabetic and need to be encouraged not to eat sweet snacks'. However, the person's daily notes still evidenced that staff had provided and they had eaten cakes, biscuits and drank hot chocolate regularly for supper. There were also multiple days where it was documented they had eaten a 'party tea' so it was not clear what they had eaten that day. Staff were not supporting this person to manage their diet in line with their diabetes.

People's weights had not always been monitored consistently. Guidance given by people's GP had not always been followed in relation to the frequency of monitoring people's weights. One person had been seen by the district nurse and staff had been advised to weigh this person weekly as they were at risk of malnutrition and weight loss. Records evidenced that they had been weighed once in May 2016. This person had not been eating sufficient amounts of food to sustain good health and had regularly declined foods.

People told us they liked the food. Comments included, "I had a fried egg, two tomatoes, one sausage and bacon for breakfast. I like my bacon sandwich"; "I eat most things, the food is fine"; "I like a party tea, we have it quite a lot".

People had not received suitable, nutritious food and hydration to sustain life and good health which is a continued breach of Regulation 14 (1)(2)(a)(i)(b)(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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 checked whether the service was working within the principles of the MCA.

Two people had DoLS in place. Staff had completed capacity assessments for these people and their relatives and other professionals had been involved in best interest meetings. Daily records showed that people made choices about their life such as declining meals and accessing activities outside of the service. However, three people had moved to the service since our last inspection and no consideration had been given to their capacity and ability to make decisions. No capacity assessments had been completed and it was not clear if they were able to come and go as they pleased.

At our last inspection we observed one person had medicines given covertly, meaning that the person was not asked if they wish to take the medicine and it was hidden in their food. Staff told us that the person continued to have their medicines administered covertly. The decision to administer the medicines covertly

had not been reviewed since our last inspection to make sure it continued to be safe and in the person's best interests. Staff had requested a health care professional be involved in making this decision but had not followed the request up to make sure the decision was reviewed promptly.

People were supported to maintain their health and have access to healthcare services. Most care plans evidenced that referrals had been made to the relevant health care professionals as appropriate, although some people had no care plan and detail about how to meet their health needs. People were referred on to specialists when required although their advice was not always followed for example, when advice was given about foods that were unsuitable as they were a choking hazard. When changes were noted in people's mental health they were supported to make contact with relevant services. Daily records showed that when people were showing signs of being unwell they were supported to attend a GP appointment. During our inspection a district nurse visited to see one person in order to take blood and a physiotherapist visited to see another person. The physiotherapist said it was only their second visit, but they believed staff were supporting people with the exercises they had recommended.

Staff had not received the training they needed to support people effectively. Some people were living with diabetes and were not supported to eat healthily and manage their diet accordingly. At the previous inspection four staff out of 29 had received training for diabetes. Twelve staff had now completed diabetes training but the cook still had not. They confirmed they had not been given training and guidance on how to meet people's diabetic nutritional needs. Staff had not undertaken epilepsy training despite supporting for people who had a diagnosis of epilepsy.

Staff had not received training in positive behaviour support or assisting people with behaviours that challenge. People's daily notes showed that staff were regularly dealing with these types of behaviours and we witnessed several during our inspection. On one occasion a staff member stopped a person from going out and pulled their top to prevent them from doing so. The person then pushed another person to the ground. Staff did not intervene effectively to de-escalate the situation and ensure people's safety. The lack of appropriate staff intervention meant people were at risk from the negative impact of other's problem behaviour.

Staff did not receive the training they needed to complete their duties which is a continued breach of Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported by the management team, who were visibly present within the service. Senior members of staff completed competency assessments as part of staff supervisions. They observed staff administering medication to ensure they were competent. Staff that had been in post for longer than one year had received an annual appraisal.

Inadequate

Is the service well-led?

Our findings

At the previous inspection on 21 and 22 March 2016 the provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and had failed to maintain accurate and complete records. We took enforcement action and served a warning notice.

At the last inspection we reported that the deputy manager and provider had audit systems in place. The audits had failed to identify and action the areas of concern found during the inspection, such as infection control issues, maintenance concerns, food storage, stock control, medicines storage, monitoring and recording and care plans not always detailing service user's care and support needs. At this inspection we found that this had not improved. The deputy manager and provider failed to identify and action the areas of concern found during the inspection, such as issues with medicines, people's care records, risk assessments, and failure to meet people's nutritional needs.

The provider's processes to check that medicines were managed safely had not been followed. For example, the provider's policy stated, 'A regular audit of all anticoagulant therapy cases will be arranged to ensure that this policy and best practice guidelines are being followed'. These had not been followed and the provider was not aware that one person had not received their full dose of blood thinning medicine on one occasion.

Other checks on medicines had not been completed and the errors had not been identified. Checks on the numbers of tablets held in stock had been completed until May 2016, none had been completed after this time and staff were not aware that two medicines, liable to abuse, were not accounted for. Checks on other medicines and the management of medicines, including records and storage arrangements, had not been completed and the provider was not aware of the shortfalls we found.

At the last inspection we found that records were not always clear and robust. At this inspection we found this had not improved. People's daily records were not accurate, were incomplete and were not contemporaneous. Daily records had not always been written to account for people's care and support. There were inconsistent food and fluid records and entries that had been made into people's daily notes had not always been signed by the person making the entry. People's health records did not detail all of people's medical appointments and contact with health care professionals. One person had been seen by a Speech and Language Therapist (SaLT). SaLT had visited the home and met with two staff on the 19 April 2016 to review a person's swallowing guidelines. However, staff had not made a record of the meeting for staff to understand the person's swallowing guidance.

One person's health action plan was missing; so the information had not been stored securely and confidentially.

One person's risk assessment relating to their epilepsy stated that staff should contact the person's relative when they had a seizure. We saw evidence in the person's daily records that they had experienced a seizure, however, the records did not show that the relatives had been contacted as described in the risk

assessment.

At the last inspection policies and procedures did not reflect the service being provided. There was a restraint policy in place which detailed that restraint could be used as an intervention by staff to prevent self-harm or self-neglect and to prevent harm to others, we spoke with the provider about the policy, they told us, "We don't do restraint". During this inspection we found that the policies and procedures had not been reviewed and updated and the incorrect policies and procedures found at the last inspection were still in place. Staff did not have up to date information and guidance to inform them about how to carry out their roles.

The provider had sent us action plans detailing the improvements they had made following our last inspection. The actions plans did not correspond with what we found at this Inspection. The provider had said that one person had, "moved to a more suitable room with suitable flooring for their needs." However, this person remained in the same bedroom.

The provider has failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. This was a continued breach of Regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the deputy manager had carried out some audits of the environment and had identified that repairs were required in areas of the service. These repairs had been added to the schedule of works for the month.

The provider had exceeded the maximum amount of people that could live at the service between the 31 March 2016 and the 4 April 2016. During this period 41 people lived at the home. The provider was registered to provide accommodation and personal care for up to 40 people. We spoke with the deputy manager about this and they confirmed that this had happened.

The provider had failed to meet the conditions of their registration. This was a breach of section 33 of the Health and Social Care Act 2008.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in March 2016 was not displayed at the service so people, their relatives and visitors may not be aware of the rating for the service.

The provider had failed to display their rating. This was a breach of Regulation 20A (1)(3)(5)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew who the provider was and that they liked them. One person said, "[The provider] is the big boss, he is alright, he is busy." Another person said, "[The provider] is very nice, I can talk to him." Staff told us they understood the vision and values of the organisation. They felt there was an open culture at the home and they could ask for support when they needed it. Management of the home was overseen by the provider. The provider visited the home daily during the week. They engaged with people and monitored the management and operation of the home. The deputy manager said they felt well supported by the provider, although the provider was not present for the entirety of the inspection.