Vaghjiani Limited

The Laurels Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 24, 25 and 30 July 2018. The Laurels Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Laurels Nursing Home accommodates up to 30 people over two floors. On the first day of our visit there were 15 people at the service and one person in hospital, and on the second and third day of our visit 14 people were using the service and one person in hospital.

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

During our inspection we found the provider to be in breach of a number of regulations 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 the report. 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.

People were not always protected from risks associated with their care and support. Risks associated with falls had not been robustly assessed and there was a lack of adequate safety measures in place to reduce the risks of falls. Risks relating to the environment had not been addressed by the provider. People were not always supported by sufficient amounts of staff, and staff were not always recruited safely. People could not be assured that the management of medicines was safe. The environment people lived in and equipment used was clean.

Staff at the service were not always supported with up to date training for their roles. Although staff ensured people received support to manage their health needs. When moving between services the care and support people required was not always made available for health professionals.

People were not always supported with their nutritional needs, people's weights were not always monitored effectively and staff did not always know the different diets people required.

The principles of the Mental Capacity Act were not always followed to ensure people had the maximum choice and control of their lives.

People were supported by a caring staff group. However, their views and choices around their care was not always considered and adhered to.

People did not always receive personalised and individualised care as their care plans did not contain sufficient information on their needs and preferences related to their care including end of life care. There was a lack of social activities to stimulate and interest people, and when people made complaints the concerns raised were not always followed up.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm. Service provision was not robustly monitored and effective action was not always taken in response to serious issues identified. There was a lack of over sight of the service from the provider which had resulted in poor care for people who lived there.

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.

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.

The risks to people's safety were not always assessed. The risks associated with falls had not been monitored and measures were not in place to reduce falls. This had resulted in avoidable falls. There was a lack of staff to meet the needs of the people at the service. Medicines were not always managed safely. Safeguarding issues were responded to appropriately and staff had an understanding of how to protect people from the risks of infection.

Is the service effective?

Requires Improvement

The Service was not always effective.

Staff were not supported with up to date training for their roles. People's nutritional needs were not always met. When people moved between services information on their care needs was not always shared. People were not always supported in line with the principles of the Mental Capacity Act. Some areas of the service were not decorated or adapted to a consistent standard to meet people's needs. When required staff ensured people had access to appropriate health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Peoples views and choices on their care was not always considered. Staff were kind and caring and were aware of how to support people with their privacy and dignity however did not have the time to support people well.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive individualised and person - centred care as their care needs were not always assessed and recorded in their care plans. People's end of life wishes were not always discussed with them and complaints made to the service were

not always acted upon. There was a lack of social activities to stimulate people at the service.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm. The service provision was not robustly monitored and effective action was not taken in response to issues. There was a lack of oversight from the provider which resulted in poor care for people.

The Laurels Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 comprehensive inspection took place on 24, 25 and 30 July 2018 and was unannounced. This inspection was brought forward due to some concerns we had raised to us in relation to a safeguarding issue at the service.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

The inspection was undertaken by one inspector and an expert by experience. During the inspection, we spoke with nine people who used the service, one relative, seven members of staff and the registered manager.

We looked at the records relating to nine people who used the service. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff records, meeting minutes and arrangements for managing complaints. We asked the registered manager to send us their training matrix, which they did following the inspection.

We did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, on the day of inspection we gave the provider the opportunity to share this information.

Inadequate

Is the service safe?

Our findings

The risks to people's safety had not always been assessed after they had been admitted to the service. One person had been admitted over four weeks prior to our inspection and they had no assessment of their current mobility needs or falls risk. Staff we spoke with told us the person needed two members of staff to support them when standing, however, their pre - admission assessments showed they needed one person. Staff we spoke with told us the person was unable to walk, but mobilised in a wheelchair using their feet. This necessitated the wheelchair to be used without foot plates. This placed the person at risk of injury to their feet should someone push the wheelchair while their feet remained on the floor.

The above person's pre - assessment information stated they had a long term health condition which affected their nutritional health. However, there was no nutritional risk assessment completed and members of staff we spoke with were unaware of this health condition. We also spoke with the person who told us they did not have a health condition that affected their diet. The lack of assessment meant there was lack of clarity in relation to the person's diet. This with the lack of discussion with the relevant health care professionals of this person's needs, meant the person was at risk of receiving an inappropriate diet which could affect their health.

There was a risk people may not receive safe support with their mobility. One person had suffered some significant health issues during the previous two months that had affected their mobility. This had resulted in them requiring additional assistance and mobility equipment to enable them to move safely. However, there was no information in their care plan to show the changes to their mobility or how staff should support them. The lack of clarity about the person's needs put them at risk of receiving inappropriate and potentially unsafe care.

Accident records show a number of people had sustained head injuries as a result of falls. We could not find any records of observations or actions taken by staff following these falls. We asked a member of staff what observations they carried out when people at the service sustained head injuries. They told us each staff member monitored this differently but there were no observation templates in use for head injuries. This ineffective monitoring meant staff may not identify deteriorations in people's heath as a result of head injuries.

There was a lack of environmental risk assessments which put people at risk of harm. For example, the staircase leading to the first floor was situated next to one of the small lounges and could be accessed by people without staff being aware. On the days of our inspection we saw one person who was reliant on staff to ensure their safety moving around the service, accessing the corridor where the staircase was located alone. At times staff were not aware the person had entered the corridor. We asked staff if the person attempted to climb the stairs unaided and we were told the person did so occasionally. There had been no robust assessment of this risk, to this person, or other people who may not be safe to access the stairs unattended. We discussed the issue with the registered manager who told us they would assess this risk and put in measures to reduce it. However, it is of concern this had not been highlighted and addressed before our visit.

The risks in relation to fire safety had not always been addressed at the service. During our visit we saw an inspection of the service had been undertaken by an external fire safety company in July 2017. This had highlighted a number of actions the provider was required to undertake. One action was to install an extra fire alarm point in the kitchen by the external door. This was to allow kitchen staff to raise the alarm should they need to vacate the kitchen by this door in the event of a fire. The report also highlighted that self-closing doors and other safety equipment should be installed before any one was admitted to the first floor Neither of these actions had been undertaken. However, two people had been admitted to a room on the first floor. This placed people at risk of harm in the event of a fire.

Furthermore, staff were not always aware of where people's personal emergency evacuation profiles (PEEPs) were, in the case of an emergency. We were unable to locate the file and asked the registered manager who also needed to search for them. Although we were able to find them it was of some concern that all staff did not know how to locate them straightaway. The PEEPs were not up to date, there had been changes to one person's mobility needs and these had not been updated in the file. In addition, there were no evacuation details in place for two new people who had been admitted to the service in the upstairs bedrooms. This placed people at risk of not receiving the required support in an emergency. This was raised with the registered manager who told us they would address this immediately

The management of medicines was not always safe. There were some practices in relation to a small number of people that were not managed safely. One person was finding it difficult to swallow tablets and another person sometimes refused their medicines. Staff had consulted these people's GP to ascertain if they could have their tablets crushed and given in their food. The local pharmacist had not been consulted to check if the effectiveness of the medicines they were crushing were affected by particular types of foods, or if the medicines could be given in another form. During our inspection we also saw the member of staff attempt to crush a number of different tablets together. We asked them to cease this practice and consult their pharmacist as mixing these tablets in this way could alter the effectiveness of the medicines they were giving. On the second day of our inspection the registered manager contacted the local pharmacist. The pharmacist offered to support the service to ensure the correct processes were undertaken so these people received their medicines safely.

Medicines were not always managed safely. During the first day of our visit we observed a member of staff administering medicines and they had noted there were some missing signatures on Medicines Administration Records (MAR)s. This meant we could not be sure if the person's medicine had been given. There were some protocols missing for some people who received medicines on an 'as required' basis. This guidance supports staff so 'as required' medicines are administered consistently at the times people need them. When prescriptions were handwritten some had not been witnessed by two members of staff. This is considered good practice to reduce the risk of discrepancy when transferring prescriptions on to MAR sheets. There was a lack of audits carried out to monitor safe practice in relation to medicines. We asked to view medicines audits on the second day of our inspection and the registered manager was unable to produce them. Without regular auditing of medicines these poor practices will continue and put people at risk of unsafe care.

The above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our examination of staff files showed safe recruitment practices were not always undertaken. While we saw the registered manager had used the disclosure and barring service (DBS) to check on any criminal records prospective employees may have. They had not always obtained references from staff's previous employers. Some references were handwritten and not on headed paper. There were some application forms missing,

and a lack of interview notes to show if previous employment and gaps in employment we identified had been discussed. This put people at risk of receiving care from staff who were not considered fit and proper.

The feedback we got from people about the staffing levels at the service were mixed. Some people felt there was enough staff to support them, but one person said, "They could definitely do with more, especially at night. I spent quite a while in the TV lounge and did not see any staff." We asked people about the time it took staff to respond to their requests for help, one person said, "Well sometimes it's a long time, but then there are only two staff on at night and if they are dealing with someone else you just have to wait." A relative we spoke with said, "I don't think there are enough staff; and in fact I wrote to the manager about this." Some people we spoke with on the first day of our visit, who were sitting in the small lounge at the front of the service were also not aware of how to alert staff if they needed any help. One person told us they would use the buzzer, but they did not know where this was. This meant people were reliant on staff passing the lounge; however, during our visit we saw there were long periods of time when no staff monitored this area. This meant people may not receive support at a time when they needed it.

Staff we spoke with told us they felt there was not enough staff to meet people's needs. One member of staff said, "There isn't always enough staff." They went on to say there were times when there was only one senior care worker and one care worker, and then the registered manager or new deputy manager needed to support staff. Staff also told us the provider had reduced their contracted hours when the occupancy levels at the service had reduced. But had told staff at a staff meeting they would not be recruiting any further staff or increasing their contracted hours until the occupancy at the service reached 20 people. We saw the minutes of a staff meeting that confirmed what we had been told. The registered manager told us this put pressure on them to work more hours than they wished to as they were required to support staff by working as a care worker to ensure shifts were covered.

Our observations on the two days of our inspection showed the staff on duty were struggling to meet the needs of the people at the service. On our second day there were three members of staff on duty until 12 midday. Following this the registered manager needed to work as a care assistant to support people. This meant they were unable to undertake their own duties as the registered manager of the service. Due to the lay out of the building, staff were unable to monitor people in the main lounge as regularly as they would have liked as they were attending to people in their rooms in a different part of the building. At one point during the visit we saw one person who lived with dementia trying to remove the belongings of another person, and we needed to find a member of staff to deal with the issue. We also witnessed that when someone came to the front door there were no staff available to answer the door and sign people in. At one point during the visit we needed to ask the cook who was preparing meals to undertake this duty. This showed the provider was not always working to provide enough staff to meet the needs of people at the service.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the environment they lived in was clean and their rooms and communal areas were cleaned regularly. During our visit we saw the housekeeping staff worked hard to maintain the cleanliness of the service. However, our discussion with the housekeeping team showed the provider had reduced the number of cleaning hours at the service and they were finding it increasingly hard to maintain the high standards of cleanliness they would like.

Staff we spoke with were able to describe the ways they would deal with infection control issues. There was personal protective equipment (PPE) available around the service, and we saw staff use the equipment

appropriately. Staff understood the importance of regular hand washing and we observed good hand washing practices during our visit. This showed the staff at the service worked to protect people from the risks of cross infection.

People we spoke with told us they felt safe. One person said, "Of course we feel safe. Why shouldn't we?" Relatives also told us they felt their loved ones were safe at the service.

Staff we spoke with were aware of their responsibilities to keep people safe from abuse. One member of staff told us they would report any issues of concern to the most senior person on duty. They told us they felt confident the registered manager would deal with any safeguarding concerns appropriately. A further staff member told us they were also aware they could contact the local safeguarding teams if they felt issues were not dealt with.

The registered manager was aware of their responsibilities in relation to managing safeguarding issues. We saw they had reported a recent safeguarding concern to us and had worked with the local safeguarding teams to investigate the issues.

Following this safeguarding, the registered manager had held a meeting to discuss the issues with staff to ensure they learned from this incident and reduce the risk of a re-occurrence of the concerns raised. This showed the registered manager was working with staff to learn from adverse events at the service.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they felt staff had the skills to support them with their needs. One person said, "They are skilled at what they do." A relative we spoke with also felt staff had the skills to undertake their roles. They said, "There is sensitive handling (when assisting people to move) staff seem proficient and competent." During our inspection we saw staff supporting people appropriately.

Staff we spoke with told us they had received appropriate training for their roles and had regular updates. However, the registered manager sent us the training matrix following our visit, which showed some staff were meant to receive update training in health and safety, infection control and dignity and respect, in June 2018. But they had not received this. The registered manager told us they were in the process of sourcing a new trainer to undertake the training, which was overdue and training that was due imminently. This meant staff may not always have the most up to date knowledge in relation to the areas of training they required.

The majority of people at the service were weighed regularly. However, one person had conflicting information in their records in relation to their weight. One record showed they had gained 8kg between the months of May 2018 and June 2018, and a second record showed they had lost 9kg during this period. There was no information in the person's care plan to show that, after weighing the person and finding they had lost weight, staff had put in measures to support the person's nutrition. We highlighted the issue to the registered manager on the 25 July 2018, and on the 27July 2018 we contacted the registered manager to check if the person had been re-weighed to establish their correct weight, they had not re-weighed them. When we returned on the 30 July 2018 the registered manager confirmed the person had lost 9kg, and they were obtaining advice to address the issues with the person's diet. However, this delay in establishing the person's weight, and the significant weight loss showed the staff at the service were not providing this person with the support they required to maintain a healthy weight.

People we spoke with told us they enjoyed the food at the service. One person said, "I like the food, oh yes, it is very nice." Another person said, "There is plenty to eat." However, we found some confusion amongst staff about whether some people at the service were diabetic and required a specialist diet. A number of staff, including the cook, told us there was no one who was a diabetic at the service. However, we found evidence in two people's records which stated they were either diabetic or pre-diabetic. A member of staff also told us two more people were pre-diabetic, but there was no evidence in their care plans to support this, and when we spoke with the cook they were unaware of this.

Although the service employed a cook, care staff also undertook cooking duties when the cook had days off. On the first day of the inspection we asked the member of staff who was undertaking the cooking if there was a folder with people's dietary needs kept in the kitchen, and they told us there wasn't. They told us if they wanted to know about people's needs they would ask other members of staff. As there was some confusion among staff about people's dietary needs this could lead to people receiving a diet that did not support their dietary needs.

During our inspection we saw people were offered cold drinks with their meals and hot drinks in between meals. However, the weather was extremely warm and people were not offered extra fluids to help prevent dehydration. We also saw one person had been given a warm drink when staff came around with a drinks trolley. The person sat with their head bowed for a period of half an hour with the drink in front of them. As there were no staff in the vicinity, one of our inspectors encouraged the person to take a drink. The person then woke and drank the whole drink straight away. This showed that people were not given encouragement to keep hydrated as staff were not always able to sufficiently monitor this aspect of their care.

These issues are a further breach of Regulation 12 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw the service was inconsistent in its approach when people's health required them to be admitted to hospital. Details of the support people required were not always sent with them to assist hospital staff deliver appropriate care. People's records showed hospital staff had needed to contact the service following people's admissions to establish what care people required. There was no clear format for staff to use to provide health care professionals with this information. This showed a lack of coordinated planning by the staff to effectively support people with this aspect of their care.

People told us the staff were quick to call the GP if they needed them. Staff we spoke with told us a recent event had made them aware of the importance of prompt action when people required support with their health care needs. One member of staff told us they would let the senior care worker on duty know if a person was unwell and needed the GP. They went on to say if they felt it necessary, they would have the confidence to contact the GP or the out of hours GP service themselves to ensure people received the care they needed in a timely way. Records showed staff had contacted people's GP's, the out of hours GP service or the emergency service when it was required. This showed staff supported people to access the most appropriate healthcare professional to meet their needs.

Parts of the service were not decorated or adapted to a consistent standard to meet people's needs. The service had been extended and the new wing housed a number of bedrooms which were decorated to an acceptable standard. However, there were some areas both in the new wing and the original building which required maintenance. For example, there was damp on the wall in one of the new bathrooms. Staff told us this had been like this for some time. On the third day of our visit we saw the lounge and conservatory roof had leaked, rendering the room unsafe to use. We also saw on the previous days of our visit this area was too hot for people to be able to use. This meant people were forced to use the smaller sitting room at the service. When we last visited the service we saw the outside areas of the home were in need of improvement. During this visit we saw some improvements to the upkeep of the gardens had been made. However, the outside areas remained uninviting and in some areas, unkempt. These issues showed a lack of consistent maintenance and improvement of the environment for the people who lived at the service.

The Mental Capacity Act (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.

Staff we spoke with showed some basic knowledge of the principles of the MCA. One member of staff told us it was brought in to protect people who may not have the capacity to make their own decisions. However,

we found the service was not always following the principles of the MCA. One person was living with advanced dementia. Their care records showed they were often resistant to personal care or taking their medicines, there was no evidence of best interest meetings to support any decisions made in relation to their care. A further person whose relative told us needed support with their personal care, due to their fluctuating mental capacity, had no records of best interest meetings to support the decisions staff made with the person's care. The relative told us they had not been involved in any meetings to establish best interest decisions for their relative's care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). A number of people at the service had a DoLS authorisation in place. We saw some conditions imposed on the DoLS for each individual had been met. However, one condition imposed for one person was for staff to regularly support the person to access the gardens. There were no records to show this was being undertaken.

This showed the service was not always following the principles of the MCA when supporting people in their care This is a breach of Regulation 11 of the Health Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were not always aware they had a plan of care in place to support their needs. None of the care plans we looked at had evidence of people's views on their care. For example, one relative, whose family member was living with dementia told us they had not seen their relation's care plan or been asked for their views on their family member's care. They told us they had visited regularly and although they had voiced their views on their family member's care needs, these views had not always been taken into consideration. The relative also felt that when staff were supporting their relation, they did not always ensure the choices around their care were explained clearly. Their family member did not always know the time of day and staff tended to get the person ready for bed during the early evening. When the person was living at home they had not gone to bed during the early evening. The person and their relative felt staff did not give the person enough information to make an informed choice on whether they wanted to go to bed, for example what time it was. The relative also told us they had come to visit and found them inappropriately dressed for the type of weather, for example wearing a jumper or cardigan in the hot weather. The relative felt staff were not offering appropriate choices with rationales to help the person make the best choice. This showed the service did not consider or support people in relation to their views and choices when planning their care.

People told us the staff looking after them were kind and considerate towards them. One person told us the atmosphere was quieter and calmer than the previous place they lived in, and said, "The staff put themselves out for you, they don't jump when you ask, but usually get round to it." The person felt this was due to how busy staff were at the service. Another person told us they felt the staff were kind and caring. A relative we spoke with told us the staff were always welcoming towards them when they visited.

Staff we spoke with told us there was a caring attitude among their colleagues towards the people in their care. One member of staff told us a number of staff had been working at the service for a long time and had formed positive relationships with people. Another member of staff echoed these views and told us, "Staff do care about people." However, staff also felt they did not always have the time to engage with people due to their workload.

Our observations supported the things we had been told by people and staff at the service. Although we saw staff were respectful when engaging with people, they did not always have time to talk with them other than when supporting a person with a task. We also saw that people's preferences were not always remembered by staff. For example, one person liked a hot drink made with a particular milk. They told us and we saw they did not get this when served with a hot drink. The person told us their relative did bring the milk in, but they didn't always get offered the milk and didn't like to keep asking for it. This showed people's preferences were not always considered when staff provided care for them.

People were supported with advocates when they needed them. Advocates are trained professionals who support, enable and empower people to speak up about issues that affect them. The registered manager told us they were aware of their responsibilities in relation to ensuring people received this support when they required it. We saw one person had the support of an Independent Mental Capacity Advocate (IMCA) as

part of their DoLS conditions. The role of IMCA's was introduced as part of the Mental Capacity Act 2005. This gives people who have an impairment, injury or a disability which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation. The registered manager told us they were in the process of arranging for another person who lived at the service to have the support of an advocate. This was as a result of some recent changes in the support the person received from their family. This showed the service was working to ensure people were supported with independent and impartial advice when they needed it.

People told us staff were careful to maintain their privacy when providing care, and treated them with dignity and respect. Staff we spoke with told us they understood the importance of their role in making sure people felt comfortable when they provided them with care. One member of staff told us, "I see my colleagues respecting people's privacy and dignity." During our inspection we witnessed staff's interactions with people which showed people at the service were treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

People did not receive the care and support they needed because information about known risks were not used to inform people's care plans of the care and support they needed. For example, one person had recently had some significant changes to their health needs and had spent some time in hospital. This had affected their diet and mobility. The person had required some changes to their diet due to swallowing issues. There was a lack of detailed information in the person's care plan to provide staff with the guidance they needed around the person's dietary needs. The new diet was not explained in the person's care plan, the person also required their fluids thickening but the care plan lacked this information. Although staff were providing the person with the correct diet, there had been no risk assessment in place to support staff identify the risks to the person should they not receive this diet. The person's mobility needs had reduced and the effect this had on the person's risk of tissue damage had not been reassessed. Had the person's tissue viability assessment been undertaken following their hospital discharge the assessment would have shown the person to be at increased risk of tissue damage. However, there was no information in the person's care plan to guide staff to reduce the risk for this person. Staff were unable to tell us how often the person was being repositioned and there was a lack of information in the person's care plan to guide staff.

People's care plans did not contain the information needed to provide them with care that was individual to them. Three people had been admitted to the service during the two weeks prior to our visit and there had been no care plans developed to guide staff on how to provide support for these people. The only information in their care records to support staff with their care was the pre- assessment information gathered before their admission. One person had been admitted for palliative care, but there no evidence to show the wishes of the person or their relatives for this aspect of their care had been discussed. None of the care plans we viewed had any information to show if people had been given the opportunity to discuss their end of life wishes. However, one relative we spoke with told us they had supported their relation to develop an advance care plan when their relation had been admitted to the service. This failure to provide people with an opportunity to discuss their end of life wishes meant there was a risk they would not receive the care in the way they wished at this important time.

A further person also had some skin issues and required regular intervention from the community nurses. The information in their care plan did not give staff any guidance on how to manage any concerns should there be any issues in between the community nurses visits.

The service used nationally recognised assessment tools when assessing the needs of people at the service. We saw there was guidance for staff on how to use the tools available; however, in some of the care plans we viewed we found the tools available had not been used, as some assessments had not taken place. For example, one person had two weight charts in place showing contradictory evidence on their current weight. One chart showed the person had gained weight and the other showed a significant weight loss. However, the nationally recognised assessment tool in place had not been used to guide staff to introduce measures to support the person following this possible weight loss.

In other care plans we identified concerns about management of risk, contradictory and missing

information, and out of date information. All of the care plans we viewed were disorganised making information about people's individual care difficult to find, which would indicate systemic failures to provide up to date individualised personal care for people at the service.

There was a lack of support for people to follow their interests and take part in social activities. One person we spoke with told us there were, "No friendships made here." They went on to say there were no activities to encourage this. They also told us they did not enjoy sitting in the lounge they were in as they said no one ever spoke. We saw people sitting in the lounge with the television on; however, the people we spoke with had no knowledge of what was on the television so they could not make a choice on the programme they would like to watch.

Staff we spoke with told us there was no activities co-ordinator at the service, and before the staffing levels had reduced they did try to play games with people during the afternoon, such as skittles. Throughout our inspection we saw people spend long periods of time sitting in either the lounge area or their rooms with very little stimulation.

The provider was also not meeting the accessible information standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. There was both a lack of detailed information in people's care plans on their communication needs, and a lack of visually adapted information around the service to support people with an impairment or sensory loss. For example, we saw one person's care plan noted they had some partial blindness. However, there was no information in their care plan to show what support the person needed to access information. There were several people who were living with dementia, but when establishing these people's choices for meals staff simply asked them and did not provide any visual aids to support people. This limited people's access to information that may have supported them to make informed choices around their care needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not always responded to consistently. We saw a complaint had been made to the registered manager who had responded with the actions they would undertake to address the concerns raised. However, when we checked on the actions they had committed to undertake, we could find no evidence to show the actions had been carried out. For example, they said they would ensure staff were aware of specific information relating to a person's care, by including this in staff handovers every day for a week. This information was meant to give staff guidance on the daily checks they should make on aspects of a person's care. We found the information was only noted on the handover sheet for one shift handover, on the day the registered manager wrote the letter. We then checked the daily care records and found the staff had only recorded they had completed these checks once since the complaint had been made. This shows the service was not responding to complaints and learning from feedback people or their relatives gave to them.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a lack of quality monitoring and over sight at the service that led to people not being adequately protected from risks associated with their care and support. During our inspection we identified a number of concerns about the failure to identify and address serious risks to people health and well-being. Specifically, we found people were not protected from risks associated with falls and their environment. There was a lack of robust monitoring of the information in people's care plans that led to a lack of clear, up to date, consistent information to inform staff of the care people should be provided with. The governance processes in place did not highlight or address the risks associated with these concerns.

There was a lack of oversight and analysis of the falls at the service. The registered manager had been recording the number of falls each month. However, it was not clear how they were gathering the information as the number of falls they recorded were far below the number of falls recorded in the accident books we viewed. For example, the number of falls the registered manager recorded from November 2017 to June 2018 was 15. However, the two accident books in place showed there had been 62 falls. There was also no analysis of the falls the registered manager recorded, to establish if there were any trends. This along with the lack of correct information being recorded month on month meant the risks to people's safety had not been reassessed to establish ways to reduce each individual's risk of falls. As a result, people continued to suffer falls which with appropriate measures in place may have been avoided.

There was inadequate monitoring of the environment people lived in. For example, the provider had commissioned an external company to undertake an assessment of fire safety at the service in July 2017. The company had produced an action plan with actions the provider should undertake, giving a varying time span for the completion of the actions. However, all of the actions should have been completed within six months from the assessment. The providers quality monitoring processes had not highlighted the actions were still outstanding. As a result, people were exposed to the risk of harm as the provider had not effectively mitigated the known risk in relation to fire safety in this area of the service. Following our inspection, we received assurances from the provider that the necessary work had taken place. However, it is concerning that the quality monitoring processes had not highlight these issues prior to our visit.

The lack of quality monitoring of the care plans had led to some people who had recently been admitted to the service not having a care plan in place, and the information in other people's care plans lacking up to date information. The care plans were disorganised and the quality of the information in some care plans was poor, and did not give staff the guidance they required to provide people with good quality care. The lack of regular quality monitoring of the care plans was evident in all the care plans we viewed. When we discussed the lack of information and organisation of the care plans with the registered manager they appeared surprised at the information. We saw they had been recording that on average six people per month had care plan reviews. However, we were unable to find any evidence of these reviews in people's care plans and they had not led to the care plans being updated or improved the quality of the information required to provide people with good quality care.

When we last visited the service in July 2017, the provider was using an external consultant to support the

registered manager to manage the quality auditing processes. This had resulted in improvements in the oversight and monitoring of the service. However, prior to this visit we found the consultant was no longer being used. We contacted the provider to check who would be responsible for the over sight of the quality monitoring of the service in the absence of the consultant. The provider told us they were undertaking this role. At this visit we could find no evidence that the provider had been regularly monitoring the quality of the service they provided. This lack of robust oversight has resulted in the issues we have highlighted throughout our report.

Staff we spoke with told us the registered manager gave them support when they needed it. They told us the registered manager undertook shifts on the floor when they were short of staff. However, all the staff we spoke with over the three days of our inspection told us they did not feel supported by the provider and they did not feel valued by them. Staff told us a lot of them had worked at the service a long time and they felt loyalty towards the people they cared for. One member of staff told us the last meeting they had attended with the provider was unpleasant. They said staff felt very uncomfortable during the meeting and said, "He (provider) thinks he can talk to us any way he wants."

Staff we spoke with told us they did not feel listened to by the provider, and although the registered manager highlighted their concerns to the provider he did not listen to her. We asked the registered manager if they had received any supervisions or appraisals during their time at the service and they told us they had not been supported in this way. We raised these issues when we spoke with the provider following the inspection, however we received no assurances that these issues would be addressed by them. This shows a poor leadership of the service.

People we spoke with told us they had not attended any meetings to discuss their views or ideas of how their daily lives could be improved. The registered manager told us they had developed a questionnaire which had just gone out to people to ascertain their views on their care. However, the results of the survey had not been collated prior to the finish of our inspection.

Throughout the visit we were not presented with any evidence to show the service had achieved any sustained improvements to the care they provided. The inefficiencies of the quality monitoring processes meant that there was a lack of drivers for improvements at the service. The staff meeting minutes we viewed lacked any evidence of feedback for staff on quality issues and the priorities of the service. This showed a lack of understanding of the principles of how good quality assurance and clear leadership could affect the running of the service.

This has led to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were aware of who the registered manager was. One person said, "They (manager) sometimes comes around and has a word with us, but then we don't see them for ages." Another person said, "I think the atmosphere in the home is open and friendly." People we spoke with told us they felt they could talk to the registered manager. None of the people we spoke with knew who the provider was and could not recall having seen them or being introduced to them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised and individualised care. Their care plans did not contain sufficient information on their needs and preferences related to their care including end of life care. There was a lack of social activities to stimulate and interest people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act were not always followed to ensure people had the maximum choice and control of their lives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always provided with safe care and treatment as risks associated with their care and support were not always assessed and there was a lack of adequate safety measures in place to protect people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints When people made complaints the issues were not always followed up.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service provision was not robustly monitored and effective action was not taken in response to issues. There was a lack of oversight from the provider which resulted in poor care for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The staffing levels did not always meet the needs of people living at the service.