Caretech Community Services (No.2) Limited

Cedar House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service over two days on 6th October 2015 and 13th October 2015. It was an unannounced inspection. We last inspected the home on 12th August 2014 and no concerns were identified.

Cedar House is registered to provide accommodation with nursing and personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for up to 12 people. The people living at the service predominantly have learning disabilities and require nursing care. There were seven people living at the service at the time of inspection, with one bed being used regularly for respite care.

During this inspection we met the manager who had been in post since February 2015 and was in the process of submitting their application to become the registered manager. The conditions of registration for the service state that a registered manager is required. There was not a registered manager in place at the time of inspection and the last registered manager had de-registered in March 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Relatives told us the staff were caring but at times there were not enough staff. People's privacy and dignity was not always maintained and there were not always enough staff to provide person centred safe care to people.

The staff we spoke with understood what abuse was and how to report it if they had any concerns, not all staff had been on safeguarding training.

Care documents contained information, such as people's personal preferences and how people communicated. These documents were not always up to date and review mechanisms were not in place to ensure that people's most recent needs were recorded.

Staff recruitment procedures were in place and the provider ensured that everyone had the necessary checks to ensure they were employing appropriate people.

However, we found several issues with the recording, storage, ordering and administration of medicines which put people at risk of harm because medicines were not safely managed.

There was a complaints procedure in place and available to people and visitors but this was not being followed by the manager.

Appropriate arrangements were not in place to manage risks to people's safety. Risks for people had not been identified or anticipated and people were at potential risk of receiving care and support that was unsafe and did not meet their needs.

We found overall that people were at risk of receiving inappropriate or unsafe care. We found breaches of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider and will report further on this when it is completed.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff to meet people's needs. People's individual needs were not met due to staff delegation and numbers.

There were unsafe practises in regards to medication storage, ordering and administration.

Inadequate

Is the service effective?
The service was not effective.

The systems for ensuring that people had enough to eat and drink were not effective in ensuring that nutrition and hydration needs were met.

Inadequate

Is the service caring?
The service was not consistently caring.

Although we saw some caring interactions between staff and people, privacy, dignity and respect were not always upheld.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

A complaints policy was in place but it was not followed appropriately and relatives felt that their complaints were not listened to or acted upon effectively.

People were not supported to take part in appropriate activities

Requires improvement

Is the service well-led?
The service was not well led. There was no registered manager in post.

Systems were not effectively used to regularly monitor, assess and improve the quality of care.

Inadequate

Cedar House

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 over two days on 6 October 2015 and 13 October 2015 and was unannounced. The inspection team on 6 October 2015 consisted of two inspectors and two pharmacist inspectors. On the 13 October the inspection team consisted of three inspectors, a pharmacist inspector and a nursing care specialist.

Before the inspection we looked at information we already held about the service. We reviewed previous inspection reports for this service. We also reviewed notifications made to the CQC, reports from the local authority, correspondence with the local safeguarding team and feedback we had received from relatives and the manager.

During the inspection we spoke with nine staff members, including the management team from within the service and three senior managers. We spoke with four relatives of people and five professionals who have contact with people and the home. We looked at four people's care files, five staff files, staff duty rotas, a range of audits, complaints folder, staff and family meeting minutes. We also looked at the incidents and accidents log including safeguarding, daily nursing and support records that the service keeps, policies and procedures, and observed interactions between staff and people, relatives and the management team.

Inadequate

Is the service safe?

Our findings

People's relatives told us there were a number of instances where there were not enough staff working to meet people's needs and ensure a safe service. For example, we were told of instances where the same nurse had worked additional shifts because there was no nurse to replace them. Their comments included, "It's very dangerous here" in respect of this. We were also told of people being left alone in the lounge for periods of time, which relatives described as "often" and felt was unsafe. We saw this occurring during our visits where four people were left alone for fifteen minutes in the lounge. We also received feedback from a healthcare professional who said that they saw one person being left alone for over an hour in their bedroom.

The manager told us that in addition to a nurse always working, expected staffing levels were three care staff throughout the day with one person being supported by one staff member at all times. The manager told us night staffing levels were one nurse and one care worker, plus a further care worker assigned to work with a specific person at all times. She added, however, that during the last two weeks they had not always managed to secure replacement nurses when needed. This had twice resulted in a nurse staying on shift for more than 24 hours including resting and sleeping. Our checks of the staffing rota and other records confirmed that on the last two Sundays previous to the 6 October 2015, the night nurse had to work until the Monday evening of 7 October 2015. On 27 September, records showed that a nurse had started at 4pm, and so worked almost 30 hours without being relieved.

During our visit on 13 October 2015, the manager told us that the agency nurse working the night shift of Sunday 11 October 2015 had not been able to leave until 6pm on the following day. The nurse had slept during parts of the night, which the manager said they had reported as a concern to the agency. However, despite the previously-identified concerns, a further instance had occurred. The provider's failure to provide replacement nursing staff in a timely manner, the length of time individual nurses had to consequently work, and the periods when these nurses were asleep meaning no nursing staff were working at that time, put the health, safety and welfare of people using the service at avoidable risk.

We saw examples where staffing levels affected the care that was provided, for example where there was less staff on there were gaps in repositioning charts where they were not signed by two people. We saw that people funded for one to one 24 hour care was not receiving this due to low staffing levels. On 13 October 2015 we saw that one person, who is funded for one to one care for their safety, was not receiving the one to one care. Throughout the day we checked to see if this person was being provided with staff supervision and support, and found on eight out of ten occasions they were left alone. We fed back to managers at 5:20pm that we felt this person was at risk because of the lack of supervision. They agreed to ensure that one to one staffing was provided for the rest of the evening. We checked on this person again at 7:30pm, 7:45pm, 8:40pm, 9:00pm and 9:05pm, 9:10pm and 10:20pm. On five out of seven occasions we found one to one staffing was not being provided. Staff told us that this person did not receive one to one staffing at night and could be left alone in their room. We asked the manager why they were not getting the one to one care at night. The manager said that there was a monitor in place, used by staff to watch the person from the lounge. The manager said that the monitor had been broken, and a new one had arrived that day. When we asked how long the monitor had been broken for; the manager said it had been broken "for officially two weeks" and when asked for further clarification went on to tell us it had always been temperamental. This was placing this individual at risk, because they were not being supervised continuously at night, despite being assessed and funded for one to one staffing 24 hours a day for their safety.

A staff member and a relative told us that some days there was no-one assigned to the daytime cooking and cleaning shift, and so care staff had to take on those roles. We checked staff rotas and found this to be the case. For example, for five times across the 12 days before our visit on 6 October 2015 there was no-one rota'ed for that role with no increase in other staffing. The provider did not deploy sufficient staff to maintain people's health, safety and welfare on those occasions.

We looked at records and found there were less care staff working than planned, for example, only two care staff working the day shifts across the previous weekend. There

were also only two care staff working across Saturday 12 and Sunday 20 September 2015.There was only one of the two planned night care staff on 16 September 2015 available to meet people's needs.

The deputy told us that all manual handling of people involved two staff. We saw many hoists in place in support of this, including ceiling hoists in people's rooms. However, one relative told us that there were occasions when lone staff members supported people to transfer, for example, during the weekend prior to our visit on 6 October 2015, the rota for that weekend showed there were less staff working than the provider's agreed staffing levels. In addition to this there was an additional person using the service on respite. People's repositioning records during the weekend of 3 and 4 October 2015 included seven hour gaps in comparison to the recommended four hours. One person's record showed only one staff signature for some repositioning during 3 October 2015 when the rota did not indicate that there was a nurse working nor additional care staff. This was putting people at avoidable risk of harm when being moved as insufficient numbers of staff were being deployed by the provider to meet people's needs.

A staff member told us a relative had just informed them that someone had not been catheterised as expected four days before our second visit. The person's MAR did not record that they had been catheterised despite a reminder in their medicines folder for weekly catheterisation. The staff member said, "I've told them [management] that mental health nurses don't know how to catheterise or set up feeds", adding that they had to stay an hour beyond their shift time to set up processes for catheterised care for the agency nurse. On the second visit we reminded the manager that nursing staff needed to be able to perform nursing functions such as catheterisation and rotating Percutaneous endoscopic gastronomy (PEG- where a tube is inserted into the stomach to help feed someone) lines to provide safe care appropriate to the needs of people using the service.

The above evidence demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's medicines were not managed safely. A relative told us of visiting the GP with their relative and a staff member recently. The person had a seizure, but medicine for responding to the seizure had not been brought along. We checked this with staff who confirmed this occurred.

The relative told us the same medicine had not been passed onto them for a trip out on the day of our inspection. We established that no such medicine was provided for journeys between the service and people's day centres. The person's seizure guidelines available to care staff dated May 2015, however, those available to nurses dated September 2015. A nurse told us, "I don't look at the guidelines as I'm so used to them" despite the guidelines being only a month old. Only three nurses had signed to say they had read the guidelines, and that nurse had not. This put people at risk of receiving unsafe or inappropriate care.

We found contradictions within guidance about how to respond to people's epilepsy needs. One person's specific guidance for an emergency medicine stated for use after four minutes of a seizure. However, within the same medicines folder, the latest epilepsy guidance from a community nurse dated 1 May 2014 stated for the emergency medicine to be given immediately. The record of recent seizures indicated that the former guidance was being followed. We also found that for one person the stocks of emergency epilepsy medicines were not recorded on their MAR and not stored in an accessible place in the event of an emergency when they would need to be accessed quickly and easily. This put the person at risk of harm as they were at risk of not being given their medicines as prescribed.

Towards the end of our first visit, one person's relative told us the person had run out of catheters. The nurse confirmed this to be the case, saying they had a change of catheter three times a day. From their subsequent discussions with the on-call GP, we established that this put the person as at risk of urine retention and infection. There were records in the service including an incident report dated 5 October 2015 stating that the catheter supply had run out and stocks were not recorded on MARs. The prescription for catheters for the person was in place and dated 28 September 2015 but these had not been ordered by staff at the service.

We found a record of a visit on 30 September 2015 by two healthcare professional to one person in respect of their PEG feed. they had raised concerns about the person having an infection, and recommended actions including acquiring a specific cream to apply to the potentially infected area. When we asked to see that the cream was being used, the nurse told us it was not and they were not

aware of the visit. They said the record had not been filed correctly. When we returned on the 13 October 2015 this had still not been resolved and we had to intervene and ask a senior manager to chase this issue up. This put the person at risk of harm and neglect.

We found that there were several recording issues regarding medicines and that on 6th October 2015, we saw that the quantities of medicines, dressings and catheters in stock at the service were not being recorded and being used for people. Therefore audits could not be carried out to check that these medicines had been used as prescribed, or for staff to check that sufficient supplies remained. This was fed back to the manager on 6 October 2015. On 13 October 2015, we saw that quantities of medicines, catheters and dressings in stock at the service were still not recorded for all prescribed items, including 33 medicines currently being administered to people, so it was still not possible to audit these medicines to check if medicines had been administered as prescribed, or for staff to check if sufficient supplies were available for people.

We found on 6 October 2015 that a prescribed steroid inhaler was not being used properly as prescribed for a person. This was a preventative inhaler and, on the MAR from 9 September 2015 to 5 October 2015, it was recorded by hand as being PRN (as required), rather than two puffs twice a day, as prescribed. The person needing the inhaler according to this record had only had three doses out of 56. The manager confirmed this was a mistake via email made by staff altering the MAR, dating back to November 2014. This confirmed that the person had been receiving incorrect and insufficient dosages of this prescribed medicine since November 2014 which placed them at avoidable risk of harm and neglect.

Infection control practises were not always followed. One relative showed us that the feed pump for their relative was dirty, as it had liquid stains on it. When we checked the record of last cleaning, it was found to be four days previously, despite a statement on the form that cleaning was to occur after each use and weekly. In total, it had been recorded as cleaned six times in 19 days, despite records showing it was used daily. Similar records of cleaning were found for another two people using PEG feeds, despite daily use. When we returned to the service a week later, only two further cleans had been recorded for the three people's PEG feed, with none cleaned for six days.

We saw on 6 October 2015 and 13 October 2015 that other medical equipment was not clean, and therefore posed infection control risks to people. PEG feed lines were sticky to touch and records of cleaning equipment were not completed. Records for cleaning suction machines and nebulisers were not completed as required. This showed that people were put at risk of avoidable infections.

We saw that staff needed reminding to use gloves and one staff member pushed spilt food back into someone's mouth with their hands. A relative told us of seeing a staff member flush two people's PEG feeds without using gloves. On the two days we visited there was hand wash in bathrooms. Relatives were concerned about sterile syringes being left in open plastic beakers, which we later observed next to where one person was sitting in the lounge, along with an open lid to a sterile water jug. This meant people were being put at risk of infections as sterile equipment was left exposed in communal areas.

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

Staff told us they had training on safeguarding and were able to describe the different types of abuse and what actions they would take if they suspected abuse. Training records showed that 19 out of 23 staff had completed e-learning training on safeguarding of vulnerable adults.

There were emergency plans in place for all people living at the service and respite visitors in the event of a fire and fire risk assessments. The fire panel indicated a working fire system. A brief check of the fire safety book showed staff tested the fire system regularly. Whilst some doors in the property had devices to hold them open but release in the event of activation of the fire alarm, we noticed that staff were using a chair to prop open the kitchen door when using it for breakfast. The manager subsequently showed us an order for additional devices that would be imminently installed. Equipment checks were all in place and had taken place within the last year.

Staff files showed that recruitment processes were safe. Application forms were completed, identification checks made, criminal record checks completed before starting work and references validated. On the second visit the

Inadequate

Is the service safe?

provider emailed across dates that criminal records checks would need to be redone and all were currently in date. This was an effective measure to ensure staff were suitable to work with people when recruiting them.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. Out of the seven people living in the service two people had applications for DoLS made by the provider that had been approved by their respective local authority. Where two further applications had been made there was no evidence in care files that these had been chased up and there were not consent documents and best interest decisions records kept that demonstrated that a process had been followed to determine the best interests of people. When asked about mental capacity one staff member was able to describe the principles and another described how when they are administering medication they explain what they are doing and the side effects if medication is not taken and takes an open mouth to mean consent and a refusal to be a closed mouth. Training records were reviewed and 19 out of 23 staff members had done e-learning within the last year on MCA and DoLS, and one out of 23 had done a classroom based course in the last year.

We found there were high levels of agency nursing staff who did not know people and their complex needs due to the lack of permanent nurses being employed by the provider. Visiting healthcare professionals who worked with people living at Cedar House reported that they had noticed high levels of agency staff usage which affected communication with them and quality of care. In the twelve days previous to our visit on the 6 October 2015 records showed that out of a total of 24 shifts, 11 of the 24 nursing shifts were covered by seven different agency staff. Therefore people were cared for by staff who may not have known their needs well and by a number of different staff. All the people living at Cedar House relied on staff that knew them and knew their care plans well to understand their needs. Communication required staff to be familiar with interpreting peoples' behaviour due to non-verbal communication skills, these concerns were fed back to the manager on 6 October 2015.

At our visit on 13 October 2015 we found that from 7 October 2015 to 13 October 2015 eight out of 14 nurse shifts were covered by six different agency nurses. Therefore people were still being cared for by people who were not experienced in providing their care and treatment and not familiar with their needs. This lack of knowledge about people affected care, with professionals and relatives feeding back to us with examples where mistakes had been made. In one example the wrong dosage for someone using PEG feeds was ordered. This put the person at risk of the wrong amount of feed being ordered and administered due to the high level of agency staff in the service.

The above evidence contributes to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's nutritional and hydration needs were not always met. during our first visit we saw that a relative alerted nursing staff that the PEG feed battery was flat and the person had only had 300ml of a 700ml prescribed feed and would be hungry. We noted that the PEG feed unit had no charge regardless of how the unit's switch was positioned. Staff confirmed that it had run out of battery due to not being charged fully the previous night and they were extending the person's feed to ensure they got the right amount. On the second visit we saw that the same person had been without their feed for over four hours, it had been switched off when they were put into bed in the early afternoon and then left off until four hours later when Inspectors intervened and informed managers that this person had been without their feed again. The feed was then switched back on. This put people at risk of not receiving the right amount of nutrition and leaving them hungry.

During our visit on 6 October 2015 we saw that one person was signalling that they might be thirsty, when we asked staff if this was the case they said no the person had had a drink three hours previously at 3pm, we asked the staff to offer a drink to the person. On the second visit the same person at 6pm indicated they were thirsty according to the gestures outlined in their communication profile, we asked staff to offer the person a drink and they said that they had had a drink three hours previously, another staff member said the person made that gesture but it did not mean anything. We saw that staff were not offering drinks

regularly and were not responding to the gestures of people who were trying to tell them they might be thirsty. Therefore staff were not meeting people's plans of care for their hydration needs.

We asked to look at the fluid records for people and were directed to the locked medicines room where care staff could not access the file easily because the nurse held the keys. We looked at the fluid charts for six people at 7pm and no records had been made throughout the day of fluids being offered, given or refused. The arrangements for the monitoring and meeting the hydration and nutritional needs of people were not effective.

We saw that place mats had been designed with the specific healthcare professional advice for each person in support of them eating and drinking safely but that these were in a pile on the dining room table rather than out and visible for each individual. We saw staff working together to encourage people to eat and drink, for example, in acquiring the support of a staff member who had a stronger relationship with a person using the service so as to encourage them to drink.

We observed home-cooked food being prepared for the evening meal, and were told of a home-cooked soup being provided for lunch. A relative said that people no longer received regular drinks, and that “the menu is rarely adhered to” adding that people received spaghetti hoops for lunch three times recently.

Another relative told us of visiting the service on a recent Saturday and finding their relative alone in the dining area with their breakfast “ice cold” at 11am. They said the last meal would have been 5:30pm the previous day. They also said their relative had received the same breakfast every day for two years, which they felt was not a varied diet, and stated “I feed them to ensure they’re fed.” Daily records in the care file of one person showed that for the seven days preceding the second visit the same breakfast was offered with no choice recorded.

The above evidence demonstrates a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records relating to people using the service were not accurate and up to date. For example, charts kept for people’s bodily eliminations, with entries prompted for three times a day had several gaps. For one person this had not been completed for 29 of 90 applicable occasions in September.

For another person, their repositioning chart showed a last entry at 5:30am and so had not been filled in by 11am for their morning support. It showed an 8:30am entry for that morning on our second visit. The chart prompted for repositioning support every four hours, but there were a number of instances when the gaps between records were between seven and 12 hours. Across the previous nine days, there were five nights when there were no repositioning records, which coincided with agency nurses working those nights. On our second day of visiting, we saw that these gaps continued. Daily body charts were being kept for people. At our first visit, we checked the charts for one person that were stored in two separate files, but found omissions on seven of the last 18 days.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that the providers’ policy on supervision had changed in September 2015 and that previously staff should have been receiving monthly supervisions but now they would be getting six one to one supervision sessions per year with their line manager. The manager said she had last done some supervision in August 2015 and they were not up to date. There were no records of clinical supervision for nursing staff, we were told by nursing staff that they had not received clinical supervision for over six months. When we asked the manager why this was she said that there was nobody to do it but that staff would be getting it from mid-October 2015. When we spoke with support staff about supervision they said they find supervision helpful, one staff member said they last had supervision three to four months ago. The staff files we looked at showed that some notes were in place but that only one out of the five files had supervision records within the last three months.

We looked at an improvement plan reviewed by a senior manager on 30 July 2015; this said that the staff should have appraisals in September as this would have given the manager sufficient time to get to know staff after their

Inadequate

Is the service effective?

appointment in February 2015. When we asked staff if they had had an appraisal in the last year they said they had not. The manager told us staff had not had appraisals but would be booked in soon.

The above evidence contributes to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

A relative told us that staff were “hard-working and caring but lack time” and staff that we spoke with, felt that within their team they were “a big family here” and when talking about people said “we treat them like our own children- with dignity, empathy and respect”.

We saw some permanent staff interacting with people in a positive way, smiling and making contact and using physical contact where appropriate, for example to let a person know that they were there and talking to them. We saw that people responded positively to the staff by smiling during interactions. This showed that people felt comfortable with the staff.

People were well presented and staff noticed when a person might need some support after eating. Staff were able to provide examples of dignity and respect when asked such as knocking on doors and drawing curtains but not always able to evidence this in practise. We saw that some staff did not always knock on doors and in one case a staff member walked into a bedroom on the phone when a person was lying in bed and did not announce themselves or greet the person. On the second day of inspection we saw that one person was having a routine procedure in a communal lounge with other people and relatives present and was partially exposed throughout. We saw that a meeting discussing private information about a person’s medical needs also took place in a communal lounge with other people, relatives and staff present in the room and walking in and out. This showed that people's privacy was not respected and maintained at all times.

We asked the manager about advocacy services for people using the service, we were told that three people had advocates but the other four did not. The manager said “I want the advocates involved" but we noted that no action had been taken to make an application for these. When we asked in what ways were people supported to promote their own independence and sense of self we were told that some people help with the washing by going to laundry room but did not see any evidence of this on the two days of inspection. The manager told us of one person who was supported to feed themselves using hand over hand support; this was also in their care plan. At mealtimes we saw that this person was fed by staff, and staff fed back that they had not been supported to feed themselves for at least nine months as the service did not have correct equipment in place to enable this to happen. This showed that people were not offered support to maintain their autonomy and independence

The above evidence demonstrates a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff were able to give examples of where individual needs were being met. For example one person with a specific cultural heritage was supported to be provided with clothing and meals that reflected their heritage.

We saw some permanent staff communicated well when interacting with people. All the people in the home needed staff to interpret gestures or understand the person’s own methods of communication and relied heavily on the knowledge of staff to be able to communicate. We saw that staff were able to communicate with people through talking, appropriate touch and showing objects to demonstrate what was about to be done. People’s plans contained person centred guidance for staff about how they communicated if they were in pain or hungry or thirsty. Most interactions we observed staff were able to recognise what the person was trying to communicate and also matched up to their communication profile.

Requires improvement

Is the service responsive?

Our findings

We looked at the opportunities people had to do interesting activities and access the community. A relative told us that people were not supported to go out enough. The manager told us "activities are not great". There was an activities co-ordinator and driver employed to take people out in to the community and the service had a minibus and a car adapted for wheelchair users. The deputy manager told us people attended day centres, there was a visiting massage therapist, and that people went out for lunch, but there needed to be more activities for people such as music therapy and trips to local places of interest. We saw a schedule for people to attend a day centre with specialised facilities such as a hydrotherapy pool. When we checked one person's care records for the previous week, it showed they had not attended their day centre as planned for two days. Another person did not attend the day centre as planned on the second day of our inspection and staff and managers gave conflicting reasons as to why they did not attend.

One person did not attend any day centre. When we checked their care delivery records for the week in-between the two days of our inspection, we found they went out once, for a meal. They were usually recorded as having watched television, despite their care plan stating an array of preferred activities such as community trips and being read to. Watching television was not included in the list of preferred activities. A healthcare professional told us that people would benefit from more staff interaction as there was too much watching television in their experience. We saw that people spent a large part of the day sat facing the television in the communal lounge and on the inspection days did not see evidence of any other in-house activity having been planned, advertised or taking place. People's personal preferences as to how they spent their time were not being met and people were not supported to be involved in their local community, therefore they were at risk of isolation.

The above evidence contributes to a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found that there had been a continued lack of response to complaints and recording of complaints received and their handling. Minutes of three family meetings showed that families consistently raised concerns that there was inadequate staffing at the service. These were not recorded on the complaints log and no written response had been given to families at subsequent meetings. People's relatives told us of their concerns and complaints not being responded to effectively. They all mentioned a meeting with the management team prior to our inspection, to which they said they had not had minutes yet nor any other response, and for which they saw no improvements on their concerns.

The manager explained to us they did not realise they had to log the complaints raised at family meetings although we saw a summary of the complaints procedure on display in the hallway. A complaint that a person had been given a food which was contrary to their religious background was recorded in the communication book but not in the complaints log. Staff confirmed that peoples' relatives visited regularly and therefore there was opportunity for the manager to respond to their complaint face to face and in writing.

The above evidence demonstrates a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Each person had a care plan and several other supporting records to document the needs and preferences and risks individual to them. One staff member was unable to describe what person centred care was, staff told us that the managers wrote the care plans with the families. These were detailed but inconsistent. For example, care documents that we looked at for one person had conflicting information about personal preferences regarding activities, cultural requirements regarding food and preferences for gender of staff. Another care plan had information crossed out and written over in pen, making it confusing as to what was correct information. Inconsistent information in care files meant that staff would find it hard to find accurate and up to date information about the people they were caring for which put them at risk of receiving unsafe care or inappropriate treatment.

Each person had a Health Action Plan (HAP), we looked in detail at one person's HAP and saw that it had a range of letters and records including medical appointment letters and records for weight and recorded individual preferences such as one person having a particular snack at a particular time of the day. The manager told us that the HAPs in place for each person were live documents. For some of the records there were gaps for example in the recording of

Requires improvement

Is the service responsive?

weight where there was a four month gap. There was also a letter from a medical professional noting that at the recent appointment epilepsy records were not brought along which they needed at the appointment.

We were told by the manager that families were involved in the review of care plans and "have quite a lot of input into how care is done" and gave an example of a relative who arranges a lot of activities for one person. Some care documents were not reviewed in a timely manner, for example for one person a manual handling assessment was dated from over a year ago with no evidence of review since then. For another person their physiotherapy had been stopped since April 2015 with no evidence of a recommendation from a professional to do so, similarly for another person their chest physiotherapy was stopped with no evidence to suggest why. When we spoke to the newly appointed locality manager they said that reviews were going to be requested for all people living at the home but had not yet been arranged. The lack of timely reviews in care files was putting people at risk of not receiving appropriate care and treatment and their needs were not being assessed on an on going basis.

The above evidence contributes to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

Our inspection found that the leadership, management and governance of the home was ineffective. The provider had not provided the required support, resources or monitoring to ensure the service was able to recognise issues with the service and make improvements. We did not find that a good quality service was being provided.

People's relatives did not think the service was well-led. "The manager just sits in the office or rubs people on the shoulder," one relative said. Another relative told us the manager and deputy were not monitoring standards of service, and did not help out if short staffed. We saw that on the first day of our inspection the manager and deputy sat in the office for most of the day and did not help out with the day to day running or planning of the shift.

Staff had mixed views about the support they received. One staff member told us they were afraid of losing their job, and another said "there's too much pressure…I can't do everything…things have broken down really badly". We found that breaks were not being taken by staff despite some of them working for over twelve hours in one shift, one staff member who was not taking breaks felt that "it's not safe" to stop working.

On the second day of the inspection we had to intervene on several occasions and tell senior managers on site where we felt people were unsafe and asked them to address concerns raised. We saw that effective systems were not in place to monitor the quality of the service. For example we saw that one person was not getting their one to one care and told managers of this, three hours later they were still not getting it and was left alone so we asked for managers to step in to ensure safe care. We also had to ask senior managers and the manager to support staff during the evening meal as there were not enough staff to support at mealtimes and people had to wait to be fed. We had to ask the deputy manager to go and support people who had been left unattended in the lounge. We had to tell the manager to provide the staffing required for peoples' safety and to check the competency of new agency nurses before they started working to ensure they had the skills to be able to provide the treatment people needed.

The manager told us that all feedback was welcome as they wanted everything in the open. Relatives told us about a "culture of intimidation" in respect of how the management team and the provider treated relatives. We found that the manager and provider had not acted on the feedback of relatives who were very involved in caring for and supporting their family members and were not following their own policy on handling of complaints.

We found that auditing of records, including records of infection control checks, were not completed regularly and effectively. A medication audit that had been completed by the manager failed to identify concerns found on the day of our inspection such as emergency epilepsy medicines not being taken out with people and an inhaler not being given to a person as prescribed. Managers from the provider attended the service to assess compliance and had written a report with suggestions and actions but had not followed up to check that these were being done. These were matters that put people at risk of serious harm and were not recognised by the managers or provider as such in a timely manner despite their monitoring of the service.

A file in the clinical room contained a 'Staff weekly responsibilities' document. It had not been filled out since the first week of September for the majority of tasks, including tasks for care staff. The clinical room was locked and the keys kept by the nurse so care staff would not have easy access to this document. These tasks included wheelchair audits, menus and activity arrangements. A similar monthly record documented that some audits had not taken place as planned. For example, monthly audits of care plans and infection control had not occurred for six months, kitchen checks for five months, and that slings had not been audited between March and September. Systems of reminding nurses to complete essential tasks were not always completed. Whilst the night nurse checklist that focussed predominantly on cleaning was up-to-date, the day nurse checklist for October had several gaps. It reminded for checks of medicines, hoists and slings, bedrooms, body charts and the cleaning of medical equipment. We spoke with a senior manager who said that they had recognised that there were gaps in essential audits and record keeping such as bowel charts, weight records, and epilepsy records and the reason for the gaps was "management oversight of the nurses and daily checks" and a plan had been put in place for additional support to be brought into the service.

Inadequate

Is the service well-led?

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

Services that provide health and social care to people are required to inform the CQC of important events that happen in the home. The registered provider had not always informed us of significant events that they were required to. For example an incident where a person was taken to hospital because of a head injury was not notified to us and an allegation of abuse was also not notified to us. This did not demonstrate an open culture by the provider.

These issues were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.