Purelake (Greenford) Limited

Greenford Care Home

Inspection report

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20 September 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 18 and 20 September 2018.

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

Greenford Care Home provides personal care, accommodation, and support for up to 18 people with a variety of complex needs including, physical health needs, mobility difficulties and people living with dementia. The accommodation is set over two floors with communal space and a patio area to the rear. There were 18 people living at the service at the time of the inspection.

At our last inspection in October 2016, the service was rated Good. However, at this inspection we found that standards had not been maintained.

There was a registered manger employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
People were not kept safe from abuse or avoidable harm. Not all staff had received safeguarding training and staff were unclear about how to report concerns so that when people were at risk of harm they did not always receive appropriate medical attention. Risks to people were not assessed or their safety appropriately checked.

Risk assessments for choking, falls, mobility and skin integrity were not in place despite risks being known. Environmental risks had not been managed safely and there was insufficient protection in place in the event of an emergency such as a fire.

There were not enough staff to meet people's needs and the provider had not used a recognised dependency tool to determine safe staffing levels.

Staff were not recruited using safe and robust recruitment processes including statutory checks, to assess the candidate's suitability for the job.

The provider had not followed best practice relating to nationally recognised guidance. Medication records in care plans did not consistently match medicine administration records (MAR) and when people were prescribed medicines to have 'as and when needed' there was no guidance for staff to explain what the medication was for, how staff would know when the person needed it and how many doses could be given in a 24-hour period.

The service was not hygienic and there was a risk from infection from mattresses that were stained with urine and faecal matter.

Incidents and accidents were not analysed or reviewed by the manager and risk assessments had not been updated. Staff did not reflect and learn from accidents and incidents and there was a lack of reporting to the local authority or the Care Quality Commission (CQC).

People had not received assessments of their needs and care planning did not refer to best practice or evidence-based guidance to ensure effective outcomes were achieved. Staff had not received effective training, supervision, or appraisal to carry out their roles. Training in key areas such as end-of-life care or dementia care was insufficient and the registered manager had not assessed staff to ensure that they had the necessary skills and competencies to support people.

People had not received the right support with eating and drinking. There were no identifiable dietary considerations given to people with food intolerances or allergies and no dietary support or guidance for people living with diabetes. Support given to people at meal times was inadequate to ensure that they were eating or drinking enough to stay in good health.

The service had failed to work with key stakeholders such as speech and language therapy, occupational and physiotherapy therapy, and the local GP surgeries, to ensure people received appropriate medical guidance to support them to eat and drink safely. People's healthcare needs were not always met. Staff did not always recognise or respond promptly when people were unwell.

The premises were hazardous in places and were not suitable to meet people's needs. The stair gates were difficult to open and presented a hazard in an emergency, some rooms lacked the space to carry out effective moving and positioning, and the bathrooms had not been adapted to meet people's needs and little consideration had been given to the needs of people living with dementia.

People had not been supported to have maximum choice and control of their lives. The registered manager and staff did not understand the principles the Mental Capacity Act 2005 and the policies and systems in the service did not support people to find the least restrictive options. Restrictions had been assessed incorrectly and DoLS applications had been submitted lawful but the registered manager had made applications for each person without considering their individual needs appropriately.

Staff treated people with kindness. They recognised some people's needs well and some caring interactions were seen. People and their relatives were consulted around their care and support but people's dignity and privacy was not always respected or upheld.

The service was not meeting the accessible information standard (AIS) and some people's care plan documentation was not written in a way they could understand. There was no evidence to show that people were actively involved in reviewing their care plans or provision for people with dementia or visual impairment. Complaints were not responded to effectively. The complaints policy was out of date and there was no information about how to make a complaint available in an accessible format to meet the needs of people living with dementia.

Activities were limited and had not been planned. People sat in chairs for large parts of the day with little stimulation. There was a limited range of activities including board games, walks to the park and manicures.

People were not sufficiently supported at the end of their lives. The registered manager had limited

knowledge of the required standard for end of life care and was unclear about how to access the right training to support people to receive a pain-free and dignified death.

The registered manager and registered provider failed to ensure that staff shared a clear vision for providing high quality person-centred care. The culture of the service was not empowering for people, relatives, or staff.

The service was not well led. Governance systems were ineffective, policies and procedures were out of date and service audits were not analysed to give oversight of the service or followed up to ensure that improvements were made. Staff had not been supported or their skills and knowledge developed and little work has been done to encourage learning and best practice from working in partnership with other professionals and health care providers. Values were unclear and behaviours of some staff had not been addressed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not Safe.

People were not protected from the potential risk of harm through comprehensive risk assessment.

People were not protected from abuse or avoidable harm. Action had not been taken to mitigate risks to people.

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

Staff had not been selected using thorough recruitment processes.

Medicines had not been managed in a safe way.

Risks from infection were not consistently managed and hygiene was poor.

Lessons had not been learned and changes made in a timely manner when things went wrong.

Is the service effective?

Inadequate

The service was not Effective.

Pre-admission assessments were not comprehensive and evidence based guidance had not been used to support people.

Significant risks around eating and drinking were not safely managed.

People did not have sufficient access to health care to meet their needs and were not supported to live healthier lives.

Staff training and knowledge was poor and staff did not receive appropriate support from supervision and appraisal.

The provider did not have sufficient knowledge of the Mental

Capacity Act (2005).

Is the service caring?

Inadequate

The service was not Caring.

Staff did not sufficiently protect people's privacy and dignity.

People were not involved in making decisions about their care.

People told us that staff were kind, caring and respectful.

Is the service responsive?

Inadequate

The service was not Responsive.

People's care plans did not consistently reflect their care needs.

Care planning around the end of people's lives was insufficient to meet their needs.

People's activities were limited and had not been planned.

People were not encouraged or enabled to raise any concerns or complaints to the service and concerns were not acted upon.

Is the service well-led?

Inadequate

The service was not Well-Led.

The registered manager was not supported and lacked the experience to carry out the role.

There was no clear vision for high quality person-centred care.

The registered manager and the provider had not taken steps to address high risk.

The provider did not seek feedback from people, relatives, or professionals so that they could understand how to develop the service.

The provider had not effectively implemented or embedded quality assurance systems or to improve the quality of the service people received.

The provider was responsive and sent an action plan immediately after the inspection.	

Greenford Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 20 September 2018 and was unannounced. One inspector and an inspection manager carried out the inspection. We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the previous inspection report from October 2016 and any notifications received by the Care Quality Commission. A notification contains information about important events, which the provider is required to tell us about by law.

We spoke with the provider, the registered manager, the deputy manager, three members of care staff, the activities co-ordinator and two domestic staff. We looked at five people's support plans and the associated risk assessments and guidance. We also looked at a range of other records including three staff supervision records, five staff recruitment files, five staff induction records, the training schedule, one month's staff rotas and eight quality audits.

During our inspection we spent time with people using the service and observed how they were supported and the activities they were involved in. We spoke with six people, one relative and one visiting professional. Some people were unable to tell us about their experiences of care so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection visit we asked the registered provider to send additional information, including the staff training matrix, the staffing rota, four additional care plans and the most recent pharmacy medicines audit. The information we requested was provided to us in a timely manner. We also spoke to three relatives and

two professionals.

Inadequate

Is the service safe?

Our findings

People and staff told us they had concerns about safety. Staff told us there was a lack of guidance in place to provide the right support people in mitigating risks such as falls and choking, and because of this people had experienced harm. "One person told us "If I didn't feel safe I would not know what to do."

The provider and registered manager had not ensured that risks to people were assessed, known and mitigated. A number of people with complex needs and associated risks did not have any risk assessments in place, including guidance for staff to follow to help mitigate the risk. Where people did have risk assessments in place, they did not contain sufficient detail about the risk, or any guidance on how what steps to take to mitigate it.

One person was at high risk of choking and had been observed by staff to have difficulties swallowing food and gagging at mealtimes. Staff told us they had witnessed these difficulties since the person began to live at the service earlier in the year. The registered manager confirmed that this was the case, and this person experienced difficulties with eating at every meal time. Despite this, they had not been referred to a specialist team (speech and language therapy (SaLT) or been referred to their general practitioner. There was no risk assessment in place regarding choking. A nutritional risk assessment dated 12 September 2018 stated: 'no risks identified, normal chewing and swallowing. Needs help to cut food up'. During our inspection we observed this person getting into increasing difficulties eating their lunch. They had been sick and proceeded to choke and gag. Staff, including the registered manager supported the person regarding the sickness, but provided no support while they were choking and gagging: they left the person alone with a bowl. We intervened and asked them to call an ambulance as the person was choking. First aid was given to the person until the ambulance arrived. They were treated by the paramedics and an urgent appointment made to the SaLT team. A choking risk assessment was put in place the same day.

Risks assessments did not adequately describe the risk to the individual or have any guidance in place to mitigate the risks. We found examples of unwitnessed falls where risks to individual's mobility had not been correctly assessed or updated following falls. For example, one person was identified as being at high risk of falls. Despite this, there was no information in the risk assessment about why this risk was present, or how to support the individual in a way in which the risk was reduced and mitigated. This person had experienced falls: their risk assessment had not been updated following these falls and there was no guidance in place to ensure they were given the support they needed to mobilise safely.

Another person had fallen at night and suffered red knees, red marks on their nose and a sore back. The actions recorded by staff included completing a body map and taking the person to their room and laying them on the bed. There was no record of follow-up action or consultation with the out-of-hours GP service. Their risk assessments had not identified the risks of falls and had not been updated following this fall.

The provider and registered manager had not ensured that lessons were learnt when things went wrong. We reviewed the records from incidents and accidents and found that there had been a lack of investigation, analysis, follow up action including changes to people's risk assessments and care plans or debriefing for

the staff team to learn from the incidents. The deputy manager told us that senior staff used daily handovers to pass on the details of any concerns that has arisen during the shift and any staff 'mistakes' were pointed out to the staff member at the time. However, this did not ensure a consistent approach to providing safe care to people was in place.

Health and safety checks for example, fire extinguishers, gas safety and electrical testing had been carried out. However, we found that in other areas, the provider had failed to mitigate environmental risk. In the downstairs bathroom we found a manual bath hoist used to lift people into the bath, with dirty and worn harness straps and a safety grab rail missing from the downstairs bath. In one of the bedrooms we found exposed hot water pipes putting people at risk of burn injuries. In another bedroom the headboard was broken and in another room, an extension cable pinned to a vanity unit near a water source. The main staircase was restricted by a double-locked stair gate that was hard to open making it difficult for people or staff to use the stairs in the event of a fire. The upstairs fire door was very hard to open and the alarm sensor was broken and had been switched off. This put people and staff at risk in the event an emergency. We discussed this with the registered manager and they were unaware of the issues. They told us that they had recently had a fire safety inspection that had not highlighted the areas of concern.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing levels were insufficient to meet people's needs and ensure their safety. People had varying and complex conditions such as dementia and diabetes. People needed support with all aspects of their care, including their personal care and mobility. Most people needed extra support with eating and drinking and around eight people needed two staff to support them individually at mealtimes and with their personal care and mobility. Staff, people and relatives told us there were not enough staff. On the first day of our inspection there were two care staff on duty to meet the needs of 18 people. The activities coordinator supported the staff on duty. We were told this happened most days, and activities did not take place due to insufficient staffing. We observed people asking for drinks and requesting help with their personal care and having to wait up to 30 minutes for this support to arrive. One person told us they had been asking since 8am for support to get out of bed. They were not supported to do this until 11:30am. Staff told us they had to 'cut corners' because 'there is never enough staff on', and gave examples of not using a hoist to move people safely 'because it takes too long and needs two staff', and instead pulled people into wheelchairs by their arms to assist them to the bathroom. We were told about two people who were cared for in bed. When we asked why this was for one person, the registered manager told us 'it's because we have left her for so long it hurts her when we get her up now'. We asked the provider to take immediate action regarding staffing levels: these were increased to four care staff on the second day of our inspection. The registered manager told us that staffing levels had not been determined in relation to meeting people's assessed needs. They told us 'it has always been three on duty'. We asked the provider and registered manager to urgently assess people's support needs in order to determine staffing levels which would safely and consistently meet people's needs. On the second day of our inspection the registered manager had completed an assessment: they had assessed people with complex health and mobility needs as being low dependency. The staffing levels they had assessed bore no resemblance to the needs of the people living at the service.

The failure to ensure sufficient staffing is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Recruitment processes were not sufficiently robust to ensure suitable staff were employed to work with people. Disclosure and Barring Service (DBS) and identity checks had been made and documented. DBS

helps employers make safer recruitment decisions. Completed application forms from staff were on all files. However, although references had been sought there were no references on file for two staff, and only one reference on file for a further two staff. For another staff member, they also had only one reference: this reference was not positive, yet there was no evidence of follow up from the provider or registered manager, and no indication that for any file the provider or registered manager had sought to obtain two references prior to an offer of employment or subsequent to the offer being made. The provider and registered manager had not satisfied themselves that staff were suitable to work with people. The registered manager told us: "I looked at the recruitment files a while ago. I noticed they weren't up to date".

The failure to operate a robust recruitment process is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, with the exception of 'as needed' (PRN medicines), were safely managed. Medicines were stored securely and kept locked in a medicines cabinet. There was a named member of staff responsible for the management of medicines in the service: they had good systems in place for the ordering and disposal of medicines. People had medicine administration records in place (MAR). They were signed to show that medicines had been taken as prescribed. All staff had received training in medicine administration. Some people had PRN medicines. There were no protocols in place which clearly described what the medication was for, how staff would know when the person needed it and how many doses could be given in a 24-hour period. This is important to ensure people are supported to take their medicine safely when they need to do so.

The failure to ensure guidelines were in place for the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not kept safe from abuse by systems, processes, or practices. The registered manager and staff did not understand or know their responsibilities to respond to and report concerns. Staff had not received training in safeguarding people, and when we spoke with staff they were not aware that practices at the service were unsafe, and could constitute abuse. The service did not have policies and procedures in place for staff to refer to. The registered manager was unaware of the local authorities safeguarding policies and how to report safeguarding concerns and when we asked how they would respond to signs of neglect they replied, "Possibly telephone the Care Quality Commission (CQC) or the police." The registered manager had not fulfilled their responsibility to raise concerns and near misses and report them to the Care Quality Commission (CQC) and local authority. Two unwitnessed falls and an assault had not been reported. The failure to report potential abuse places people at risk of further harm as the local authority were unaware of the need to investigate concerns and put action plans in place to ensure people were protected from harm.

Failure to operate a robust safeguarding process is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a daily programme of cleaning that was carried out by housekeeping staff. They were aware of their responsibilities regarding infection control, and used correct equipment such as gloves and aprons. People's rooms were kept clean. However, people were at risk of infection as a number of areas in the service were not hygienic: we found commodes in people's bedrooms that had not been emptied leaving strong odours. There were several mattresses stained with urine and faecal matter. There was no toilet seat on the upstairs toilet and no taps on the sink. During lunch, we observed the registered manager assisting people with their lunch: they also had recently (prior) supported a person with their personal care. On both of these occasions they did not wear an apron to protect people from cross contamination and infection. Following the inspection all mattresses were disposed of and replaced.

The failure to have robust infection control systems in place is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We checked four care plans and found that people had personal evacuation plans (PEEP). A PEEP sets out people's physical and communication needs to help staff ensure safe evacuation in the event of an emergency. Staff told us about the fire drills that had taken place and were aware of marshalling points and the evacuation procedure in the event of an emergency.

Inadequate

Is the service effective?

Our findings

When people moved to the service their support needs had not been adequately assessed. Assessments undertaken did not describe the support people needed with their health, and there was no guidance in place to ensure people received care which was effective and safe. One person had recently moved to the service. They had complex needs which included risk of falls, poor vision and difficulty with swallowing. Their assessment did not identify or address these risks, and no care plan or risk assessment had been put in place to ensure they received care and treatment to meet their needs. On the day of our inspection this person choked on their lunch and they received treatment from the emergency services. Neither the registered manager or the staff felt if was necessary to call an ambulance. We intervened and ensured an ambulance was called.

We spoke with staff about their response to the incident, Staff told us that the person had difficulties in swallowing at every mealtime, and that this was 'normal'. None of the staff we spoke with recognised that the person was struggling to breath and needed urgent medical help. The registered manager was reluctant to call an ambulance. They told us it wasn't needed, and despite us asking them to call an ambulance they did not do so immediately and we had to intervene twice for this to happen. The registered manager was unable to tell us why they had not referred this person to a speech and language therapist (SaLT) or seen a GP in relation to their known difficulties with swallowing. An urgent referral to SaLT was made by the ambulance service, and a choking risk assessment was put in place.

People's healthcare needs were not monitored or met: one person was living with epilepsy. Their care plan contained no details about how their epilepsy presented, or how it impacted on their life. There was no guidance for staff to enable them to recognise the potential triggers, or any guidance about what action to take should the person have a seizure.

A number of people were living with diabetes: there were no care plans in place to describe how their condition impacted on their lives, including their health. No special diets had been considered for people living with diabetes, no health checks had been sought with healthcare professionals, and staff we spoke with (including the cook) were unaware of who needed a special diet. The registered manager told us they had made provision for people living with diabetes as they offered people plain biscuits.

When people were unwell, they could not be assured that they would receive appropriate support. Healthcare professionals we spoke with told us they rarely heard from the service. They had not been contacted when people were unwell, or when people needed specialist assessments, for example regarding mobility or experiencing swallowing difficulties. People did not receive effective care and treatment with their mobility. When people had been identified as needing to use a hoist, this was not done. Many people were left either in their chairs or in bed if they were unable to mobilise independently. One person's mobility had deteriorated to the point where they were almost permanently in bed. The person's care plan detailed a gradual decline in mobility since spring 2017. As the person's mobility had decreased, the service had not sought professional advice about the person's ongoing healthcare needs and we found no evidence of information, explanation or medical treatment options that had been considered or discussed with the

person over the 15-month period. The service had not referred the person to a physiotherapist to help maintain their movement or strengthen in their limbs and the person was now so stiff that they became agitated and were in a lot of pain whenever staff tried to get them up. The person's care plan contained risk monitoring for pressure sores and urinary tract infections, but the information was from 2016 and the guidance had not been appropriately updated to reflect the person's changing support needs.

The failure to assess and meet people's health needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People could not be assured they would receive enough to eat and drink. Some people required one to one staff support to assist them to eat and drink. We observed lunch on the first day of our inspection. The dining experience for people was chaotic and undignified. People who needed help to eat did not receive it: meals were put in front of people and no support was given: several people's meals went cold and congealed on the plate. Many people who needed assistance fell asleep, or tried to eat their meal with their hands. At times a staff member would stand in front of a person and put a spoon of food in their mouth, and then leave. We became concerned at the lack of support people were receiving and spoke with the registered manager. They said they would support people, but halfway through supporting one person they walked off to answer the phone and did not return. People's meals were removed from them uneaten. We asked staff to bring lunch to people where this was the case which they did. Staff told us that every mealtime was like this: they said there was no time to give people individual support, and although they tried to ensure people had enough to eat, this was not always possible because of lack of staff.

Some people had been assessed as at risk of malnutrition or dehydration. Charts were in place to record what people ate and drank. However, none of the charts were completed, and there was no measurable way of demonstrating how much people were drinking or eating. We discussed this with staff and with the registered manager and asked them how they would recognise if people were malnourished or dehydrated: they told us they didn't know, and were not aware that the charts needed to be completed, or that urgent referrals to health professionals should be made for people who were not receiving enough to eat and drink.

The failure to ensure people's nutrition and hydration needs were met is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff, including the registered manager had not received sufficient training to support people effectively or carry out their roles. One staff told us that they had received no mandatory training apart from moving and handling and no induction, they had just been told to read policies. Another staff confirmed that 'training' involved reading through a series of booklets. We noted that the staff member had several incomplete booklets in their file.

We asked the registered manager how they monitored staff training. They told us that they did not assess the staff's knowledge but sent the completed knowledge papers to the training provider when they had been completed. There was no direct training input from a recognised training provider such as Skills for Care. The role of Skills for Care is to ensure that the adult social care workforce has the skills and qualifications to deliver high quality social care. The registered manager was unaware of the training that could be accessed through the local authority and the local hospice in key areas such as end of life care or dementia care. As well as not receiving training, staff had not received support from the registered manager: staff did not have regular supervision (this is a one to one meeting where work issues are discussed, including identifying areas of development and training). The registered manager had not assessed staff through regular supervision or appraisal to ensure that they had the necessary skills and competencies to

carry out their roles.

Failure to provide appropriate support, training and professional development is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had completed food hygiene training, the kitchen was clean and appropriate food preparation guidance was in place. The service had received a five-star rating from the environmental health officer on 4 May 2018.

People's consent was not consistently sought in line with legislation. We looked at people's care plans who lacked the mental capacity to make their own decisions. Some people had representatives with lasting power of attorney to support them to make decisions in their best interests. We also asked the registered manager to tell us about how people's consent was obtained when they lacked the mental capacity to make their own decisions and did not have a representative. The registered manager showed us examples of two best interest's assessments they had completed. Both had been applied to a wide range of decisions such as, "unable to manage any of their daily living or personal care needs" rather than to specific decisions as the Mental Capacity Act 2005 (MCA) requires.

We also asked the deputy manager to tell us how staff obtained people's consent when they lacked the capacity to make their own decisions. The deputy manager told us that they did not know what we meant, whilst other staff told us that they had not had any training in this area. We also spoke to a relative who was concerned about pre-assessment processes and questioned why the person was living at the service. There was no evidence of independent advocacy to support people with their decisions and staff were unclear about the need to make every effort to gain people's consent which left them at risk of being unable to take part in decisions about their day to day care.

The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that they had submitted DoLS applications for everybody in the service because of the use of key-coded doors to prevent people from leaving the premises without supervision. They had not yet been authorised and the registered manager had followed up the applications with the local authorities concerned.

The failure to put in to practice the requirements of the MCA is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service did not offer facilities that met people's needs. There was one bathroom in use at the service. The registered manager told us that the service was waiting on a quote for a new bathroom. We reminded the registered manager that this had been noted at the last inspection in 2016 but not actioned. We noticed that whilst some people's bedrooms had been personalised with memento's, small items of furniture and photographs, many rooms lacked the space to ensure that the correct techniques and equipment could be

used to support people who required moving and positioning. There were also a number of walking frames and wheelchairs with no room to store them when not in use. They presented a trip hazard, especially for people that had been identified as being at high risk of falls.

The service did not provide a dementia-friendly environment in line with best practice guidance. For example, instead of minimising distractions whilst people were eating so that they could concentrate and focus on their food, the staff played loud pop music during lunch. There was also no consideration about the use of adaptive technology to help people maintain a sense of their environment such as light sensors to make sure lights came on when natural light was reduced. There was no clear signage on cupboards, drawers and taps to help people navigate their way safely around the service. The garden area at the service was bland and covered in cigarette butts and there had been no effort made to landscape it or make it a suitable outdoor space for people living with dementia by offering sensory stimulation from plants and shrubs.

Failure to ensure that the premises remain suitable for the purposes they are being used is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People told us they were treated with kindness and we saw some positive interactions between staff and the people they were supporting. One person told us, "I have no complaints about the place, they are nice people, they look after me and help me if they can. The staff here are lovely." Another person told us that the home was fantastic and the care was "very good". One relative told us that the staff, "Go above and beyond" and another praised specific staff members who had looked after their mother "very well."

Despite these positive comments, we found that people were not always treated with dignity: During the inspection we found two people sharing a room with no partition between them to provide essential privacy for washing and personal care. Two commode chairs had been placed side by side in the room so that people were denied basic privacy when using the toilet.

People's care records showed that the frequency of bathing or hair washing was between five and eight weeks. We asked the registered manager about this who told us that it was a recording error, but they were not sure if people had baths as they hadn't checked. Staff told us they were not able to support people frequently with bathing as there was not enough staff and 'it takes too long'. Another person had a condition that required dressings to their legs. We noticed that the bandaging was stained and dirty, we spoke to the registered manager who was not aware of this but confirmed that they would ask the district nurses to attend to change the dressings.

We observed the interaction between people and the staff during lunch. We noticed that six people who required assistance, were given their meals but not supported. One person was left scooping their meal up with their hands because they could not use a knife or fork. Staff supported them to eat the meal after about 10 minutes once they had attended to other people in the room. Staff were observed standing over people spooning food into people's mouths. In some cases, there was no eye contact and little discussion. One staff member walked away several times to answer the telephone and two people fell asleep with their meals left in front of them to go cold. We looked further at the care plans and noted that people had not been consulted about how they wanted to receive their care: Examples included, "staff to shave [person]", "staff to ensure [person] has clean clothes daily and "guide [the person] when dressing." People were not encouraged to be independent or to participate in small tasks with staff support. For example, one person loved to read a daily newspaper but when the staff went to collect the daily papers they did not set aside the time in the rota to involve the person in coming with them to the newsagent or in helping to distribute the papers to the people who had requested them. Another person told us, "What bugs me is that I don't have the independence as I did in the community. I miss not being able to jump on a bus and go into town. Staff do not support me to do this."

People's confidentiality had not been respected. A number of people's confidential records had been left on top of a filing cabinet outside the locked staff office. A daily report book contained confidential information from 26 June 2018 about several people's urine samples and specifically named a person with an 'open sore on the bottom'.

The failure to ensure people's privacy and treat people with dignity is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people and their relatives had been given opportunity to contribute to the care the person received. We spoke to one relative who told us, "Yes mum can make her own decisions." We also spoke to the person who confirmed that they had been consulted by staff about having new reading glasses following an eye test. The options had been discussed but the person had decided against the idea.

There was no information at the service for people or their relatives in an accessible information format. The service was not meeting the accessible information standard (AIS). The AIS is a standard that was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for adult social care services to comply with AIS. There was no information in large print or braille and no information in a dementia friendly format. The registered manager and staff team were unaware of additional sources of information that could support people and their relatives such as admiral nursing, independent advocacy, skills for care and the social care institute for excellence. This is an area for improvement.

Inadequate

Is the service responsive?

Our findings

People's care was not planned responsively or care plans personalised to reflect their individual needs. Care plans did not include details of people's support needs, and when people's needs changed, care plans had not been updated to reflect this. Care plans combined a standardised set of support plans covering a range of needs such as, "communicating", "breathing", "eliminating" and "mobilising". Each support plan focused on an aspect of the person's care. Under "eating and drinking" one plan stated, "Family buy [person] quite a few treats which does comfort [person]. They are in a bag and [person] just likes to go through the bag." The assessed need was then supported by the guidelines that stated, "Staff to monitor the intake especially of sweet food." The person was diabetic, had issues with swallowing plus impairments to their sight and hearing. All of these factors could have affected their experience of eating and enjoying food. However, none of the issues were addressed in the care plan at any depth and there were no details of how the staff had involved the person in helping to personalise these aspects of their daily support.

Another care plan contained a brief life history, but again, it lacked detailed information about the person aside from their medical conditions. Most people at the service lived with dementia but care plans provided little personalisation to assist staff to understand how each person was affected by the differing stages of the condition so that care planning could reflect each individual's changing needs.

People sat in chairs for large parts of the day with little stimulation. Some enjoyed a limited range of activities including board games, walks to the park and manicures. Relatives also visited the service and praised staff for their friendliness and warm welcome. However, activities lacked daily coordination. One relative commented, "I think people could be more stimulated." We asked the registered manager why there was no clear activities plan for people and they told us, "We used to have a planner on the wall but the frame broke and we didn't replace it." We could also see from the rotas that the activities coordinator was mostly on shift undertaking a carer role due to insufficient staffing.

We spoke to the activities coordinator who knew people well. They provided information about different people's life histories for example, one person had been a nurse and the co-ordinator had supported the person to spend time with relatives using a photo album with pictures from the person's life and career to make connections with their past. The activities co-ordinator also used another person's family connection to an apple farm to help them to reminisce over lunch whilst they ate apple crumble for dessert. However, none of this information had been used to inform the care plans and develop person centred care around people's preferences and interests.

People were not supported effectively by the service to have a dignified, pain-free death. We asked the registered manager to tell us about the support people received at the end-of-their lives. They told us that staff had not received training in end of life care and that they had not liaised with the end of life facilitator at the local hospice to access additional professional support. We looked at one person's care plan who had been placed on palliative care by their GP. The support plan around pain management and dying advised staff to "call district nurses if [person's] condition changes and [person] needs to have anticipatory medication" and "staff to monitor and if there are any changes in [person's] health, to ensure a doctor is

called." There was no information about what changes staff were to look for, or details about the anticipatory medication and how it might support the person to manage their pain, especially when their care plan stated, "[person] is unable to communicate their needs." There were no guidelines to support staff should the person begin to deteriorate rapidly and no indications about what a dignified death might mean to the person or details of any social, cultural, or religious considerations that staff might need to be aware of.

Failure to carry out appropriate assessment of people's needs or provide person-centred care is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's complaints and concerns were not responded to effectively. The complaints procedure was out of date and not accessible for people living with dementia. We discussed this with the registered manager and they agreed that it was out of date and unsuitable. We asked the registered manager why they had not updated the policy and procedure and they said, "I don't know". The registered manager told us that no complaints had been received. We asked a staff member about this and they told us, "Although we report [concerns] nothing ever changes." We also spoke to a relative who told us, "Mum had an upset stomach and for two weeks the home ignored my concerns…mum ended up in hospital with gastroenteritis." We asked the relative whether they would know how to make a complaint and they replied, "No, I would not know how to make a complaint, there is no literature."

The failure to effectively operate a complaints system is a breach of Regulation 16of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People had been supported to express their spiritual beliefs: cultural and religious holidays such as Christmas and Easter were celebrated.

Inadequate

Is the service well-led?

Our findings

The service was not well led and did not have a clear vision or strategy to ensure people received care and support that was safe and met their needs. The registered manager defined the culture as "to make sure people lead a happy life." However, they were unable to tell us how they ensured this happened in practice. Staff described the registered manager's leadership as weak and ineffective. One member of staff told us: "I am not confident raising concerns as the registered manager doesn't do anything."

The service had not worked effectively in partnership with other multidisciplinary agencies to achieve positive outcomes for people. The registered manager told us that the local GP surgeries "did not seem to care", "did not always listen to people's needs" and "did not send out people's medication on time". We asked the registered manager whether they had liaised with the local surgeries to ensure that information could be shared and care and support managed effectively across organisations. The registered manager had not spoken to the local practice managers or tried to find a proactive way to improve the service's professional relationship with other providers.

The lack of planning and co-ordination with other professionals had left people at risk. One person had moved to the service with a history of epilepsy. There was no evidence of co-ordination with other specialist services to provide epilepsy support guidelines for staff, apart from a note in the person's care plan to contact the GP surgery if staff felt the medication was not meeting the person's needs. Staff were not epilepsy trained and so were not qualified to make an assessment without co-ordinated support from other professionals.

Referrals had not been made in a timely manner even following serious falls. Following the inspection, we asked for a copy of the person's care plan who had required medical assistance during our inspection. The person's daily notes stated that issues relating to their swallowing difficulties had first been identified 17 days beforehand and yet no referrals had been made prior to inspection. This had left the person at significant risk of harm and demonstrated the service's inability to provide 'joined up' care.

There had been a lack of oversight by both the provider and registered manager which meant that they had failed to pick up on the decline in standards of the care people experienced. Risks to the organisation were not understood or managed effectively. The service had not been monitored effectively by the registered manager or provider. We looked at service audits between January and June 2018 which reviewed areas such as care plans, health and safety, maintenance and cleaning. The results were compiled and sent to the provider as a "head office report" however, issues such as the smell of urine in certain rooms was repeatedly highlighted but nothing had been actioned. We asked the registered manager what was done with the results from the audits and they told us that an area manager checked them. We spoke to the area manager and they told us that they had met with the registered manager and provided them with action plans highlighting areas for improvement. We checked the records during the inspection but we were unable to find any of the action plans.

People and their relatives had not been involved in developing the service. A relative told us that the

provider did not seek feedback from families so that they could develop the service and make improvements. The registered manager had not been proactive in networking with other care home providers and was unaware that information about professional networks was available through the local authority. There was no business plan available to focus the service on areas for improvement in the coming year. Staff had not been empowered to develop new ways of working or to develop links with the local community.

Staff outlined a culture of bullying and intimidation within the staff team by the management team. They told us, "we feel victimised". There was a lack of effective supervision and appraisal at any level within the organisation. Staff were unclear about their responsibilities and the responsibilities of key staff in the service: The manager and deputy manager often worked as the cook. Cleaning staff undertook caring duties, the activities coordinator worked mostly as a care worker. This lack of clarity about responsibilities and accountability within the team was confusing for staff and lacked continuity for the people being supported. As a result, staff lacked motivation, staff turnover was high and the team was disjointed.

The failure to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively and consistent record keeping is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Since the inspection the provider has submitted an action plan telling us how they plan to address the issues raised during the inspection.

It is a legal requirement to display CQC ratings. This is because the public has a right to know how care services are performing. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. We checked the service at the start of the inspection but the rating was not on display.

The failure to display CQC ratings in the premises and on the services' website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The failure to assess and meet people's health needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Failure to carry out appropriate assessment of people's needs or provide person-centred care is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to ensure people's privacy and treat people with dignity is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to put in to practice the requirements of the MCA is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The failure to ensure guidelines were in place for the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The failure to have robust infection control systems in place is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The failure to ensure people's nutrition and hydration needs were met is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to operate a robust safeguarding process is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to ensure that the premises remain suitable for the purposes they are being used is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The failure to effectively operate a complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively and consistent record keeping is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to operate a robust recruitment process is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The failure to display CQC ratings in the premises and on the services' website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The failure to ensure sufficient staffing is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Failure to provide appropriate support, training and professional development is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.