Care Quality Commission

Veecare Ltd

Sevington Mill

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 10 and 11 November 2015 and was unannounced. Sevington Mill is a care home which provides care and support for up to 50 older people. There were 41 people living at the service at the time of our inspection, with four people in hospital. People cared for were all older people; some of whom were living with dementia. People were living with a range of care needs, including diabetes. Many people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more independent and needed less support from staff.

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

Sevington Mill was last inspected on 28 April 2015.They were rated as requires improvement at that inspection. We made Requirement Actions and asked the provider to submit an action plan to us to show how and when they intended to address them. We found that the provider

Summary of findings

had not met the Requirement Actions during this inspection. In addition we identified further areas where the provider was not meeting Regulations in the delivery of care to people living at Sevington Mill.

People's safety had been compromised in a number of ways. Medicines had not always been managed safely, assessments had not been consistently carried out to consider risks to people's health, safety and well-being and the premises had not been properly maintained. The service was not clean or hygienic and there was a risk that infection could be spread due to the lack of proper cleaning systems.

There were not enough staff on duty and rotas showed that there had been shortages on several shifts in the weeks before our inspection. People's needs were not being adequately met because of this. Not all staff knew how to recognise and protect people from abuse and we observed an incident where a person suffered harm during the inspection. This has been referred to the local authority safeguarding team for investigation. Staff recruitment checks had not consistently been made in line with the provider's own policy and our Regulation.

The service was not working within the principles of the Mental Capacity Act 2005 (MCA).Records about people's capacity were confused and sometimes contradictory. Consent had not always been sought from the proper person. Staff and the registered manager had a poor understanding of Deprivation of Liberty Safeguards (DoLS) and as a result people's right had not always been protected.

Some people were satisfied with the food on offer while others described it as "Tasteless". Food and fluid records had not been properly completed; leaving people exposed to risk. Dietician advice had not always been followed. Training was ineffective as staff were unable to describe how they put their learning into practice. Training had been delivered by the provider's family member and was in DVD format which staff said they found difficult to follow. Supervisions had increased but staff told us they did not feel supported by management.

Staff were not consistently thoughtful when delivering care and people's needs for meaningful social interaction had not been consistently met. There was no activities coordinator and day to day events were sparse. People complained of being bored and we observed little interaction between people.

The service was not well-led. Requirement Actions from the last inspection in April 2015 had not been met. Staff described a culture of fear and bullying, in which they were afraid to speak out. They said they did not all feel supported by the registered manager. Auditing had not been effective in identifying the shortfalls found during our inspection and no checks had been undertaken on maintenance jobs, which meant they went unaddressed for long periods and could have affected people's safety.

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.

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?

Inadequate

The service was not safe.

The systems for management of medicines were not always safe.

Risks had not been appropriately mitigated to ensure people's health and safety.

Appropriate standards of hygiene had not been maintained.

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

Is the service effective?

Inadequate

The service was not effective.

The service was not working within the principles of the Mental Capacity Act 2005 (MCA).

Applications to deprive people of their liberty had not been made appropriately.

Records of food and fluid intake were inadequate and exposed people to risk.

Staff training was ineffective in helping them to carry out their jobs.

Is the service caring?

Inadequate

The service was not always caring.

Staff were not always thoughtful when supporting people.

Peoples' dignity was not always considered.

People were not involved with their care planning.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs for social interaction were not consistently met.

Care planning was not person-centred or wholly accurate.

Complaints had not always been appropriately recorded and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

Staff described a culture of fear and bullying; where they were afraid to speak out.

Requirement Actions made following the last inspection in April 2015 had not been met.

People's views had not been sought about the service overall.

Audits had not always been effective in identifying shortfalls in the safety or quality of the service.

Sevington Mill

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 10 and 11 November 2015 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. The expert by experience had personal experience of caring for older people.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had also sent us an action plan following the last inspection.

We met and spoke with 15 people who lived at Sevington Mill and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with five people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with nine care workers, kitchen and domestic staff, seniors, the deputy and the registered manager.

We 'pathway tracked 'five of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

One person told us, "I don't always feel safe here you know; you can't get staff to come to you at night". Another person said, "Most of the staff are lovely but there are one or two that you just can't trust".

Medicines and creams were not safely managed. We observed two occasions when staff left medicines with people to take but did not check that they had swallowed them. One person told us they would take the tablets "When I get around to it" and another said "Can you give me some water [to take the tablets]?"This was not safe practice as staff could not be sure that medicines had been taken at the times they were given or at all. The registered manager and staff told us that no one was responsible for their own medicines and that these were all administered by staff.

We checked records about Controlled Drugs (CDs). These are medicines for which there is legislation about their possession, storage and administration. All administrations of CDs should be witnessed by a second staff member to ensure the safe and correct doses are given to people. The CD register showed that there was no record of a witness on at least five separate occasions. The balance of CDs had not always been recorded to show how many were left after each administration. These were unsafe practices which could lead to errors happening.

Medication administration records (MAR) had not been properly completed to detail why people had sometimes not had their medicines. One person's MAR showed that they had not had two of their prescribed medicines for 16 days in one case and 21 days in another. There was no record on the MAR to show why this had happened. This person had lost more than 17% of their bodyweight in previous months and the medicines they had been prescribed were to supplement their intake of important minerals. Staff told us that this person was "Really poorly and deteriorating". We spoke with the deputy manager about the medicines which had not been given to this person. They did not know the reason until they spoke to other staff. They told us that this person's medicines had run out and that they had placed an order for them the day before our inspection. However, this person had been placed at potential risk through the lack of supplies of two of their prescribed medicines.

Prescribed creams and eye drops were found in people's bedrooms, but there were no assessments in place to show that the risks of this had been considered. We asked the registered manager and deputy about this but they confirmed that this had not happened. Many of the people using the service were living with dementia and the deputy manager told us how one person had burnt their skin through self-applying too much of a pain-relieving cream. This had not prompted an assessment of the risks of leaving prescribed medicines and creams in bedrooms.

Topical cream application records created a confusing picture of which creams people had applied by staff. We spoke at length with the registered and deputy managers to try to gain an understanding of this, but we were unable to evidence from the records or from our conversations that people had had their creams as prescribed to them. For example; one person had two creams listed on the MAR but there was no creams application record in place at all. Another person had two named creams showing on the creams records with instructions for application, but only a third, unlisted cream was shown as having been applied in November. People were at risk of deterioration in the condition of their skin through the lack of appropriate systems for applying and recording creams.

We found four people's eye drops and two people's liquid laxatives had not been dated when they were initially opened. The instructions for the eye drops were they should be discarded after 3-4 weeks. However, as they had not been dated, it was not possible to tell when they were due to be thrown away. This created a risk that people might receive eye drops or liquid medicines after they had reached the proper disposal dates.

The unsafe storage, administration and recording of medicines administration is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not clean and hygienic. We heard that there had been an outbreak of diarrhoea and vomiting in the week before our inspection. The registered manager told us that the home had had a thorough deep-clean at the end of the outbreak; which was the day before we inspected. There was a strong odour of urine in several areas of the service and there was general debris on some carpets. Some surfaces in people's bedrooms were dusty and grimy and the seat risers in two communal toilets were heavily soiled around the fixings. Staff told us that these

Is the service safe?

toilets had been deep-cleaned the day before and cleaned again that morning. We showed the registered manager these toilets and she agreed they were not adequately clean. We asked staff about how the service had been cleaned following the bout of illness. Some staff said that surfaces had been wiped over with chlorinated water but one staff member told us" If I'm honest, I don't really know what a deep-clean is".

A commode pan and urinal bottle were on window sills in two toilets, which left them exposed to any germs there. Used latex gloves were seen in open waste bins in the lounge and dining area and there were no designated clean and dirty areas within the sluice room; which meant that clean equipment could be contaminated by dirty items stored there. A clinical waste bin in the laundry was full of soiled continence pads which were giving off an extremely offensive odour. Staff told us that this bin had not been emptied for several days and we noted that some pads had not been wrapped in individual bags before being placed into the larger bin. Dirty washing had been piled up in the laundry and was touching clean shirts hanging there. The registered manager explained that the laundry staff was away; but the laundry had been left in an unsanitary condition.

Cleaning staff only worked in the mornings and care staff told us that they sometimes had to complete cleaning duties in the afternoons and evenings. They said that there were often not enough cleaning supplies available and as a result, different coloured cloths designed for cleaning particular areas, were used for other surfaces. This created a risk of cross contamination between areas. The service had not appointed a staff member to act as lead on infection control issues and two relatives told us that they worried about hygiene standards. One relative said "It's no surprise they've had diarrhoea and sickness here several times-it's just not clean enough".

The kitchen had two doors opposite each other which created a 'Walk-through'. Although there were signs on these doors to state that only authorised persons should access the kitchen, they were propped open for much of the inspection and we observed staff using this route to pass from one area to another. There was a risk of transferring dirt or germs on clothing into a food preparation area. Records of temperature checks made on hot foods had generally been missed at weekends so the service could not be assured that meals served at those times was hot enough to kill bacteria.

The inappropriate standards of hygiene are a breach of Regulation 15 (1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff on duty to adequately meet people's needs. The building was divided up into five sections for staffing purposes, with staff allocated to work in each of those sections. These did not include lounges or dining areas. The registered manager told us that there were five care staff plus a senior and the deputy manager in the mornings and three care staff plus a senior and deputy in the afternoons. A further staff member covered the 4.30pm to 8pm 'Twilight' shift. However, on the first day of our inspection there were only two care staff plus the senior and deputy on duty between 2pm and 4.30pm. One person asked staff to take them back to their room for dinner. A staff member responded by saying "No, you're going to have your tea down here. There's only two of us for the whole building". Another staff member who was helping a person called to the second staff on duty and asked them to respond to a buzzer which had been ringing for many minutes. The second staff member replied "I can't, I've been told to stay here". The person's bell continued to ring and other call bells were going off continuously. Several people told us that they had difficulty gaining a response to call bells during the night. We observed that staff only just managed to stop a person from falling on several occasions, by running across the lounge to them. Staff told us that although each of them was assigned to one of the five areas of the service, there were no staff allocated to cover communal lounges.

Staff told us that there were often fewer staff on duty than shown on rotas. We checked these and staff signing-in records and saw that several shifts had been short-staffed in the weeks prior to our inspection. The registered manager told us that staffing levels had been worked out based on people's dependencies. This included numbers of people who needed help with eating and drinking and moving around the service, but did not take account of the high number of people who chose to spend much of the day in their bedroom. On both days of our inspection around 18 people out of 41 had their lunches in their rooms, for example. Although one extra staff had been

brought in for the night shift to support a person at very high risk of falling; there had been no increase in daytime staff to address that need. We observed staff struggling to prevent this person falling while trying to complete other tasks. Records showed that the staffing numbers determined by looking at people's dependencies had not always been met. Staff said that they did not have enough time to spend with people and that baths and weighing people for example, were sometimes missed due to lack of staff. One relative told us how their family member had not had a bath for three weeks.

The failure to ensure sufficient staffing is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been protected from abuse and improper treatment. Not all staff spoken with were able to describe types of abuse and how to recognise and report it. Some said they had received safeguarding training but this was DVD-based and did not help them to understand the issues very well. During the inspection we witnessed one staff member raising their voice and physically restraining a person. We reported this to the registered manager immediately and appropriate action was taken. We have referred this matter to the local authority safeguarding team. Some staff told us that they had witnessed similar behaviour by a colleague in the past. They said they had reported this to a senior or the registered manager but one staff member said there was "No point because nothing would happen". The registered manager said that she had not been made aware of any concerns.

This is a breach of Regulation 13 (1) (2) (4) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four staff recruitment files were checked and we found that in two cases, full employment histories had not been obtained or recorded. the provider's policy about recruitment states, 'Any apparent gaps in employment history will be discussed and recorded with the candidate'. There was no evidence that this had happened and the registered manager was unable to tell us what staff had been doing during these gaps.

The failure to properly operate a robust recruitment procedure is a breach of Regulation 19(3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessments about different risks to people had not always been made in order to minimise them. Some people had short-term care plans in place, even though they had been resident in the service for several months. These did not contain detailed assessments about the risks to people and how they would be managed. For example; one person's care file recorded only that their mobility and communication was "Bad". Another person had a continence assessment that stated they used continence pads; but there was no guidance about how often these should be checked or changed. We visited this person in their room and noted a strong odour of urine there. We spoke with the deputy manager about this and they told us that they were unaware that this person was using pads as they had not had a continence assessment. They told us they had "No idea" where this person had obtained the pads, but there were entries in staff notes about changing them.

Accidents and incidents had been documented and showed a high number of falls in the previous three months. There were 32 falls in September, 33 in October and 35 in November 2015. One person had a significant number of falls in each month and special equipment had been put in place to prevent further falls. However, the actions taken were not always effective. During the inspection we observed this person attempting to stand and walk on numerous occasions. They had fallen again since the introduction of special equipment. We read an accident report which recorded that staff reached them too late to prevent a further fall. There were no action plans in place for any of the other people who had several falls in any month. The registered manager told us that if there were any trends she would investigate further but that people had fallen due to 'Community-acquired pneumonia'. There was no record of this in the care files we reviewed.

The failure to adequately assess the risks to people's health and safety and appropriate actions to mitigate those risks is a breach of Regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The premises had not been properly maintained which left people exposed to unacceptable risk. A maintenance book recorded that three automatically-closing fire doors on people's bedrooms were not working on 23 October 2015. 'Emergency Fire' had been written alongside the entry but it had not been signed off as completed. The registered

Inadequate

Is the service safe?

manager told us these doors had been repaired but when we checked, we found that two were still propped open with a chair or door stop; meaning they could not close in the event of a fire. Staff told us that they had reported this issue on a number of occasions but that nothing had happened. The doors were repaired during the second day of our inspection but people had been placed at risk through inadequate maintenance.

One ground floor fire door led out onto an uneven and unlit pathway that was overgrown with weeds and covered in loose leaves. The leaves made the path slippery and it would have been dangerous to attempt to evacuate people via this route; especially at night. Another fire door was inside the sluice room. As a result the internal door to the sluice could not be locked and people would need to evacuate through an area containing contaminated equipment.

The registered manager told us that fire alarms were tested every Tuesday afternoon. However all of the staff we spoke with said that this had not happened since around April 2015. We have reported our concerns to Kent Fire Safety Team.

There was a flat on the upper floor of the service which was rented out by the provider. This was currently occupied by staff. The flat was only accessible by walking through the home and there was no external private entrance. This meant that any visitors to the flat would also need to walk through the home. As there was no way of supervising who was visiting the flat, this was a potential risk to people; particularly those with bedrooms on the floor below. No assessment had been made by the provider about any risk connected with access to the flat.

The lack of proper maintenance and suitability for purpose is a breach of Regulation 15 (1) (c) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had documentation to show that equipment such as hoists and the passenger lift had been regularly serviced.

Inadequate

Is the service effective?

Our findings

One person told us, "I can eat what I like at breakfast, so I make the most of it, because lunch and tea can be a bit uncertain". Another person said, "The food is not what I'd like or want; it doesn't make me happy".

At our inspection in April 2015, we found that people were not being protected from the risks of inadequate hydration. We made a Requirement Action and the provider sent us an action plan to tell us how they would address this. This stated that new fluid charts had been introduced, which would be added up at the end of each 24-hour period. At this inspection we saw that this had not happened. We checked food and fluid charts for six people and saw that fluid intake had not been totaled up each day. This meant that it was not immediately clear if people were not drinking enough and could be at risk because of this. Drinks were available during the day but one person had a glass of water which had been placed out of their reach. This person's care file recorded that they had recurrent urine infections; and it was important that they drank plenty.

Charts that recorded people's food intake contained insufficient detail to ensure that any problems would be highlighted. Following significant weight losses, one person's care file included dietician advice that they should have snacks between meals but charts did not show that any had been offered. The dietician had also prescribed a food supplement to be taken three times a day. However, records showed that this had only been offered once each day. The deputy manager told us that this person would not take any more than one supplement each day, but there was no evidence that any more had been offered or refused by them. This person had continued to lose weight but the service had not followed the dietician's instructions to contact them with any concerns.

Another person had seen the dietician and advice had been given about their food intake. However, this information had not been included in this person's care plan for nutrition or any updates to it. This meant that the dietician guidance could be overlooked, placing this person at continuing risk.

Some people said that meals were adequate but others were not satisfied. One person told us," When chicken is served they are just lumps of tasteless, chewy solid".

Another person said "Bacon is burnt" and a further person commented, "Salads are chewy or mushy-I look forward to going out for lunch, I wish I could go out more often". Menus were pinned to the notice board in plastic wallets and were headed 'Winter menu 2013'. It was not possible to read the menus without removing them from the wallets. They were four weekly menu cycles and it was difficult to work out which week was the current one. There were no pictorial menus in use to help people living with dementia to make their food choices.

The failure to ensure people's nutritional and hydration needs were met is a continued breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Information about people's mental capacity and their ability to make their own decisions was confused and sometimes contradictory. One person's care file had a completely blank mental capacity assessment, but a form giving consent to care had been signed by a relative. Another record stated that this person 'Is able to decide for themselves and make decisions when needed'. If the person was able to make their own decisions, then consent should not have been obtained from the relative. We found blank consent forms in two further people's care files. Another person had been assessed as having capacity to make their own decisions, but consent to medication had been signed by the registered manager on their behalf and consent to a flu vaccination had been signed by care staff. The service could not show that it had acted in accordance with people's wishes.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Inadequate

Is the service effective?

Staff told us about a person who had tried to leave the service alone on a number of occasions. We also read records about these incidents. Staff told us that this person did not have capacity to make their own decisions. However, the registered manager had not made a DoLS application to the supervisory body (the local authority) about this person. Nor were there any records of best interest meetings about preventing them from leaving the service. This meant that this person's liberty had been restricted.

The registered manager told us that there was a combination lock on the front door and that around two-thirds of people lacked capacity to make their own decisions. None of the people who lacked capacity had been told the combination code to allow them to leave and no DoLS applications had been made for any of them. This amounts to unauthorised deprivations of people's liberties.

The registered manager and staff showed a lack of understanding about restraint. During our inspection we observed a person who was at risk of falls being told that they could not leave their chair. One staff member said repeatedly "Stay sat down; you're not allowed to stand up". Another member of staff told them loudly, "You do not get up" and was observed to restrain this person in their chair by holding their arm. Consent had repeatedly been sought from a relative about this person's care but there was no MCA assessment to show this person lacked capacity to make their own decisions. There was no evidence of best interest meeting records to show that the least restrictive approach to supporting this person had been agreed. The service's policy about restraint was inadequate as it only described the use of restraint in relation to violent episodes and made no mention of MCA or DoLS. Staff did not know that there was a restraint policy in the service.

The failure to ensure appropriate consent is a breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff training records showed that some subjects had not been refreshed often enough to ensure that staff knowledge was up-to-date. For example; seven staff working in various roles, last had safeguarding training in 2011 and two others in 2008. Not all of those staff spoken with could properly describe how they would recognise abuse. Five staff had last had training about MCA and DoLS in 2013. There have been significant developments around deprivation of liberty since that time which would not have been covered in training delivered in 2013. A further three staff last had MCA/DoLS training from 2009 to 2012.Staff did not show a good understanding of DoLS and restraint when we spoke with them. While most staff had training in infection control, two senior care staff and a cook had not received updates within the three year timescales shown as necessary by the provider. There was a risk that some staff did not have the most current information about how to do their jobs effectively.

All of the staff we spoke with said that the training was ineffective and did not help them to carry out their roles. Not all staff could remember which training sessions they had attended or describe what they had learned. Staff told us that the majority of training was delivered by a relative of the provider and that sessions were DVD-based. They said that training in more than one subject was delivered one after the other; which they found difficult and "Too much to take in all at once". Staff told us that paperwork did not always correspond to the DVD shown which left them feeling "Confused". One practical training course about moving people safely had been held in a cloakroom which staff said had been restrictive and did not allow them to properly try out equipment. Staff were not confident that their training equipped them to carry out their roles properly.

The failure to ensure staff receive appropriate training is a breach of Regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection in April 2015 we found that staff were not receiving appropriate support through individual supervision and appraisal. The provider's action plan stated that all staff would now receive these on a regular basis. Staff told us they had received more supervision since the last inspection but some staff also said that they did not feel supported by senior staff or management. One staff member said, "We're not supported in any way, shape or form". Another staff member remarked, "The manager doesn't ever help us out and there's very little support from the senior or deputy. One of the seniors should come and help us on the floor when needed, but it depends which senior is on duty". Records of supervisions did not note any areas for improvement or identify any training needs; which meant they were ineffective in developing staff.

The failure to provide staff with appropriate support is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service effective?

The service had not been suitably adapted for people living with dementia. There was no appropriate signage throughout the home to help people orientate themselves around it. All bedroom and other doors were a similar style and colour which might also prevent people from locating their own room easily. There was no special equipment or activities provided for people with cognitive difficulties and staff told us there were no books or other prompts specifically for reminiscence. Some staff said that they had attended dementia awareness training, but were frustrated as the provider had not reacted to their requests following it to make suitable changes.

The lack of suitable adaptations to meet people's needs is a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People had access to GPs, opticians, chiropodists and dentists in order to maintain their health.GP visits had been documented and appointments with other health professionals listed. District nurse input had been sought for people who had skin wounds that required dressing and their visits and advice had been recorded and followed in the files reviewed.

Inadequate

Is the service caring?

Our findings

One person told us," Staff are very good and I have no problems" but another person said," Some of the staff are ok but there are others that you can't trust". A relative said, "Staff are wonderful".

At our last inspection in April 2015 we reported that people's clothes had not been managed in a dignified way. We made a Requirement Action for this. The provider's action plan stated that new laundry staff had been employed and that people would be helped to wear the correct clothing. At this inspection we found that this had not always happened.

Continence underwear and a variety of socks and tights/ stockings were in a chest of drawers on the first floor corridor. None of these items had been named. We asked staff about this and they confirmed that these were shared by people. Some people were wearing the same clothing on both days of our inspection and in some cases this was noticeably unclean. We saw a large pile of clothes in an upstairs lounge area. We asked staff about these and were told that they were items for which the laundry staff had been unable to identify the owner. One person said "I seem to have lost a shirt, I want my clothes back". Another person had dirt and grime under their nails which were ragged and sharp. They said "I'd be grateful if someone could do my nails". This was not dignified for people and showed a lack of regard for their self-respect.

We observed other times when people's right to privacy and dignity had not been properly considered. Two people were left on commodes in their bedrooms with the doors wide open. One person was left like this for 20 minutes. Another person came out of a toilet with their underwear around their knees but this was not immediately addressed by staff.

The failure to ensure people received dignified treatment is a continued breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some of the staff were spoken highly of by people and we observed some kind and caring conversations. However, we also heard one staff member shouting at a person and being brusque and off-hand to another two people. This was abusive behaviour and we made the registered manager aware of this immediately. People's call bells were not always responded to promptly during the inspection and several people told us that they had difficulty gaining a response to call bells at night. People's needs were not consistently met.

Although most other staff appeared to have caring attitudes, we observed a lack of attention to detail which could affect the quality of people's lives. For example; one person was left without water to take their tablets and another had their water placed out of their reach in their bedroom. We assisted both people to have a drink. Another person was slumped right over in an armchair in their bedroom and their breakfast had been placed on a table in front of them. We checked on this person an hour after our original observation but they were still in this position and had not eaten their cereal. Another person told us that they sometimes did not receive their breakfast early enough. They said," My breakfast was too late today, then I'm not hungry for lunch and then tea is not enough". This person's preferences had not been taken into account in the delivery of their care.

At lunch we noted that several staff were engaging well with people as they ate in the main dining area. However, two other people had been seated separately and facing the wall in a smaller area and had minimal interaction with staff or other people. We asked staff why people were seated like this and they explained that people's wheelchairs could be more easily pushed up to tables from this direction. However, staff had not considered minor rearrangements to tables which would have allowed those people to look out into the room and made interaction more likely.

We spoke with one person who said they had fallen recently. They had a mobility aid but it was not working properly. They said they had asked for it to be repaired but nothing had happened. Other people drew our attention to a dripping sound onto the conservatory roof, where they were sitting. One person told us, "I can't sleep at night, it drives me crazy some nights: drip, drip, drip-it like torture". These people said that they did not feel listened to at times; which they found frustrating.

There was no evidence in the care files reviewed to show that people had been involved in their care planning. Documents showed the care that people would receive but did not seek or record their views or input about any aspect of it. People's independence was not consistently considered within care plans. Some of those reviewed gave

Inadequate

Is the service caring?

guidance to staff about encouraging people to complete tasks themselves, but others had no information about independence and how to support people to help themselves.

The failure to ensure people's needs were properly assessed and met is a breach of Regulation 9(1) (a) (b) (c) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Two staff were observed giving encouragement to a person who was painting a picture in the dining area. They spoke in positive terms and the person was clearly delighted with the feedback.

Another staff member gave a bag to a person who was trying to carry some books. They spoke to the person kindly and gently suggested that they use the bag. Later on we saw that this person was proudly showing their bag to other people.

Inadequate

Is the service responsive?

Our findings

One person told us, "I get quite bored-there's only so many times you can read the paper". Another person said, "I couldn't believe it when the music lady turned up this afternoon-especially after I told you we just don't have organised activities".

We observed very little social interaction between people during our inspection. Those who were able read newspapers or did crosswords and one or two others watched TV. In the main, people kept themselves to themselves. There was no activities coordinator but the registered manager told us that she was attempting to recruit one. Staff told us that there was, "Hardly anything for people to do day to day, except watch the television". We also read a complaint form in which a relative had raised concerns about the lack of stimulation for people.

There were no structured activity plans so that people knew what would happen each day and there were few opportunities for people to engage with staff, as they were constantly busy. Entertainers came into the home once a month and two people came in at weekends to play games such as bingo and skittles. We observed a 'Music for health' entertainer on the first day of our inspection but only nine out of 41 people took part. Those who did participate enjoyed the session of sing-alongs and light exercise. Staff said they felt people would benefit from more frequent activities like this one.

There were no meaningful activities designed for people living with dementia. One staff member told us about a person who walked around the home frequently. They said, "I'm sure it's just because they're bored". There were some records about general activities that people had taken part in, but the most recent of these was dated 25 September 2015. These showed that the number of participants in events had ranged from three to nine. Individual social activities sheets were in place for each person but had not been completed since May 2015. Some people had blank 'Social and leisure' assessments in their care files and other people had no assessments at all. This meant that people's preferences and needs relating to hobbies and interests had not been taken into account.

There was a lack of private space available for people to see their visitors; apart from in their bedrooms. There was only communal space downstairs except for the smoking room, which was quieter, but unsuitable for people who did not smoke. A lounge on the first floor was cluttered and contained a divan base and piles of clothes; which made it unwelcoming as a place to entertain or spend time in.

The care plans reviewed had no information about people's life histories to help staff to understand and engage with individuals. Assessments of people's spiritual and religious needs had not been completed even though people told us that they held a particular faith. Staff told us that a priest visited regularly to give Holy Communion but when we asked what denomination the services were, none of the staff knew. One person spoke to us about their religion and that they would like to attend church services suitable for their faith. They said, "Unfortunately, there's nothing like that for me here".

People's need for social stimulation and religious or spiritual support had not been consistently assessed or met which is a breach of Regulation 9(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care plans had not always been updated to reflect the most current information about people's needs; which meant there was a risk that people would not receive appropriate care because of this. For example; changes to one person's mobility had not been included and another person's nutrition information had not been amended to show the most up-to-date position. Some people had short-term care plans in place despite them having lived in the service for several months. These plans did not include risk assessments or detail about how people's care needs should be met.

The failure to ensure people's care plans were sufficiently detailed to ensure their needs were met is a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us that they knew how to make a complaint if they needed to but also commented that issues had not always been addressed when they had raised concerns. We heard that people had reported the water dripping onto the conservatory roof and broken equipment, but those matters remained unresolved at the time of our inspection. One relative said that they had complained about a lack of cleanliness both formally and informally but the standards of hygiene had not improved.

Five complaints had been logged by the registered manager since February 2015. However, the registered

Inadequate

Is the service responsive?

manager had not completed the complaints record forms in two cases, as described in the provider's complaints procedure. Complaints that had been lodged through suggestions/ complaints forms available in the service, had not received adequate responses. One of these complaints had a single note made on it to state that one attempt had been made to call the complainant. No further follow up action was recorded and it was unclear what had happened to address the concerns raised.

The failure to ensure complaints were appropriately recorded or responded to is a breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

One person said, "The place has gone right down since the new owners took over" and a relative remarked, " I feel sorry for anyone living here who doesn't have relatives coming in". Another relative was more complimentary and said that the service had helped their loved one in the transition from another service.

Many of the staff we spoke with reported a culture of fear and bullying in the service. Some of them did not want to give us their names initially, as they alleged that they would lose their jobs if it was discovered that they had criticised the provider. Staff told us that they had raised concerns "Over and over" about fire doors that were not working and other maintenance and staffing issues. One staff member said that the response from the provider had been, "If you don't like it, you know where the door is". We repeatedly heard that staff did not feel "Valued", "Appreciated" or "Respected" and that morale and motivation was low as a result. This was in evidence during our inspection when we saw that they were challenged by insufficient staffing levels. One staff member told us, "It's depressing at times, I go home and think; those poor people". Another staff member said, "I go home and cry some days".

There had been a staff survey to seek views about the quality of leadership and teamwork within the service. This was undated however, and the registered manager was unable to tell us when it had been issued. Some of the feedback we read was positive but there were also a number of negative responses. For example; one of the survey respondents had stated 'No' to each of these questions: 'Do you respect the proprietors of this home',' Is teamwork encouraged'? and 'Do seniors demonstrate strong leadership?' The registered manager had not carried out any analysis of the surveys and so no action plan had been put in place to address the discontent felt by some staff. Staff told us that they did not think they were listened to or that their opinions were taken seriously.

People had not been asked for their feedback about the general quality of the service and no survey or similar had been issued. However, a questionnaire about food had been given out in the two months prior to our inspection. Returned surveys had not been analysed and no action plan had been implemented. Although suggestions/ complaints forms were available for relatives to complete, we found that no actions had been recorded on those reviewed.

Feedback was neither consistently sought nor actions taken on feedback about the services provided. This is a breach of Regulation 17(1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some staff said that they did not feel supported by the registered manager and that she spent long periods outside smoking, when they needed her input. Others told us that the registered manager was "Ok". There were a number of times during the inspection when we needed to speak with the registered manager but could not locate her. On most of those occasions, we found her in the outside smoking area. Staff told us that they felt frustrated because the registered manager did not know people or their needs; which they believed she should in order to be able to manage effectively. The registered manager was unable to answer many of our questions about specific people and consistently referred us to the deputy for that information.

At our inspection in April 2015 we reported that records had not been complete, accurate and up to date. We made a Requirement Action for this. The provider's action plan stated that they would put this right and that their efforts would be 'On-going'. At this inspection we found that records had still not been adequately completed. For example, cream application charts, food and fluid records and care files had not always been maintained properly; which created risks to people.

Very large quantities of confidential documentation were found in the flat on the upper floor. The door to the flat was open and there was nothing to prevent access to it. The paperwork included information about people's benefits, solicitors' letters and care file sheets with photos attached in some cases. We asked the registered manager about these documents and she told us that they were old and related to before the provider took over in late 2014.However, we saw paperwork for people currently using the service and dated August 2015. The registered manager later informed us that the provider had removed this paperwork to a secure location. People's private and confidential information had not been maintained securely.

Inadequate

Is the service well-led?

The failure to ensure complete, accurate and up to date records and the failure to store records securely is a continued breach of Regulation 17(2) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requirement Actions in relation to people's hydration, their dignity and staff support had also not been met, despite the registered manager submitting an action plan to the Commission which stated that they would be completed.

Some audits had been carried out to monitor and assess the quality and safety of the service; but these had not always been effective in identifying the issues found during this inspection. For example; the most recent medicines audit in October 2015 had scored 100% in relation to liquid medicines being dated on initial opening, staff conducting safe administration processes and

The Controlled Drugs register being signed by two staff for each activity. This did not reflect our findings just five weeks after the audit.

An infection control audit in October 2015 noted that the service had a named infection control staff member but both the registered manager and staff said there was not one. This audit also confirmed that there was a 'Clean to dirty flow' in the laundry, but this was not in operation during our inspection and presented a cross-contamination risk.

We observed that people's call bells were sounding almost continuously at certain points. We asked the registered manager whether she had carried out any form of auditing to establish the reasons for this, but she had not. This meant that the issue went un-checked and that people were not having their care needs met in a timely way.

Maintenance jobs had not been checked or audited. The records in the maintenance book were scant in places with no reliable record of when repairs were completed. The registered manager had not followed up on this, even though some of the jobs reported affected people's safety; such as fire doors not working.

Fire alarm testing had not been carried out. The registered manager and staff told us this was because the staff responsible for this had left. However, the registered manager had not reinstated the testing to ensure that the alarms were in working order and that people, staff and visitors reacted appropriately to them.

The failure to ensure effective quality and safety assurance systems is a breach of Regulation 17(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.