Only Care Limited

Rosewood Court

Inspection report

175 London Road
Dunstable
Bedfordshire
LU6 3DX

Tel: 01582500820
Website: www.onlycareltd.com

Date of inspection visit:
12 September 2017
13 September 2017
20 September 2017

Date of publication:
02 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Rosewood Court was added to the provider's registration in April 2016. It is a purpose built care home that provides accommodation, nursing and personal care for up to 66 older people, some of whom are living with dementia.

Our last inspection took place on 11 July 2017 and included information received from the local authority on 1 August 2017. We rated the service as requires improvement with three breaches of regulations.

This unannounced inspection took place on 12 and 13 September 2017. We also received information by email from the provider on 20 September 2017. There were 19 people receiving care, and one person in hospital, at that time.

Prior to this inspection we received further concerns from the local authority and Clinical Commissioning Group in relation to the management of the service and the care people received.

Before this inspection the provider's representative told us they planned to temporarily stop providing nursing care in order for them to focus on making the necessary improvements to the service.

During our inspection visit on 12 September 2017 the provider's representative told us they had decided to close the service. They engaged a consultancy company to assist senior managers with the closure.

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. The service had not had a registered manager since January 2017. Since that time the provider had appointed five managers. The current manager took up post on 6 September 2017. However, they were not present during our inspection and senior managers told us the new manager was unlikely to return to work. The compliance manager was managing the service during our inspection. The lack of stable management had negatively impacted on the service, causing confusion and low staff morale.

The provider had failed to follow the required process to notify CQC of changes in the service's managers.

Systems to continually assess, monitor and improve the quality and safety of care provided at the service were lacking and remained ineffective.

There were opportunities for people and their relatives to provide feedback to the provider. However, these were not always communicated to them and that little had changed as a result of their comments. Relatives were not always informed of changes in their family member's well-being. We therefore concluded that complaints were not always thoroughly investigated and complainants were not always kept informed of the progress of their complaints.

Not all staff received sufficient training and support to carry out their roles.

Staff had not always supported people with decision making. The provider told us this would be addressed by 20 September 2017.

People's nutritional needs were met. However, people's health care needs were not always effectively monitored or met and people did not always receive their prescribed medicines.

Potential risks to people had not always been assessed and were not always well managed.

There was not always enough sufficiently skilled and experienced staff on duty to make sure people's needs were fully met and people were kept safe. Staff knew how to recognise incidents of potential harm but did not always know how to, or feel confident in, reporting these.

Some people were happy with the care they received. However, staff did not always follow people's care plans and people did not always receive the care they needed. However, we were aware the provider was in the process of reviewing people's care plans.

People received care from staff who were kind, respectful and supported their independence. Staff treated people with dignity and respect. However, care was not always person-centred and people were not always involved in every day decisions about their care.

There were opportunities for people to develop and maintain interests and hobbies.

At our previous inspection on 11 July and 1 August 2017 we found two breaches of the Health and Social Care Act (Registration) Regulations 2014 and one breach of the Health and Social Care Act (Regulated Activities) Regulations. We were waiting for the provider's action plan detailing the improvements they planned to make. During this inspection on 12, 13 and 20 September 2017 we found a further five of the Health and Social Care Act (Regulated Activities) Regulations 2014 had been breached, in addition to the breaches identified at our previous inspection. You can see what action we told the provider to take at the back of the full version of the report.

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.

Potential risks to people had not always been assessed and were not always well managed.

There was not always enough sufficiently skilled and experienced staff on duty to make sure people's needs were fully met and people were kept safe.

Staff knew how to recognise incidents of potential harm but did not always know how to, or feel confident in, reporting these.

Medicines were not always well managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff received sufficient training and support to carry out their roles.

Staff had not always supported people with decision making.

People's nutritional needs were met.

People's health care needs were not always effectively monitored or met.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care from staff who were kind, respectful and supported their independence. However, care was not always person-centred.

People were not always involved in every day decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always follow people's care plans, not all people's needs had been addressed within their care plans, and people did not always receive the care they needed.

There were opportunities for people to develop and maintain interests and hobbies.

Complaints were not always listened to or addressed.

Is the service well-led?

Inadequate

The service was not well-led.

Effective systems were not in place to continually assess, monitor and improve the quality and safety of care provided at the service.

The changes in manager and lack of registered manager limited the provider's ability to drive or sustain the improvements that were required.

The provider had not formally notified the CQC of changes in the person managing the service.

Rosewood Court

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 unannounced inspection took place on 12 and 13 September 2017. We also received information by email from the provider on 20 September 2017. On 12 September, the inspection was carried out by two inspectors, a specialist advisor for medicines and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service. On 13 September, the lead inspector returned with another inspector to complete the inspection.

Before our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from the local authority, the local clinical commissioning group and Healthwatch Bedfordshire.

During our inspection nine people told us about their experience of living at Rosewood Court, and we also spoke with two relatives. We also spoke with the provider's representative, the compliance manager (who was managing the service during our inspection), one agency nurse who worked regularly at the service, two senior care workers, three care workers, an activities co-ordinator, the head house keeper, three domestics and a cook. We also spoke with a management consultant who was supporting the provider. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at care records relating to eight people and the medicine administration records of 19 people. We also looked at staff training records and other records relating to the management of the service. These included audits, rotas, meeting minutes and records relating to complaints, maintenance, and accident and incidents.

Following our inspection visits we spoke with three further relatives. We also received information by email

from the provider on 20 September 2017. This included further information in relation to staffing the home, medicines and people's hospital appointments.

Inadequate

Is the service safe?

Our findings

At our last inspection on 11 July and 1 August 2017 we identified that risks were not always well managed at the service. This remained the case at this inspection. Whilst we saw that risks were identified, we couldn't be certain the measures in place were effective.

Whilst most people told us staff knew how to care for them, one person said, "The staff seem to know what they are doing but sometimes the agency have not been told I am paralysed down one side and they tend to pull at that bad arm." Another person's relative raised a similar concern and said they had had to stop an agency staff member from moving their relative inappropriately.

Staff did not always follow basic good practice to keep people safe and comfortable. The day before our inspection a staff member had given a person their own handbag to hold to calm the person's anxiety. Later, staff found the person holding a packet of the staff member's medicines which had been left in the handbag. The staff member confirmed no medicines were missing, however by leaving these medicines in the bag and giving this to the person, the staff member had placed the person at risk of harm. During the first day of our inspection we saw a person being pushed in a wheelchair without their feet being on footplates. When we asked staff about this, they apologised and assisted the person to place their feet on the footplates to ensure their safety during the manoeuvre.

Care plans contained a range of assessments that identified the risks across people's lives. These included mobility, eating and drinking and personal care. Whilst we saw some risks were identified, we found staff did not always follow guidance. For example, a person's falls risk assessment provided clear advice for someone scoring 'significant high risk'. This included increased observation and supervision, referrals to health care professionals for advice and possible treatment, and to review the risk assessment each week until the level of risk had reduced. Despite this advice, records showed the person's falls risk assessment was only reviewed once in five months. In addition, the nurse on duty could not tell us whether the other advice had been followed. Although the compliance manager told us she thought the person had been referred to the falls co-ordinator, there was no mention of this in the relevant section of the person's care record.

We found that the ongoing risk was not always evaluated. We could see falls were recorded but risk assessments and care plans had not always been reviewed taking this information into consideration. For example, the person whose care records we referred to in the paragraph above fell, but their risk assessment had not been reviewed to take account of this two days later.

The compliance manager told us analysis of the accidents and incidents that had taken place at the service had not been carried out. This meant that any trends or themes that may have emerged may be missed and that action to reduce the risk of recurrence may not be taken.

This meant that staff may not be taking reasonable precautions to reduce the risk of people being exposed to preventable harm. This is a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their medicines as prescribed. Prior to our inspection the local authority raised several concerns about medicines management at the service. These included prescribed medicines running out, medicines not being administered in line with the prescriber's instructions and records not being signed.

Two people told us that staff assisted them with their medicines. One person told us staff "do stand and watch me take it." However, the other person said that this was only "sometimes" the case. During our inspection we saw staff waited patiently while people took their medicines.

One relative told us they felt staff managed their family medicines, "Very well." However, another relative expressed concern that their family member's medicines had run out and a third relative questioned whether their family member received their prescribed cream when there was no senior care assistant on duty. We looked at this person's record and saw that staff had not signed to confirm the medicine had been administered.

A new monthly medicines cycle had started the day before our inspection. Staff had failed to identify that one person's medicines had not been delivered to the service until the person required them. Although staff had then identified, and followed this up, the delay meant that the person did not receive their medicines as prescribed. Another person had not received a prescribed inhaler, to help them breathe, on three occasions in two days. This was because this medicine had not been copied onto the new month's MAR. We raised this with a staff member and they took immediate action to ensure the person received their medicine as prescribed. Staff had identified that another staff member had failed to give five people their prescribed medicines on one occasion in the last month. The compliance manager had taken action to reduce the risk of this happening again.

We were able to reconcile some, but not all of the medicines held in the service with the records. This was because staff had not always recorded how many tablets had been carried forward from the previous month's medicines cycle. For one controlled drug, received in April 2017, we were very concerned that the record did not tally with the balance held in stock. The provider's audit had failed to identify this. Following our inspection the management consultant investigated this and concluded that it was most likely the medicines had been administered to the person for whom they were prescribed, but that this had not been recorded. They told us systems had been reviewed to reduce the risk of this recurring. We found that medicines were stored securely.

Protocols were in place that helped staff to identify when to administer medicines that had been prescribed to be given 'when required'. We noted that some people had swallowing difficulties and had multidisciplinary agreements in place to consider their best interests and give medicines covertly. These had not been reviewed after three months as per the provider's policy, but a management consultant told us they were addressing this.

We looked at the training matrix and saw that some staff had received medicines awareness training and competency assessments in 2016.

This shows that medicines were not always managed safely and there were not always sufficient supplies of prescribed medicines available for people. This is a breach of Regulation 12 (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives commented on the high staff turnover at the service. One person said, "You get used to the [staff] then one by one they start to leave." The person told us this had resulted in longer waiting times

for their call bells being answered. Another person said, "Due to staff shortages, [staff] don't answer the call bell very quickly, luckily I wear a pad but I prefer to go to the toilet." Relatives also commented on the long time it often took staff to respond. One relative cited they, "Called for nearly an hour," before staff responded. Two ancillary staff members told us they would not want a family member cared for at this service because of the poor response times to people's call bells. One staff member told us they had timed response times and found it wasn't unusual for it to be in excess of 30 minutes before staff responded. They said, "There's not enough staff on half the time."

We found there was not always sufficient numbers of staff on deployed. The rota showed that there should be 'four staff on each floor'. Despite this, staff told us there had been occasions when there were only two or three staff on duty on the ground floor, caring for up to 15 people. They told us that five people needed two staff to assist them with their personal care and one staff member needed to stay in the lounge area to maintain people's safety. This meant that at times there were insufficient staff on the ground floor to meet people's needs in a safe manner.

Staff told us of occasions when a senior care worker was not on duty on the ground floor. They told us the nurse, who was based on the first floor, administered people's medicines, but they said they felt they had "No one to go to if there were problems." They told us of occasions when care assistants were left to co-ordinate the shift and handover any information to staff on the next shift. One care assistant told us that management staff had instructed them to do this even though they had not been trained and did not feel competent to do this. A relative commented on a recent shift when there had not been a senior care worker on duty. They described the shift as, "Chaotic." They were concerned their family member had not received a prescribed topical medicine because the senior care worker was not on duty. We checked the person's record for a specific date and could find no evidence that the medicine had been administered. Although the rota showed a senior care worker as being on duty that day, the staff member told us this had not been the case.

In addition to the senior care worker, two other staff also told us the rota was inaccurate. A senior manager told us that staff did not always sign in and out and that errors in the 'clocking in and out' system meant that these records were not always accurate. We could not therefore rely on records for information about the staffing levels of the service.

Senior management were unable to provide us with information to satisfy us that there were always sufficient staff on duty. They told us a senior manager had used a recognised tool to assess people's level of need and this determined how many staff were on duty. During our inspection they were unable to access this tool for us to see. In addition, the compliance manager who was running the home during our inspection was not able to tell us the minimum number of staff needed on duty to keep people safe.

This meant there were not always sufficient staff deployed to support people's needs safely and in a timely manner. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider's representative told us they had employed a consultant to help them oversee the closure of the service. Part of the consultant's role was to help them ensure there were sufficient staff on duty to keep people safe. They completed a new assessment of people's needs and sent us information to satisfy us that there would be sufficient staff on duty to keep people safe until the service closed.

Staff told us that satisfactory checks had been obtained before they were allowed to work with people.

However, the compliance manager's audit found significant shortfalls in the records the provider held in relation to the checks that had been carried out prior to staff being employed. These had included information such as criminal records checks, references and health information. They therefore could not be confident that appropriate checks had been carried out to ensure that staff were suitable to work with the people receiving a service. As a result, the compliance manager showed us that missing information had been requested, and had been mostly received. We sampled their spreadsheet against staff records and found it to be accurate. The spreadsheet showed the provider had received satisfactory checks for the majority of staff working at the home.

Seven people told us they felt safe at the service. One person said, "I do feel safe here staff are very kind and polite, that makes people as old as me feel safe." Another person told us, "I am safe and happy here they look after me that's what counts." However, one person described themselves as feeling only, "Relatively safe," because "People are starting to wander in my [bed]room at night." Another person said, "I am safe here but in some ways I'm not because staff regularly pull out the [call] bell cord from its plug when making my bed, or they hoist me in the chair and the [call bell] is not left within reach for me to call someone, but I'm safe as a person."

The compliance manager provided us with information that showed of the 54 staff employed by the service, only 24 had received safeguarding training. The provider's record showed that this should be updated each year. However, only seven staff had received this training within the last year. This meant that staff member's knowledge of how to safeguard people from harm may not be up to date.

All the staff we spoke with were aware of what may constitute abuse. They told us they understood the need to report their concerns. However, they did not all feel they could report these to the management team or that if they did, their concerns would be followed up. One staff member told us, "I would not report [a concern] to the management here, I don't trust them." Another staff member said there was only one member of the management team they felt confident of raising concerns with. In addition, not all staff knew how to escalate concerns outside of the provider's organisation. This meant that people were at an increased risk of harm because not all staff had the knowledge or information to report concerns, or the confidence that these would be properly dealt with.

Requires Improvement

Is the service effective?

Our findings

During our inspection people felt the permanent staff knew them well and understood the care they needed. One person said, "Staff know what they are doing, we are well looked after." However, this was not always the case with agency staff. One person told us that not all agency staff knew their particular needs and sometimes pulled at their "bad arm."

Prior to our inspection the provider sent us an action plan that identified 'training of existing staff' would be completed by 7 September 2017. However, we found not all staff had received sufficient training to carry out their roles. One staff member told us, and records and the compliance manager verified, that they had worked at the service for 11 weeks and not had any training. They told us, "There were no shadow shifts [working with a more experienced care worker]. I was thrown in at the deep end. I've been happy to help because I'm sorry for people. It's not what I expected." Another staff member said they had worked at the service for two months before they received any training. They described having, "Learned on the job." One staff member told us, "As training has not happened, mistakes are happening and staff are being suspended ... Instead of staff being trained so mistakes did not happened."

Records showed that 13 of the 33 staff who may be expected to carry out tasks that involved moving people had received no training to do so. In addition, the provider's record showed that this training should be updated each year. Of the 20 staff who had received training to assist people to move, only 11 had received this within the last year. This meant that only one third of the staff team had up to date training in how to assist people to move. We saw this was also the case for other training including safeguarding people from harm, dementia awareness and the Mental Capacity Act.

Prior to our inspection the provider sent us an action plan that identified 'staff to receive a minimum of supervision bi-monthly' and would be completed by 30 September 2017 'and will be ongoing'. We therefore didn't inspect this area. However, we were concerned that staff had mixed views about the support they received. Some staff told us they felt well supported and able to approach managers if they had concerns. However, we were concerned that other staff did not feel this way and found the senior management team unapproachable and unsupportive.

Staff told us that they understood they should have a regular supervision meeting with a line manager. However, they told us these rarely took place. One staff member told us their last supervision meeting was with the previous manager who had left in August 2017. They said, "[The meeting] was very short, I was in and out in five minutes." Another staff member told us the previous manager had insisted they signed a record to say they had attended a supervision meeting when this had not been the case. None of the staff we spoke with had had a supervision meeting since the previous manager had left. This meant that not all staff members were supported to care for people.

This meant that not all staff members were sufficiently supported or had received training and up to date knowledge of how to care for people. This is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our inspection on 11 July and 1 August 2017 we found that people's care and treatment was not always provided with their consent. In addition, the principles of the MCA had not always been followed to support people who lacked the capacity to make their own decisions. This was a beach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection people told us that staff checked for consent before providing care. One person said, "The [staff] always tell you what they are going to do and ask if it's alright." Another person told us, "The [staff] always communicate well with me and explain things to me." However, staff told us that a person had been moved from the first floor to the ground floor with no consultation or time to get used to the different environment. The compliance manager said the person had spent time on the ground floor prior to moving. However, there was no mention of this in the person's care records and a mental capacity assessment and best interests decision had not been completed in relation the move.

Staff had a working knowledge of the MCA and supported people to make informed choices about their care in a way each individual could understand. For example, one staff member told us, "A person who has dementia can still make a choice. We can't force people to do things." Another staff member told us about a person who sometimes refused personal care. They told us, "I go away and try later... or we try again with [a different staff member]."

We found that a management consultant had audited records relating to the MCA. A second management consultant was acting on this audit and addressing the shortfalls that had been found. This included applying for DoLS authorisations that had expired. They expected to complete this work by the end of the week. We have requested an action plan from the provider in relation to this breach.

The local authority had raised concerns that not all staff were aware of when a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNARCPR) decision did not apply. We spoke with senior staff during this inspection. They were clear that in the unlikely event of a reversible cause of a person's respiratory or cardiac arrest that did not match the circumstances envisaged when that decision was made, they would attempt CPR. The provider had recently re-issued their policy to all staff.

Prior to our inspection a person at the service choked on food that was not suitable for them. The local authority had raised concerns that staff were not all aware of peoples' dietary needs, that fluctuations in people's weights had not been identified and that food and fluid charts had not been completed.

During this inspection we found people received sufficient, appropriate food and drink. Most people told us that food was satisfactory and they were given a choice of what to eat and drink. One person told us, "I think the food is very good, if you don't like what's made they will change it for you." Another person said, "I think we get good food that chicken pie was lovely." However, another person said, "I would say the food is not that good." However, they went on, "But if I don't like what's cooked they will always try to accommodate me with something else."

Staff were aware of people's dietary needs, for example if people needed food of a specific consistency, and who was at risk of weight loss and required a fortified diet. People's care records showed that their dietary needs had recently been assessed and where required referrals were made to the appropriate health professionals. This included people who received nutrition via a percutaneous endoscopic gastrostomy (a tube to allow food and medicines to be delivered directly to their stomach).

We observed lunch being served in both dining rooms. Staff members wore appropriate protective clothing whilst serving food. Staff offered people a choice of meal and prompted people to eat. Where necessary, staff gave further encouragement and assistance. However, we noted that one care worker started to assist a person but then left the room. Although there were five members of staff in the dining area no one approached the person for an hour, and then did not offer to warm the food. A relative told us that their family member needed to use an adapted plate (with lip) and adapted cutlery but staff did not always remember this. They told us that when prompted, staff did bring these items.

Prior to our inspection the local authority told us they were concerned that people had not been referred to appropriate healthcare professionals and had not been supported to attend hospital appointments. This included staff failing to raise a healthcare issue with a person's GP at their relative's request. This led to the person being admitted to hospital to treat an infection.

During this inspection we saw people had been referred to healthcare professionals such as speech and language therapists and dieticians and that staff followed their advice. People told us they regularly saw a visiting chiropodist. People told us that when they had been unwell, staff had called their doctor. One person said, "[Staff] are quite quick to call the doctor." However, we also noted that a person at high risk of falls had not been referred to the falls co-ordinator.

The reasons people had not attended hospital appointments were not always easily available in people's records. However, following our inspection a management consultant investigated why three hospital appointments had not been kept and found reasonable explanations. These included that the person had refused to attend and that a relative was rescheduling the appointment so they could attend with their family member.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and respect. One person said, "[The staff] are very caring. We have a laugh and a joke with them." Another person said, "The [staff] are very kind to us." A third person described the staff as, "Very kind and caring." Relatives agreed with these views. One relative told us, "The staff are all lovely." Another relative said, "The carers employed are very good and very nice." However, relatives also told us that staff didn't always understand what was important to their family members. For example, one relative said their family member disliked their hair growing over their ears. The person was booked in for a haircut, but it didn't happen and no explanation was provided. Another relative described their family member as "very tidy" and said that it was important to them that their bed was made. However, they said staff didn't do this "three or four times a week." Although the person found it very difficult, they made their bed on those days when staff didn't do it. A third relative told us that staff often forgot to put their family member's hearing aid in, or failed to notice that the battery wasn't working. They told us, "It's been a big issue from the beginning…It's really important. [My family member] can't hear and [it means they are] isolated. [My family member] is second guessing what [staff are] saying.

We asked nine staff if they would be happy with a relative being cared for at this service. Three staff members said they would. They said this was because they believed the care provided was good. One staff member told us, "I would" be happy for a loved one to be a resident here because of the care, [They are] well looked after." However, the other six staff said they wouldn't be happy for a loved one to be cared for at this service. They main reason they gave was the lack of management and staff, both of which they felt negatively impacted on the care people received. One staff member told us, "I don't think the management or care is that good." Another staff member said, "The care staff are lovely but sometimes there's a lack of staff."

Relatives had mixed views as to whether the staff kept them informed of their family member's well-being. One relative told us, "[Staff] are good at communication. If [my family member] is not well they always get in touch." However, other relatives said they had not been contacted, for example, when their family member had fallen. One relative told us that they had asked to see the records of the fall their family member sustained. However, when staff showed them these, they found their family member had had another fall but that staff had failed to inform them of this.

People told us that care staff supported their independence. One person said, "I'm very well supported here. I choose my own clothes when I get up and lay them out on my bed, which gives my independence. I like that. Then a carer will come and assist me to wash." They told us that staff respected their choice to get up early and provided support at the appropriate time.

People told us staff showed them respect. One person said, "[Staff] are very respectful towards me and go at my pace [when assisting me]." Another person told us, "[Staff] are respectful towards me and always talk to me whilst they assist me." A relative commented, "[My family member] is always clean and presentable and her clothes are lovely and clean."

During our inspection we observed staff being respectful towards people. They approached people in a gentle unhurried manner, engaging with people face to face and at eye level, bending down if they needed to.

Requires Improvement

Is the service responsive?

Our findings

Prior to our inspection the local authority told us that staff did not always meet people's care needs and care plans were not always accurate.

During this inspection people had mixed views about whether staff understood and met their care needs. Some people were happy with the care they received. One person said, "I am happy and I am well looked after." Another person said, "I cannot fault the care I have had here." However, other people told us staff did not always carry out the care they requested. One person said, "I have asked for my nails to be cut [showing us long finger nails] but I suppose I will have a wait for that as well."

The majority of people we spoke with did not know what a care plan was and had not been involved in its review. One person said, "I know what a care plan is, it's about my care and what I need, like and dislike. Look at my walls there are notices up on my preferences. My [relatives] do that so staff can follow them, but [staff] don't always do that." However, we were aware the provider was in the process of reviewing care plans and were working to involve people in this.

We saw people had a variety of care plans to help staff to meet people's needs in a consistent way. For example, how to move people and manage their healthcare conditions. However, not all people's needs had been addressed within their care plans. For example, one person was very anxious and displayed behaviours that challenged themselves and other people but there was no care plan to advise staff on how to approach the person and help them reduce their anxiety. Records showed that the person was confused and became disorientated and entered other people's bedrooms without their permission. Again, there was no care plan in place to advise staff on how to manage this behaviour. This put people at risk of being supported in a way which was not centred on the person.

Permanent staff spoke knowledgably about people, their preferences and their care needs. However, staff did not always follow people's care plans and people did not always receive the care they needed. For example, one person's care plan stated their catheter bag should be emptied at least every two hours. The person and their relatives told us that staff didn't always do this. During our inspection we noted that the person was left for in excess of two hours before their catheter bag was emptied. This meant the person's care was not provided in line with their care plan.

Although people's care plans had been reviewed, relevant information was not always taken into consideration. For example, a person's falls care plan had been reviewed but did not take into consideration that the person had had a fall since the last review. This meant that information used was not always up to date.

This shows that staff did not always follow people's care plans, not all people's needs had been addressed within their care plans, and people did not always receive the care they needed. This is a breach of Regulation 9 ((1) (2) (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they would make any complaints they had to a staff member. However, people and relatives who had complained about aspects of the service told us they had not always received a response to their concerns and were not confident their complaints had been investigated. One person said, "I let [staff] know if I need to complain, although they don't always listen". Four of the five relatives we spoke with told us they had raised complaints with the management of the service. Three of the relatives told us they were unhappy with the responses they received, or that they had not received a response at all. The fourth relative told us their complaint was addressed quickly and things had improved for several weeks, but that the service was again inconsistent.

Records showed there had been eight complaints about the service since our last inspection visit on 11 July 2017. The investigation and response records varied considerably. We saw that one person received comprehensive information about the investigation, outcome and actions taken to improve the service. However, for other complaints, there was little or no information to show how, or if, an investigation has been conducted. For example, one relative complained that their family member had been left unattended in a room and received their breakfast late because staff had not supported them at the required time. The records showed that a senior staff member had apologised to the relative and spoken with staff about this, but there was no record of any investigation having taken place.

We therefore concluded that complaints were not always thoroughly investigated and complainants were not always kept informed of the progress of their complaints. The provider had not carried out audits of complaints received to help identify trends or themes. This is a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that there had been an increase in both group and individual activities in recent weeks. People told us staff supported them to develop and maintain interests and hobbies and that a range of activities were available. One person told us, "The activity [co-ordinator] is great. I always enjoy the quizzes, I'm quite competitive". Another person said, "The activity [co-ordinator] is very good… She plays some lovely music… We don't get bored."

We saw a timetable advertising various activities including quizzes and gentle exercises. During our inspection we saw that the activity co-ordinator was trying to involve everyone in the activities on offer. However, relatives told us this was not always the case and there was often a lack of social stimulation. One relative said, "You can notice the difference today, one of the carers doing activities with [people], that's unusual. I very often observe carers just sitting chatting [with each other, rather than the people using the service]. I noticed [a care worker] playing carpet bowls today, that's great. I do believe these people are being bored to death." Another relative said, "[My family member] sits in [their] room and gets lonely. Staff don't spend time with [them]." They went on to comment that their family member didn't get the "friendship and conversation" that they needed.

Inadequate

Is the service well-led?

Our findings

This service has had a history of failing to meet fundamental standards. The service was added to the provider's registration on 18 April 2016. At our first inspection in July 2016 we found serious concerns and the service was as rated as inadequate with nine breaches of regulations. Following this we imposed a condition of registration preventing further people from moving to the service. The provider submitted an action plan detailing the improvements they planned to make.

At our inspection in November 2016, we found the provider had made improvements to the service but still had work to do. We rated the service as requires improvement. There was one breach of regulation in relation to staffing. As we had seen improvement, we granted the provider permission to admit up to two people to the service each month.

Our last inspection took place on 11 July 2017 and included information received from the local authority on 1 August 2017. We rated the service as requires improvement with three breaches of regulations. Following an incident of concern at the service in August 2017, we revoked permission for the provider to admit people to the service. At our request the provider sent us their action plan showing how they would ensure people's safety and meet their legal obligations.

Prior to our inspection the provider's representative told us they planned to temporarily stop providing nursing care. They said this would give them time to focus on making the necessary improvements to the service. Arrangements were being made for people with nursing care needs to move to other services. During our inspection visit on 12 September 2017 the provider's representative told us they had decided to close the service. They engaged a consultancy company to assist senior managers with the closure. After to this inspection, the provider's representative informed us that all those people who lived at the service had been moved to alternative homes.

At our inspection on 11 July and 1 August 2017 we found that despite finding some improvements at the service, there were not effective systems in place to continually assess, monitor and improve the quality and safety of care provided at the service. This was a beach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Senior managers had made efforts to introduce audits and quality systems to improve the safety and quality of the service. For example, they had completed an audit of staff recruitment checks and implemented an action plan. We sampled this and found it had been effective and appropriate checks had been obtained. The compliance manager had completed a care plan audit in July 2017 that identified numerous improvements that needed to be made to people's care plans. Work had started on this, but had not been completed. For example, one person did not have a care plan to advise staff of how to support the person and maintain other people's safety when the person displayed behaviours that challenged others. This had been identified in the care plan audit, but no action had been taken.

We noted that audits had not been completed to identify themes or trends from accidents or incidents. For

example, staff raised concerns that one person had fallen several times, that senior staff were aware of this but that no action had been taken to reduce the risk of the person falling. The compliance manager confirmed there was no monitoring of falls at the service. We asked to see audits relating to the management and prevention of infection control. The compliance manager told us that during the inspection they had discovered that cleaning schedules had been discontinued by a previous manager in May 2017, but they would be reinstated the following day. The compliance manager told us they had requested the previous manager, who left the service in August 2017, completed various audits. These included an audit of staff training. However, the compliance manager said they could find no evidence that these had been completed and they were now addressing these.

We found basic systems were not effective to ensure the smooth running of the service. For example, three staff told us that not received their full salary this month, and said this was not unusual. They told us this was causing them financial hardship. The staff said they had reported this. One staff member expressed their frustration that this had not been sorted out. They said, "It's as though [manager's have] no concern." The compliance manager explained there was a problem with the system staff used to 'clock in and out' and they were trying to resolve this. A relative told us that basic systems to pay fees were not effective. They said, "A lady came from head office and we talked through finances but all the paperwork got lost. They didn't take payment for 3 months. I supplied with standing orders but they didn't take payment. There's no management structure to ensure it."

This showed that systems to continually assess, monitor and improve the quality and safety of care provided at the service were lacking and remained ineffective. We have requested an action plan from the provider in relation to this breach.

At our inspection on 11 July and 1 August 2017 we found that the service and provider had not always acted in an open and transparent way with relevant person's in relation to people's care. This was a beach of the Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they had had opportunity to provide feedback to the provider, but that these were not always communicated to them and that little had changed as a result of their comments. One person said, "When I first came here I did attend a couple of meetings I complained about the food and the lengthy time to wait when I ring my buzzer but things haven't changed in that respect." Some relatives told us that although they knew meetings were arranged, the provider didn't always let them know about these. One relative told us, "I have been to meetings…I did ask them to let me know by letter to remind me when the meetings are but I have not had one." Another relative said, "We couldn't make the meeting [two weeks ago] as we were away. We've had no update about what was discussed at that meeting."

A relative told us that although they attended meetings, the management team were not always clear about the changes they planned. For example, a relative told us, "They were not very clear that a good number of people were being brought from nursing dementia section [to live on the ground floor]…There was no consultation regarding people moving. It was another relative told me about it." They went on to say that this had negatively impacted on their family member. "[My family member] is increasingly surrounded by people with erratic behaviour. There are a number of people going in and out of [my family member's] room. It's not acceptable. They need more help than they are getting."

Two relatives told us they were not always informed of changes in their family member's well-being. This was particularly in relation to when their family member had fallen. They told us they had asked various members of the management team for explanations as to the circumstances of the falls, but they had not received satisfactory explanations. In one instance, whilst requesting information about one fall, a relative a

member of the management team had provided them with information about a fall that they had not previously been aware of rather than they fall they were enquiring about. They told us how disappointed they were in the service their family member had received. They said, "[The service has] not been brilliant. It's costing a lot of money. We thought it would be absolutely super. We thought we were getting the best we could but all that glitters isn't gold. It's the care that has to be right."

This showed that the provider had not always acted in an open and transparent way with relevant person's in relation to people's care. We have requested an action plan from the provider in relation to this breach.

The service had not had a registered manager since 25 January 2017. Since then the service has had four managers. The current manager took up post on 6 September 2017 and told us of their intention to register with the CQC. However, they were not present during our inspection and senior managers told us the new manager was unlikely to return to work. The compliance manager was managing the service during our inspection.

People told us they were not sure who was managing the service. However, most people said they felt able to speak with staff if they had any concerns. Relatives said they had lost confidence in the management of the service. One relative said, "I know they're trying to pull it round. I'm optimistic every time there's a new manager. But I'm not confident." Another relative told us, "[The new manager] promised me the world. I've heard this so many times in this four month period. I've no trust in the management. There's no leadership. I feel as though I've been talking nonstop ... I'm just looking out for my [family member]."

Staff also told us they felt the lack of stable management had negatively impacted on the service provided. One staff member told us, "There's been so many changes. There's uncertainty about what is going to happen. You come in and you don't know what's going to happen." Another staff member said, "The last six months have been bumpy. The change of managers has been crazy. It's been really unsettling. We get the spiel 'We're here for the long haul and to stay' [but they've all left]." Some staff became visibly upset during our inspection when they spoke about how stressful they had found the changes in management and the effect that this had had on them. One staff member told us, "[There's] stress day after day after day. You don't know what you are coming into…There's no communication… We were told [the service was] on embargo by a man in the street." Another staff member told us, "There's no-one to go to if [there are] problems. I don't feel [manager] is approachable…I find her abrupt." They told us that each new manager had introduced new systems and ways of doing things. They said this had caused confusion and further lowered staff morale.

Although the provider had informed the CQC of changes in manager at the service, they had not completed the required process and submitted formal notifications to us. This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

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 15 Registration Regulations 2009 Notifications – notices of change
Treatment of disease, disorder or injury	The provider had not formally informed the CQC of changes in manager at the service. Regulation 15.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Staff did not always follow people's care plans, not all people's needs had been addressed within their care plans, and people did not always receive the care they needed. Regulation 9 (1) (2) (3) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Staff may not be taking reasonable precautions to reduce the risk of people being exposed to preventable harm. Regulation 12 (2) (a) and (b) Medicines were not always managed safely and there were not always sufficient supplies of prescribed medicines available for people. Regulation 12 (2) (f) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Treatment of disease, disorder or injury	Complaints were not always thoroughly investigated and complainants were not always kept informed of the progress of their complaints. The provider had not carried out audits of complaints received to help identify trends or themes. Regulation 16 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were inadequate processes in place to assess staffing requirements and deployment in the service. We could not be certain there were sufficient staff on duty to meet people's assessed needs at all times. Not all staff members were sufficiently supported or had received training and up to date knowledge of how to care for people. Regulation 18 (1) (2) (a)