Mr & Mrs F Ruhomutally

Northgate House (Norwich)

Inspection report

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Ratings

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

Overall summary

This inspection took place on 16 and 25 November 2015 and was unannounced. It was carried out to establish whether improvements had been made since our last inspection.

Northgate House is a residential home providing accommodation and care for up to 22 older people. At the time of this inspection ten people were living in the home.

There is a registered manager in post. However, this November 2015 inspection established that they were not in charge of the home on a day to day basis. They were working in the kitchen. 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 registered manager was a partner in the business. The other partner was managing the home on a day to day basis. This person has been referred to as the manager throughout this report.

We last inspected this service on 03 and 04 June 2015 when we found that the service was not meeting several

Summary of findings

requirements of the of the Health and Social 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for: person-centred care, dignity and respect, the need for consent, safe care and treatment, meeting nutritional and hydration needs, premises and equipment, good governance and staffing.

As a result of our June 2015 inspection the service had been placed into special measures. Due to the extent of our concerns we took urgent enforcement action on 12 June 2015 under Section 31 of the Health and Social Care Act 2008 to prevent further people being admitted to Northgate House.

Following our June 2015 inspection we had been receiving monthly action plans which told us what changes and improvements had been made or were planned. The last action plan we received was in mid-August 2015. Following our June inspection the provider had enlisted the services of a consultant to help make the necessary improvements to the service. The consultant ceased supporting the service in mid-September 2015. The manager had not commenced implementing some of the improvement measures we had been told about and other improvement work was still underway.

This November 2015 inspection had found some improvements, particularly in relation to the environment. However, we found that few effective measures had been implemented to rectify many of the breaches we found during our previous inspection. The provider was still in breach of regulations for: personal care, the need for consent, safe care and treatment, meeting nutritional and hydration needs, good governance and staffing.

We found that there was a poor understanding of the Mental Capacity Act 2005. The provider did not ensure that they acted in accordance with this legislation. This had led to decisions being made without people's consent. The manager provided care based on what they thought was best for people who were unable to make decisions for themselves.

Staff providing care during the day were also required to carry out other ancillary duties, which meant that people did not always have their needs met in a timely manner. Staff did not receive the appropriate training or support they needed to ensure they provided the safest and most effective care possible. The recruitment processes were not robust, which meant that there was a risk that unsuitable staff were employed.

Risk assessments were not always in place and when people's needs changed their records had not been updated to reflect their current needs. Therefore staff had little guidance to refer to in order to ensure they could support people safely and effectively.

Medicines were not always administered to people safely. Records in this area were inconsistent and in some instances incorrect.

There was little choice given to people regarding meals. Although we observed staff assisting some people to eat, some people were not supported with appropriate encouragement and prompting.

The home was poorly managed. The change from one partner to the other managing the home on a day to day basis had not resulted in an improved experience for people. There was a poor culture in the home. However, relatives were positive about the care and support their family members received.

Whilst some audits had been implemented since our June 2015 inspection these were not always effective. Other areas of the service management we were told by the manager were still "…a work in progress".

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service remains 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people's wellbeing were not always identified and actions to minimise risks were not always taken.

The risks of administering medicines that people required frequently too close together had not been identified or mitigated.

Staff were not effectively deployed to ensure that people's needs could be met in a timely manner.

Recruitment procedures were not robust.

Inadequate

Is the service effective?
The service was not effective.

Managers and staff did not have the skills or training necessary to support people effectively.

There was little understanding of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were not adequately supported with their nutrition and hydration needs.

Inadequate

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

People's dignity was not always upheld.

People's views were not routinely obtained.

Requires improvement

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

People's needs were not properly determined or planned for in their care records.

Some improvements had been made to support people with social activities, but further improvements were still required.

Requires improvement

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There were widespread and significant shortfalls in the way that the service was being managed.

Whilst there were some systems in place to monitor the quality of the service, these were not effective.

Northgate House (Norwich)

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 16 and 25 November 2015 and was unannounced. The inspection team comprised of an inspector and an inspection manager.

Prior to this inspection we reviewed information we received from the manager, their consultant and the local authority's quality monitoring team. We also reviewed information we held about the service.

During this inspection we spoke with six people living in the home, relatives of two people, both providers and four care staff members.

We observed care and support being provided to people on both days of our inspection.

We looked at the care plans of five people and at various records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Our June 2015 inspection found the provider to be in breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). This regulation refers to the assessment of risks to people's health and safety and ensuring that all reasonable steps are taken to reduce these risks. Some of the concerns established during the June 2015 inspection were no longer relevant as the people our concerns related to were no longer living in the home.

However, during this inspection we found other concerns relating to the assessment of risks to people's welfare and how these were mitigated. Two people told us that they were physically unable to put their feet up on wheelchair footplates. This put them at risk of injury if their feet were to become trapped under the wheels of their wheelchairs when they were in motion.

One person told us, "I'd like to go out more, but my feet get caught in the wheels or stubbed on the floor. I told the [registered] manager but he didn't seem interested." Whilst the person's care plan referred to the person being aware of the risks of being unable to use wheelchair footplates, there was no risk assessment in place to assess the risks and determine what actions could be taken to reduce the risks to the person's safety as far as were possible.

The mobility care plan for the second person was last reviewed in August 2015 and stated, '…prefers to use the wheelchair for long distances without footplate as has pains in leg.' A manual handling assessment and safer handling plan, also dated August 2015 referred to the person's physical restrictions which prevented them being able to raise their legs on to the wheelchair footplate. There was no risk assessment in place to assess the risks and determine what actions could be taken to reduce the risks to the person's safety as far as was possible. This issue had been known about for some time and no action had been taken by the service to reduce the risk to this person's welfare.

One person had recently returned to the home after a stay in hospital and was being looked after in bed. Prior to their hospital admission they had been assessed as at high risk of developing pressure ulcers. This had not been reviewed upon their return from hospital. There was no updated risk assessment or plan of care to show how staff were to reduce the risk of pressure ulcers. Repositioning charts were in the person's bedroom, but they did not stipulate how often the person needed repositioning. There were significant gaps in the records for some days and nothing at all recorded for other days. The manager did not know how often the person required repositioning and told us they would seek professional advice.

We also identified concerns in relation to the timing of medicines administration. One person living at the home told us that they received their medicines, but that the times of administration varied and were often delayed. When we examined medicines administration record (MAR) charts, we found that these were completed without gaps. However, on both inspection days we observed medicines being administered at different times to that indicated on the chart. For example, one person was given their medicines at approximately 11:55am but the chart showed the medicines had been given at 10am. This meant that the charts did not accurately show when people had received their medicines and for people taking medicines prescribed with multiple daily doses there may be a risk that they could have subsequent doses administered too close to the first.

One person had returned to the home from hospital a few days before our inspection. When we commenced our inspection, their MAR chart showed that some of their medicines had not been given in the few days since their return to the home. There was a handwritten record on the chart indicating that some medicines had been stopped in hospital. We asked a member of staff about this who said that the hospital discharge record did not show all the medicines that the person had been taking previously and that they had not yet checked this with the GP to confirm what medicines should have been administered. However, the person's medicines care plan had been reviewed upon their discharge from hospital and stated, '[Person's name] medication no changes on same medication.' Later during the inspection, we were told the GP had now been contacted and confirmed that the person should continue to have their original medicines as prescribed. This meant that the person had not received their medicines as the prescriber had intended from the time of arriving back at the home until the day of our inspection.

Inadequate

Is the service safe?

We found that oral medicines were stored safely and securely, however, we observed that some medicines prescribed for external application were being kept non-securely in people's rooms placing them and others living at the home at risk of accidental harm.

When we checked stocks of medicines against the MAR charts, we found that a medicine for one person was recorded indicating it had been given, but we noted it remained in the medicine container. This meant the medicine had not been administered as indicated which could have put the person at risk of not having relief for their health condition.

As a consequence of these findings the provider was still in breach of Regulation 12 (2)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We found that progress had been made in respect of the fire list. This is list that detailed people's needs in the event that the home needed to be evacuated. Our previous inspection found that this had not been up to date and contained incorrect information. A new up to date fire list was now in use. We found that personal emergency evacuation plans had been put in place for individuals. In the event of an emergency staff had adequate information to safely evacuate people from the building.

Our June 2015 inspection found the provider to be in breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). This regulation refers to the safe management of medicines.

This inspection found that some improvements had been made. For example, storage arrangements for specific medicines had been corrected so that they were secured in accordance with the regulations.

We determined that the provider was no longer in breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

There was still room for improvement in the way that the service managed medicines. Records of the administration of topical creams, were not being recorded. Therefore, we could not be sure that people were always receiving these medicines as prescribed.

Our June 2015 inspection found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). This was because adequate staff numbers were not always deployed to ensure people's needs were met.

During this inspection one person living in the home told us that there were not enough staff on duty. They said, "Staff treat me well, but they are so tired all the time."

Staff we spoke with told us that they did not feel that there were enough staff on duty. One member of staff told us that they had no time to sit with people and that they felt rushed all the time. Another member of staff also said they had no time to spend with people.

Two care staff, including a senior, were on duty during the day. They told us that they were responsible for preparing, serving and clearing up after breakfast, which meant they had to spend time in the kitchen. They also said that at lunch time they had to serve the meal, assist people, clear up and wash up. This again meant they spent a lot of time in the kitchen. We were also told that care staff were responsible for doing the laundry and this took them away from their care duties.

We observed long periods of time in the morning when no staff were present in the communal areas. On the first day of our inspection, there were five people sitting in the lounge, four of whom were asleep. During a two hour period staff were busy attending to other people in their rooms or assisting in the kitchen. They only came in to the lounge on a few occasions to check whether people were safe and their needs were being met.

There were ten people living in the home. The manager told us that there was always a senior carer and a second carer on duty during the day. There were also two carers on duty overnight. We reviewed staff rotas for the period 02 November to 29 November 2015. There were two afternoon shifts when there was only the manager and a senior care staff member present. There were three days scheduled which showed that only one care staff member was on duty from 7am until the senior care staff member was due on duty at 10am.

The provider had not organised staffing arrangements to ensure that people's needs could be met. Therefore, we found that the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Inadequate

Is the service safe?

The service did not follow safe recruitment procedures to ensure that the risks of employing staff unsuitable for their role were minimised. We looked at the staff files for two new members of staff. We found that application forms had been completed, two references had been received and there was a Disclosure and Barring Service (DBS) check in their file.

However, we found that in both cases there was no information about the staff member's conduct where they had been employed in a care position or evidence of attempts to obtain this information. References that had been obtained were personal, provided by friends or people who knew the applicant in a personal capacity. The names of people giving the references did not match the names of referees to be approached given on the application form. The provider had taken up personal references rather than professional ones where the referee would be able to comment on the person's professional competency.

Our June 2015 inspection found the provider to be in breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). This was because people's safety had been compromised because staff had been administering insulin to people without being trained to carry out this task. Following our June inspection staff had received training from the community nursing team. At the time of this inspection there were no insulin dependent people living in the home. Consequently, the provider was no longer in breach of this regulation.

Our June 2015 inspection found the provider to be in breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) in relation to cleanliness and infection control. Our findings included an unclean bath chair lift, stained seat cushions and dirty wheelchairs. This inspection found that improvements had been made. The bath chair lift had been replaced and seating in the home was clean. Cleaning schedules were in place. In July 2015 Norfolk County Council's Public Health team carried out an Infection and Prevention Control Audit in the home. The provider had subsequently made significant improvements in relation to the findings of this audit and our previous inspection. Consequently, they were no longer in breach of this regulation.

However, one staff member told us the service was periodically without gloves, but several staff often bought their own in to use. They told us the manager had informed them that they should only use gloves for personal care when the person had opened their bowels. This put staff and people at risk of cross contamination.

Our June 2015 Inspection found the provider to be in breach of Regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) because of safety concerns we had identified in relation to the premises. This inspection found that improvements had been made. For example, a severely rucked up carpet we had found in one person's room that presented a trip hazard for them had been replaced. A rusted radiator which had an abrasive surface had been repaired. We determined that the provider was no longer in breach of this regulation.

Aside from the issues relating to wheelchairs, people we spoke with felt they were safe. Relatives we spoke with also felt their family members were safe living in the home. Most staff we spoke with understood their obligations in relation to reporting any suspicions of abuse. However, one member of staff we spoke with had not received any training in safeguarding and showed limited understanding of what to do if they had any safeguarding concerns.

Inadequate

Is the service effective?

Our findings

Our June 2015 inspection found the provider to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) because people had not been effectively supported with their nutritional needs. We had identified poor nutritional assessments, little choice available for people and some out of date food.

This inspection did not find any out of date food. However, we still found concerns relating to people's nutritional and hydration needs. One person we spoke with told us, "The food is not good." They said that they never got asked what they wanted and that, "Staff just put it down in front of me." However, another person told us that the food was good and they were happy with what they received.

A staff member told us that one person required a high fibre diet and that the manager had told staff to give the person a breakfast of cereal which comprised of porridge and Weetabix mixed up. The staff member told us they were very uncomfortable giving the person this breakfast because the person didn't like it.

One person was at risk of choking and required their drinks to be thickened. Their prescription advised that the service follow the directions on the tin of thickener which stated that one scoop was required for 100 mls of liquid. A notice in the kitchen said that half a tablespoon per 100 mls was required. The registered manager told us that sometimes they just used a teaspoon of thickener and if the person was unable to drink it, added more. One teaspoon was considerably less that one scoop. When we asked the manager how much thickener the person needed they gave us three different answers. Therefore, instructions had not been correctly implemented and the thickener may not have been used consistently and appropriately.

We observed that the menu for the day was written on a white board in the dining room. The menu was not written very clearly and would not have been easy to for anyone with visual impairments to see. In addition, there were no pictorial menus to assist people with cognitive impairments to make a choice. We did see printed breakfast menus on the dining table showing a wide choice of breakfast was available. However, one member of staff told us that the menus were never used and people were offered what they had available, such as breakfast cereals.

The registered manager told us that they went around the day before and asked people what they wanted for lunch the following day out of the options available. However, they were unable to provide any documentation which showed what choices were available and what people had chosen. They then told us that they knew what foods people liked and made sure people received food they enjoyed.

We observed that one person did not get the support they needed to maintain a good diet. During the first day of our inspection, we observed the person being assisted with their meal. The staff member did not spend sufficient time with the person to give them a chance to eat at their own pace and assumed the person didn't want the meal. They did return with some cheese on toast but did not take time to prompt the person to eat and the person fell asleep. On the second day we observed this same person in their room in the morning. At 9.45am there was a sandwich on the table in front of them which was untouched. At 10.35am the sandwich remained and a plate with some biscuits had been added. We spoke with this person but they were unable to tell us whether they had already had breakfast. When asked, they replied, "No, I go downstairs for that."

This same person had been referred to a dietician due to weight loss. The dietician advised that snacks should be given between meals, "..little and often". In the person's records it stated that food intake should be monitored and foods should be fortified. There was no record of snacks being given and a general lack of records relating to their dietary intake. This meant that staff could not monitor whether the person was having a sufficient nutritional intake. The registered manager told us that no-one living in the home required their food to be fortified.

These findings meant that the provider was still in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Our June 2015 inspection found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) which refers to the training and support of staff. At our June inspection the provider had been unable to give us an overall view of training staff had received. Where they had told us about the training staff had received they were unable to provide training certificates to evidence this. Staff had not received supervisions or appraisals.

Inadequate

Is the service effective?

During this inspection one staff member we spoke with told us that they had received an induction when they started working at the home. However, this consisted of shadowing only and they had not received formal supervision since they started. This person had received some training in their previous role but could not recall having training in areas such as safeguarding, whistleblowing and the Mental Capacity Act 2005. They also told us that they had not received any further training or seen any policies and procedures relating to the service. Nor had they been given any opportunity to look at people's care plans.

The 'Trainee Induction Record' for this member of staff showed that their induction consisted of one day during which only some areas were covered. Key subjects such as fire precautions, infection control, lifting and handling and health and safety had not been signed as completed. When we looked in the person's recruitment file, their application form showed they had not worked in a caring role since 2005.

The manager had accepted that a new staff member had received training from their previous employer and had not reviewed the person's training certificates to confirm this.

There was no training recorded for the registered manager. The manager had taken over management of the home after our previous inspection in June 2015. However, much of the manager's training was not current. Their last training in dementia, first aid and medicines administration was several years out of date. They had recently undertaken Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, but it was clear from people's care records that they had a poor understanding of this.

Only one staff member had received first aid and challenging behaviour training. No staff had received any training in dementia care since 2008. The principal cleaner, who worked six days a week, had not received any training in the safe handling of hazardous substances. The manager told us that eight staff members were employed who were authorised to administer medication. However, only three staff members had up to date training of a suitable level. This meant that people could not be assured they were having their medicines administered by trained and competent staff.

It was recorded that several staff had received training in infection control, but records showed this was done by the manager in 'bite size' sessions. The manager had not undertaken any training in this area themselves since 2006 and was therefore not best placed to provide staff with this training.

Consequently, the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) in reference to the training and support of staff.

Our June 2015 inspection found the provider to be in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) which refers to consent. We had found that there was a poor understanding of the MCA and DoLS. This November 2015 inspection found that despite staff having received training for this in July 2015, there had been little improvement.

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 the 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. We checked whether the service was working within the principles of the MCA.

The service did not ensure that consent to care and treatment was always sought in line with legislation and guidance.

At our June 2015 inspection we were told that everyone living in the home was able to make their own decisions about their care. During this inspection we were told by the manager that two people lacked capacity to make a decision.

In the records for both people there was a 'Consent to Care and Sharing Information' form. In both cases the forms were signed by relatives alongside a printed statement 'signature of person with Power of Attorney'. There was no evidence that the relatives signing had Lasting Power of Attorney (LPA) for health and welfare and therefore legal authority to consent to care on their family member's behalf. We also saw a document signed by a relative to provide consent to vaccination.

Inadequate

Is the service effective?

When we asked the manager whether the LPA had been verified they told us that the relative was the next of kin. Relatives have no legal authority to consent on behalf of another adult unless this has been granted by the Office of Public Guardian or a court of law.

Later in the day the manager confirmed to us that one of these relatives did not have an LPA for health and welfare. This means the service was not acting in accordance with the law by ensuring that decisions made for people who lacked capacity were being made by those with legal authority to do so.

When we looked at the records for these two people we found that the service had contacted a GP to carry out a mental capacity assessment. We considered this to show a lack of understanding about the MCA. The service has the responsibility to assess a person's capacity to make a specific decision at the time it needs to be made.

Another person's care records stated that the person had capacity, but their relative told us that the person sometimes didn't recognise them and they were doubtful as to what extent the person was able to make decisions regarding their care themselves.

We found that there were no assessments of people's capacity to make decisions about their care. We saw no best interests decisions and records did not demonstrate how decisions were being made for people who may lack capacity. For example, a GP had expressed a view that one person lacked capacity to make their own decisions. However, the person's care plan stated throughout that they were able to make decisions. Their care plan showed that due to weight gain their diet was to be changed to 'cut down on fat intake, reduce sugar - no puddings, no mid-morning or afternoon snacks.' However, there was nothing to show the person had consented to this or that this decision had been taken in their best interests. When we had tried to speak with this person they had been unable to communicate with us. A staff member told us the manager had told them not to give the person any biscuits.

The manager told us that they had not made any applications to the local authority to deprive anyone of their liberty in order to keep them safe. In the absence of MCA assessments or best interests decisions we could not determine whether anyone was potentially being deprived of their liberty. The manager was unable to determine whether any applications needed to be made.

As a result of our findings we determined that the provider was still in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We received feedback on the service from three health care professionals who attended the service on a regular basis. They all told us that the service sought their advice when appropriate and that staff followed advice and direction given in relation to people's specific health issues they had been involved with. Whilst reviewing people's care plans we saw instances where staff had identified health concerns in relation to people and that they took prompt action to seek support for the individual.

However, there were also occasions where the service had not acted promptly or in accordance with guidance. No advice had been obtained in relation to the repositioning requirements of one person who had returned home following a hospital stay and was being cared for in bed. The service had not been following guidance from the dietician in relation to one person's nutritional requirements or a GPs instruction in relation to adding thickener to another person's drinks.

Requires improvement

Is the service caring?

Our findings

Our June 2015 inspection found the provider to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which refers to treating people with dignity and respect. During our June inspection we had found several concerns in this area, including poor consultation with people, people's privacy not being upheld and the condition of the external and internal environments.

At this November inspection we received mixed views of the service from people we spoke with who lived there. One person told us, "I wouldn't want to live anywhere else." They had a hospital appointment scheduled on the first day of our inspection. The manager told us that a staff member had accompanied them to hospital. On the second day of our inspection the person told us how pleased they were that someone was there with them on that occasion. They had asked for someone to go with them on previous occasions but no-one had been available to do so. Another person told us they were not very happy in the home but did not want to expand upon this.

One person had made it clear that they did not want to go into the lounge. However, the person had been taken to the lounge at the request of a family member. Upon arrival in the lounge the person became distressed and was then assisted back to their room. The situation had not been handled well because the person's wish to stay in their room had not been respected.

People's dignity was not always upheld. One person was dressed in clothes that were heavily soiled with food.

A health professional told us that on one occasion they had been present staff had failed to protect a person's modesty when they were repositioning them. Another example was given where they requested assistance from staff, who then left a person suspended in a hoist to assist them.

We found that there had been improvements since our June 2015 inspection and determined that the provider was no longer in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However our observations showed that on occasion people continued to be treated without respect for their privacy and dignity and that further improvements were required.

We observed mainly positive interactions between staff and people throughout our inspection. Staff were friendly, patient and kind when supporting people.

Since our June inspection substantial work had been undertaken to improve the environment for people. Repairs had been made both inside and outside of the building.

During this inspection we received positive feedback from the visiting relatives of two people. One relative told us how their family member enjoyed company and when a room became available on the ground floor, their family member had been offered the room, which they had accepted. The service had recognised that the person might prefer to move rooms.

Another relative told us how their family member's health needs were changing and that they required more support than they had previously. They told us staff were very caring and were doing all they could to support the person.

We found that improvements had been made to people's care plans in that there was evidence that people or their relatives were being consulted about some aspects of care provided and we noted some details about people's life histories.

Resident meetings had been scheduled for September and early November but there were no minutes available for these. The last meeting for which there were any minutes had been held on 31 July 2015. People had stated that they wanted more choice for breakfast, would like to go out shopping or for a coffee and have small parties in the home. None of this had taken place.

Requires improvement

Is the service responsive?

Our findings

Our June 2015 inspection found the provider to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to person centred care. During our June inspection we found that people's care needs had not been adequately assessed and planned for and people's social needs were not being met.

During this inspection one person told us that they did not feel they had their needs met very well. When we asked another person if staff helped them when needed they told us, "You just have to do it yourself." Another person told us they had, "….told everyone there are not enough staff on duty but they don't listen." However, relatives told us they were happy with the care that their family members received, they felt that staff communicated well with them and that their needs were being met.

We were not assured that people received personalised care that was responsive to their needs. For example, the care plans for one person for medication and pain stated that they were unable to verbally express when they were in pain. The guidance for staff stated 'Ensure [person] takes their daily medication' but did not provide staff with guidance to assess whether the person was in pain.

All care plans we reviewed stated that the person had agreed to their care plan being reviewed every three months. This had meant that when people's needs changed the service had not always updated their care plans or risk assessments outside of the three monthly review.

One person's health and care needs were changing quite quickly. Their GP was visiting them on a weekly basis. However, their care plan was last reviewed in September 2015. Consequently we could not be sure that their care plans were still relevant and appropriate. Given the amount of ongoing health professional interventions there were few updates recorded in recent months. On the first day of our inspection the person was shouting out very loudly for about an hour. We queried whether the person was in pain and staff said that they were not, but they tended to do this 'for attention' sometimes. There was nothing recorded in the person's care plan regarding this and how staff should respond. The prolonged period of shouting was not recorded in the person's daily notes.

We asked for staff assistance to speak with one person because we were unable to communicate with them. A staff member told us that the person may respond better to them. The person didn't always respond to the staff member's questions, but upon being asked if they were in pain twice stated that they had a headache. The staff member didn't explore this with the person or ask whether they wanted any pain relief. They told us the person was tired and would feel better after a sleep. The person had not been listened to and practical action to relieve their discomfort had not been considered.

Another care plan for 'personal safety' stated that the person preferred to stay in the lounge during the day. On the second day of our inspection we observed this person in their bedroom for the morning. We asked a member of staff why and they said the person was more content in their room and that they could ask to go into the lounge if they wished. We spoke with another member of staff who told us the person was not able to make decisions for themselves. When we spoke with the person they were unable to say whether they preferred to stay in their room.

People's care plans were not always written in a person centred way. One person's care plan stated, 'Keep [the person's] resistive behaviour to the minimum before and during transfers.' There was no information to show staff how to reduce the person's anxiety when being moved.

There had been some improvement in supporting people with their social needs. However, further improvements needed to be made to ensure that activities were tailored to people's individual needs.

An activities staff member worked three to four days a week between 2pm and 6pm. This time period spanned tea time so although employed to carry out activities for four hours a day some of this time was spent helping out during tea times. We observed small groups of people doing quizzes or playing games. The manager told us they were advertising for a second person to come in and support people with activities two mornings a week between 9:30am to 2:30pm.

There was a whiteboard which showed activities due in November. No dates or times were given so people would not know exactly when these were taking place. For Fridays 'talking' had been listed as the activity.

Requires improvement

Is the service responsive?

Whilst there had been some improvements since our June 2015 inspection, the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that they would be happy to raise concerns if they had any and felt that they would be responded to appropriately. Most people living in the home were unable to tell us their views about this. However, two people did not feel confident that any concerns they had would be acted upon.

Inadequate

Is the service well-led?

Our findings

The Health and Social Care Act 2008 requires that where the provider is a partnership, as in this case, that there is a registered manager in post and that the registered manager should be in charge of the day to day running of the service.

After our June 2015 inspection we were advised that the registered manager would not be overseeing the day to day running of the service. This would be carried out by the other partner in the business who is referred to as the manager throughout this report. The manager advised us of their intention to register as the manager and informed us that the registered manager would support the service by working as the cook. No applications to change the registered manager of the service were subsequently received.

During this November 2015 inspection the registered manager told us that they dealt with the finances and did the cooking and wished to remain as the registered manager. The other partner, and the manager, was responsible for all other aspects of the service including people's care, staffing arrangements and the day to day management of the home. Despite being the registered manager of a service with significant issues the registered manager had not participated in staff meetings, resident meetings and was not included on the staff training records.

The providers did not understand the regulatory requirements in relation to the post of registered manager.

Our June 2015 inspection found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which refers to good governance. The June 2015 inspection found that systems were not in place to identify or address issues that affected the quality of service people received.

This November 2015 inspection found that some audits had been implemented, but these were not effective. For example, some questions in the Health and Safety monthly audit were unanswered. These were around whether all staff had fire training, whether there were enough qualified first aiders and about accident reporting. We had found areas of concern in all these areas. There were no comments to say what action needed to take place or when these actions were due for completion. The manager told us it was a "…'work in progress."

The kitchen audit was last carried out on 24 November 2015 and stated that people's lunch choices were recorded in the kitchen. However, people were not routinely given choices and they only received food according to what their perceived likes were.

Whilst some training had been carried out the provider had not ensured that all staff had received the necessary training following our previous inspection in June 2015.

We asked the manager for a record of complaints made but they were unable to produce one. The manager told us that there had been a recent complaint which had been dealt with but it had not been recorded anywhere. They told us that setting up complaints recording was a 'work in progress'. We were unable to establish how many complaints had been made or whether they had been dealt with appropriately.

There was no care plan auditing. Care plans and reviews were usually written by the manager. They told us that they were training senior carers to do this. During the inspection we found that care plans had not been regularly updated when people's needs changed, information was inaccurate and/or contradictory.

There was no system in place to analyse incidents and accidents. People's medicines were not being audited on an individual basis which could have picked up the issues we identified during this inspection. The manager told us that they were working on these issues.

Consequently the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had little confidence that the manager would have been able to identify and act upon some of the areas of concern we found. Until we had raised concerns about the way new staff were vetted and explained our concerns the manager had not appreciated the risks associated with the recruitment of staff.

There was a poor culture in the home. Some staff were wary of repercussions if they raised concerns. We were told that the manager sometimes insulted staff in front of

Inadequate

Is the service well-led?

people or shouted at them, which put everybody on edge. One staff member told us that the manager ignored staff if they raised queries or concerns and wouldn't speak to them.

There had been improvements in the environment. Our June 2015 inspection found the provider to be in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to premises and equipment. The June inspection found that external and internal maintenance of the premises was required and a bath chair lift that was overdue for a service.

This November inspection found that improvements had made to both outside and indoor areas that required attention. The manager gave us a tour of the premises and showed us the changes that had been made. The bath chair lift had been replaced. Consequently, the provider was no longer in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our June 2015 inspection found the provider to be in breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 because they had not sent us information in relation to deaths in the home. Since our June 2015 inspection the provider has used the appropriate notification forms. The provider was no longer in breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because the provider had not assessed risks to the health and safety of service users and do not do all that was reasonable practicable to mitigate these risks. Regulation 12(1)(2)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of staff were not deployed to ensure people's needs were met. Staff did not receive adequate training or support. Regulation 18(1)(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of service users were not being met because people did not always receive suitable food, were not offered choices and appropriate support was not provided. Regulation 14(1)(4)(a)(c)(d)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11(1)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not provide person centred care because people's needs were not always assessed or planned for to ensure their needs and preferences were met. Regulation 9(1)(3)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have adequate systems in place to identify or address issues that affected the quality of the service or the risks people were exposed to. Feedback was not sought from staff or acted upon. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.