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Woolton Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

The home provides accommodation for people who require nursing or personal care. The home is registered to provide accommodate for up to 66 people. The provider closed the nursing unit in the home. The home at the time of this inspection only provided support to people who required assistance with their personal care. At the time of our inspection, there were 21 people who lived in the home. This inspection took place on 16 July 2018 and was unannounced.

There was no registered manager in post at the time of our inspection. 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. At the time of this inspection there had been no registered manager in post for a number of years. This was a breach of the provider's conditions of registration with CQC.

At the last inspection in February 2018, there was an acting manager in post who was being supported to manage the home by a consultant. At this inspection another support manager had also started to work at the home to support the acting manager too. This support manager told us that they were planning to apply to CQC to be the registered manager. They said however that they were not planning to work at the home for long as they had plans to work elsewhere. Another consultant from a different organisation had also been commissioned by the provider to audit the quality and safety of the home. The consultant identified that a range of improvements still needed to be made at the home. Some of the improvements identified by the consultant corresponded with the concerns and improvements that CQC has previously identified in the provider's last three inspections. An action plan to improve the service had been developed by the consultant and the acting manager told us that they had been given a copy of this.

At our last inspection, we found breaches of Regulations 9,10,11,12,13,17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this visit we followed up the breaches we identified at our previous visit. We found that the provider had not taken appropriate action to address our concerns and all of the breaches we identified previously remained. This meant people who lived at the home continued to be placed at serious risk. The rating for the service has not changed. The service remains inadequate and in special measures. This is the fourth consecutive inspection where the service has been rated inadequate with multiple breaches of the health and social care regulations.

At our last three inspections people's needs and risks had not been properly assessed and managed. Information in relation to people's care was confusing, contradictory and difficult to follow. At this inspection, we found that no improvements to people's care planning and risk management had been

made. People's care plans contained some person-centred information but this information was limited. Where people had made their preferences or needs known, support had not always been provided in accordance with them. This placed people at risk of unsafe and inappropriate care.

Concerns were raised at our previous inspections with regard to the implementation of the Mental Capacity Act and people's capacity to make specific decisions about their care. At this inspection, people's decision making was still not appropriately supported in accordance with this legislation. This meant that people's consent was not always lawfully obtained.

People still had no access to social or recreational activities in support of their emotional well-being and we observed that the majority of people sat all day watching the TV. This was the same as at the last three inspections, yet despite this, no effort had been made to ensure that people's social and recreational interests were catered for. People told us there was nothing to do at the home and the place was very quiet.

At our last three inspections, records showed that people did not receive the support they required with their personal care to preserve their dignity and skin integrity. We found the same at this inspection. Records showed that people went significant periods of time without a bath or shower and for the most part only received 'strip washes' or 'bed baths. We also found that some of the records in relation to these issues were untrustworthy.

The number of staff on duty was not always sufficient to meet people's needs. We heard call bells ringing constantly and people waiting unacceptable amounts of time for staff to respond. People we spoke with told us that there were not enough staff and they often had to wait for care and support.

Staff recruitment was not robust enough to meet the regulations. We spoke with one new staff member who had moved over from another care home. They had not been recruited safely and had only received a verbal induction in the home.

Staff were polite and pleasant to people but their support was not always provided in a dignified or respectful way and staff were not always attentive to people's well-being. We saw examples of staff asking people personal questions in public places.

The condition of the building had deteriorated since our last inspection which resulted in people being placed at risk of serious harm from unsafe premises. We also had infection control concerns as continence equipment was not cleaned safely or appropriately which placed people at risk from cross contamination.

The provider's governance arrangements were ineffective. The managerial systems and the provider's oversight of the service failed to identify and address all of the concerns we identified. The provider's lack of action to address these issues both at this inspection and three previous inspections demonstrates they lack the competency and accountability to ensure the service is safe, effective, caring, responsive and well-led. This means that people continued to be placed at serious risk.

At the end of our inspection, we discussed the concerns we identified during the inspection with the acting manager and the support manager. We found they lacked understanding of the issues to be able to ensure that sustainable changes were made in the home.

The overall rating for this provider is 'Inadequate'. It has been inadequate since 2016. This means the service will remain in 'Special measures' by CQC. The purpose of special measures is to:

-□Ensure that providers found to be providing inadequate care significantly improve.
-□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
-□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks were not always assessed or managed adequately.

Staff recruitment was not always safely carried out in accordance with the regulations.

Staffing levels were insufficient to meet people needs at all times.

Medication was not stored safely and the administration of topical medication remained unreliable.

Parts of the premises and its equipment were unsafe and not fit for purpose.

Is the service effective?

Inadequate

The service was not effective.

The provider failed to implement the Mental Capacity Act appropriately when people needed support to make decisions.

Staff were not adequately trained or supported to do their jobs properly.

People's records relating to their health were not always adequate to meet their needs.

Is the service caring?

Inadequate

The service was not caring

People failed to receive adequate personal care as access to a bath or shower continued to be limited.

The way in which people were supported was not always dignified and staff were not always attentive to people's well-being.

Confidentiality of personal information was not always

maintained.

Is the service responsive?

Inadequate

The service was not always responsive.

People's preferences and wishes in relation to their care were not always clearly documented so person centred care could be delivered.

People's needs had not been properly assessed or care planned.

People still had no access to any social or meaningful activities in support of their emotional well-being. People expressed concerns about this.

End of life care plans had been put into place without consultation with the person.

Is the service well-led?

Inadequate

The service was not well led.

The service has had no registered manager for a number of years

The service has been rated inadequate at four consecutive inspections.

The governance systems in place were ineffective in identifying and addressing the serious concerns we had about the service.

The provider has consistently failed to take effective action to mitigate the risk of harm and lacks the competence to do so.

Woolton Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 July 2018 and was unannounced. The inspection was carried out by one adult social care inspector, an adult social care inspection manager and an assistant inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with people who lived at the home, the acting manager, the support manager, three care workers, the cook and a domestic staff member.

We examined a range of documentation including the care files belonging to six people who lived at the home, staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our last visit to the home in February 2018 we identified serious concerns with the safety of the service. These concerns had been raised with the provider in previous inspections that took place in July 2017 and November and December 2016. At this inspection, we found similar issues again. This was extremely concerning as despite the provider having knowledge of these concerns at three previous inspections they had taken no effective action to address them. At this inspection we identified continued breaches of regulations 12, 13, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care files belonging to six people who lived at the home. We saw that the assessment and management of people's risks remained poor. For example, one person had a progressive health condition that placed them at risk of seizures. We found that there was no risk assessment or risk management plan in place to advise staff how to support this person with regards to this condition and no risk assessment or risk management plan in place to assess and mitigate the risk of a seizure occurring. This was a reoccurring issue from the last inspection. We also found reoccurring issues in relation to catheter care and choking risks. None of these issues had been dealt with.

The risk assessments in use for bed rails were still inadequate. The same risk assessment that the provider had been advised was insufficient at the last two inspections was still in use in some people's care files.

We looked at one person's risk assessment for their skin integrity and saw that they needed to have their position changed every two to three hours. We then saw another record that said that the person needed to be moved every hour. We checked the person's records and they had been repositioned every hour during the night but then were left for three and a half hours in the same position. We checked on them a number of times during this period and their position had not changed. This meant that the person was not receiving the support they needed to mitigate the risk of a pressure sore developing in accordance with their care plan.

We looked at the way medicines were managed and found that no significant improvements had been made since the last inspection. This meant the provider continued to be in breach of Regulation 12 with regards to the safe medication management.

Some medicines needed to be given at specific times in order to work properly and to avoid unwanted and potentially dangerous side effects. We found that the time at which medicines were administered was not recorded by staff at the time that they were administered. This meant staff could not be sure that time specific medications or medications that required a set time between doses were given safely. This placed the person at risk of receiving too much or too little of their medication.

Some people who lived at the home required the application and use of prescribed creams and ointment or other 'as and when required' medications. Some of these medicines were not stored securely for example, eye gel was found in one person's room and a tub of prescribed indigestion medication in another person's room. We also found that staff had little or no information on how and when to apply people's topical

medication such as prescribed creams. When we checked people's records we saw that the application of these creams was often inconsistent and unreliable. This was similar to what we found at our last two inspections. It was clear no effective action had been taken to ensure people's creams and other topical applications were administered properly.

Some aspects of the premises and its management were not properly managed and were very unsafe. We saw that a large part of the home was not in use and we were told that these areas were not accessed. We saw that there was a set of double doors leading into these un-used areas that simply had a sign on the door stating 'No access'. These doors were not locked which meant that nearly all of the un-used areas of the building were easily accessible to people who lived at the home and others. This meant there was a risk that people could get lost and go missing in these areas without staff knowledge. We walked around these un-used areas of the home and found that these areas were hazardous. There was broken furniture and equipment was haphazardly stored. There was an open electrical cupboard with a sign that said "Danger 415 Volts" and the home's sluice door was jammed open with the seat from a commode perched precariously on top of the door frame. These areas presented serious risk to anyone who accessed them and especially to people who lived at the home, some of whom had poor mobility, memory loss and confusion.

We pushed open one fire door in the disused part of the building and nothing happened. A second fire door set off an alarm but no-one came to find out why the alarm had gone off and no-one checked to ensure that all of the people who lived at the home could be accounted for. For instance, some people needed to be deprived of their liberty for their own safety, which meant they were not able to leave the home of their own accord. Despite this neither the acting manager, support manager or staff team checked to ensure that these people had not left the building via the open fire exit. We spoke with a staff member about the fire exit alarm. It was clear that they knew the fire exit alarm was ringing but they were unable to tell us which fire exit alarm was sounding. This was because the fire alarm panel which should light up when a fire exit alarm sounds was not working. This meant that a person would be able to leave the building without staff being able to identify where from.

At the last inspection, the provider did not have an up to date fire risk assessment to ensure that the fire safety arrangements at the home were sufficient to mitigate the risk of a fire occurring. This was despite the provider being advised in writing by Merseyside Fire Authority to do so, two years prior. We also raised concerns about this with the provider at the last inspection but again at this inspection they still did not have an up to date fire risk assessment in place. This meant that the provider continued to not know if the fire safety arrangements in place at the home were adequate to keep people safe.

We saw that there was a door kept open all day in the dining room. This gave access to outside. We were concerned about this as this room was often left without staff and people could freely access this area to go outside and leave the service without staff knowledge. We went outside and saw that there was a fire escape stairwell that led to the upper floor that was not in use. At the top of the stairwell was a doorway covered in corrugated iron. The stairwell was littered with broken slate tiles that had fallen off the roof. One slate tile was sticking straight up out of the stairs. We saw further broken slate tiles in a pile in the garden. It appeared that a number of tiles had fallen off the roof. One person we spoke with told us that the roof tiles often fell off the roof and told us that they though this area was extremely unsafe for that reason.

During the inspection we became very concerned about infection control and cleanliness. The sluice was in the part of the building that was no longer in use. We asked the acting manager how continence aids were cleaned and they told us that there were no continence aids in use; that people either used incontinence pads or accessed the toilet. Whilst we were walking around the home we found a urine bottle that was left full of urine in a person's bedroom and commode type seat in use on a person's toilet. We asked two

different members of staff how these were cleaned and both staff members told us these items were cleaned in the person's own bathroom. This meant that people were placed at significant risk of cross infection as their continence aids were cleaned in the same place that they had a wash and cleaned their teeth. This was completely unacceptable and we asked the acting manager and the support manager to take immediate action to rectify this.

One person had a broken bathroom floor, a broken bedroom floor and a faulty door guard which meant that they used a tin of sweets and a walking stick to keep their door open, otherwise the door guard sometimes released without warning. This was reported to both the acting manager and the provider at the last inspection in February 2018. Despite this no action had been taken. This meant the person's bedroom and bathroom remained unsafe and unpleasant for the person to live in.

This evidence indicates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as parts of the premises and its equipment were unsafe.

The acting manager told us that there had been no safeguarding incidents since the last inspection in February 2018.

We saw that staff had received safeguarding training but we were concerned that they did not fully understand their responsibilities in relation to safeguarding. We found issues with safety, lack of personal care and infection control that placed people at risk from potential harm or neglect yet no one in the home had recognised these issues or taken any action to report or respond to them.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding people from the risk of abuse.

At our previous inspections, we found that the number of staff on duty was insufficient. At this inspection no changes had been made. During our visit, we saw that there were limited opportunities for staff to interact with people in any meaningful way and most of the interactions were task related. When people rang their call bell for staff assistance, they rang for long periods of times which meant that people's needs were not met in a timely manner. Some people who lived at the home chose to stay in their bedrooms during the day and we observed that they waited regularly for staff to respond to their needs. For example, one call bell rang for over ten minutes before it was responded to. A number of people who lived at the home sat in the lounge for most of the day and we saw that a staff member was not always present in the lounge to support them. There was no accessible call bell in the lounge to enable them to call for staff assistance when staff were not present in this room which meant there was no way for them to alert staff when they needed help and support.

We asked the acting manager to provide evidence of how they had used information about people's needs to plan safe staffing levels. They showed us a dependency tool that identified if people living in the home were low, medium or high risk. We saw that some people's dependency level had not been assessed correctly using this tool For instance, some people of the people whose needs and care we looked at during our visit had a higher dependency level than this tool indicated. This meant that the information used to plan safe staffing was inaccurate. We asked the acting manager and support manager how they used this tool to determine staffing levels. The acting manager told us that the staffing levels were "what she thought was needed". It was clear that there was no method for determining what low, medium and high dependency meant in terms of staffing. This meant there were no adequate systems in place to ensure that the staffing levels were safe and on the day of our inspection, staffing levels were insufficient and unsafe.

To find out how staffing levels affected people, we asked people who lived at the home for example how often they had a shower or a bath. One person told us, "When [staff name] can, not very often." We asked the resident to clarify 'not very often' for us. "Maybe once a month. They are just always so short staffed."

Another person told us, "They are shorthanded sometimes, that is why I try and help as much as possible by washing myself."

We asked people whether there were enough staff. One person told us, "I do not think so." People's experience of how quickly staff responded to call bells was varied. One person told us, "Sometimes it is not worth pressing the bell."

Another person told us, "Short-staffed they say, but I see them standing around. When I press my bell, they come quite quickly."

On our tour of the home we visited people in their rooms. One person who could not move without assistance said to us, "Can you please call staff for me. I cannot find my buzzer." The person's buzzer was slightly out of their reach and it was not clear how often staff looked in on this person to keep them safe.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about staff recruitment. The acting manager told us that no staff had been recruited since the February 2018 inspection. During the inspection we became aware of one staff member who had "transferred" from another care home that had closed. This was a separate organisation to the care home. This meant it was not possible to simply transfer the person's employment from their previous employer to Woolton Manor Care Home without following safe recruitment procedures. We asked to see this person's recruitment file. We saw that all of their recruitment and employment information related to their previous employment at the other care home. We also saw that they were employed in a different job role at the previous care home to the one they were currently undertaking at Woolton Manor Care Home. No safe recruitment procedures or checks had been carried out prior to their employment at Woolton Manor Care Home and their induction into the home and their new job role was poor.

We asked to see the support manager's recruitment file as they had also "transferred" from another care home. There were no records available in relation to their appointment either.

At the last inspection, the provider was found to be in breach of Regulation 19 of the Health and Social Care Act, as staff had not always been recruited in a safe and robust way. At this inspection, no improvements had been made. The provider continued to disregard the need to ensure effective and robust recruitment procedures were undertaken to ensure that person's employed were safe, suitable and competent to work at the home. The meant at this inspection there was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw that the gas and electrical safety certificates were in date. We also saw that legionella tests had been carried out on the water supply in the home. Moving and handling hoists, beds and air-flow pumps for people's beds had been checked and almost all carried a sticker to attest this. There were also records in place for these inspections. These were both improvements from the last inspection. We questioned however why some equipment to lift people had been marked with a 12-monthly re-test date, when it needed to be six-monthly in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Inadequate

Is the service effective?

Our findings

At our last inspections in July 2017 and February 2018 we found that the provider had failed to ensure people's legal right to consent was obtained in accordance with the Mental Capacity Act 2005 (MCA). This meant they had breached Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we looked at this again and found insufficient improvements had been made to ensure people's consent was lawfully obtained.

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. We found this legislation was not properly followed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found this legislation was not properly followed.

We saw that one person with mental health needs had bed rails in place to prevent them from falling out of bed. Bed rails require formal consent for use, as they are considered a form or restraint. There was no evidence that the person's consent had been sought and no evidence that a mental capacity and best interest process had been followed to ensure that the bed rails installed were in the person's best interests. This was a concern identified at our last inspection that had not been addressed.

We saw that a number of people had anticipatory care plans and DNA CPR (Do not resuscitate) plans in place. These had been put into place without consultation with the person involved, some up to four years previously. These plans all stated that the person did not have capacity to make the decision but there was no mental capacity assessment or best interests meeting minutes to show that they had tried to consult with the person or that the person had been involved in these decisions. This meant that the plans were unlawful and the person could be denied treatment as their consent had not been sought. People's care file also contained conflicting information about people's ability to make informed decisions about their care and treatment. This made it difficult for staff to know how to support people's ability to consent appropriately.

No effective action had been taken to improve the implementation of the MCA at the home since our last inspection. We spoke with the acting manager and the support manager about the MCA. They had limited knowledge of what this legislation was and when it needed to be applied in respect of people's decisions about their care. The provider's and consultant's involvement with this aspect of people's care was also inadequate and ineffective. This meant there continued to be a breach of Regulation 11 of the Health and Social Care Act as people's consent had not always been obtained in accordance with the MCA.

During our visit, we observed the serving of lunch and saw that some people ate their meals in the second communal dining room. The main dining room was being decorated. The support manager told us that they had prioritised this space as it needed to be improved. We saw that table cloths had been added and the tables were laid nicely. This was an improvement since our last inspection. The atmosphere in the dining room were people at their meals was muted. There was limited social interaction between people who lived at the home and staff. Some people were left sitting in the dining room for a long time after the meal had ended.

We saw that people's nutritional needs were assessed and people had a dietary notification sheet in place to advise staff of the person's dietary requirements. We found that some people had health and digestive conditions that impacted on the diet they should receive. The risks these conditions posed had not been assessed and no consideration had been given as to whether the person's diet needed to be modified to prevent unwanted symptoms. For example one person had an inflammatory digestive condition which meant there were certain food types likely to cause unwanted digestive symptoms. Despite this there was no information about what food types this person should avoid and catering staff had no adequate information about this person's dietary needs. Similar concerns were identified at our last inspection. This placed people at risk of receiving a diet that was not suitable for them.

We looked at how staff were supported in their job role and found the arrangements in place to be inconsistent. We looked at three staff files belonging to staff who had worked for the provider for over 12 months. All of the files we looked at contained evidence that staff members had received supervision (support) from their line manager. Some staff files contained evidence that staff member had had received an appraisal but other staff members had not. This meant that the systems in place to review staff competency were inconsistently applied.

We looked at the staff file of a newly employed staff member. There was no evidence that the staff member had received an induction into their job role when they started to work at the home. We spoke with the person. They told us that they had a verbal induction when they commenced working in the home.

We were provided with a copy of the provider's training schedule which was designed to list all of the training undertaken by staff and the date it was completed. The provider offered training in a variety of health and social care topics such as safeguarding, moving and handling, dementia, infection control, fire, food hygiene, diabetes, mental capacity act and first aid. We found that there were significant gaps in all of the training provided. It was impossible to tell therefore whether staff were sufficiently trained to do their jobs. This was a repeated concern from the last inspection.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to staff training and support.

People's health conditions and allergies were identified in their care file. People's health conditions and the support they required to keep them well were poorly described. It was unclear what support they were receiving from staff or other health and social care professionals in respect of these needs, as people's care plans had not always been properly updated. This meant it was difficult to tell if people were in receipt of the support they needed to maintain their health. This was a repeated concern from the last inspection.

Most people had an 'emergency transfer' sheet in their care file designed to be used to provide emergency service personnel and hospital staff with the most important information in respect of the person's needs and care in the event of an emergency admission. Most people's emergency transfer sheets were only half completed. This meant that should a person be admitted to hospital unexpectedly this information would

not be up to date and critical information would be missing. This placed the person at risk of inappropriate care as relevant information in respect of people's care would not be available to other health and social care professional when it was most needed. This was again a repeated concern from the last inspection.

It was clear that despite the provider being advised that people's health and welfare remained at risk due to a lack of clear information and guidance about the care and support people needed, they had failed to take any action to address this. This meant people continued to be placed at risk of avoidable harm. It also meant that there was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At our previous inspections in July 2017 and February 2018 we identified concerns with the way some people's care was provided as it did not always support their right to dignity and respect. At this inspection, these concerns remained.

At the last two inspections, people's personal care charts indicated that people did not receive regular baths or showers and showed that they often went for significant periods of time without having either. This did not demonstrate that people were receiving the care they needed to maintain their dignity or preserve their skin integrity. At this inspection, records showed that no improvements had been made and people continued to go for significant periods of time without having a bath or shower. We also had concerns about the authenticity of people's personal care records. For example, we looked at one person's records and made notes about the frequency of personal care they had received. Some records were missing so we returned them to the office and asked for all the person's records to be provided. When they were provided again we saw that the original records we had previously looked at had been amended to reflect a more favourable picture of the number of baths and showers the person had received. On one occasion, the person's records had been changed to reflect the person had both a bath and a shower on the same day. We asked the acting manager and the support manager if these records had been amended prior to them being returned to us and they said that they had not.

We spoke with one person and saw that their finger nails were over a centimetre long and were not very clean. We looked at the records and saw that the previous week's records said that the person was self-caring with their nails. The three previous weeks prior to this nail care had been ticked almost every day to indicate that it had been completed. It was clear that it had not and that these records were not a true reflection of the care the person had received. We spoke with the person about their nail care. They told us that they couldn't cut their own nails and that staff had to do it for them. They also told us that they were "Desperate to get them done." We spoke to the support manager who told us that they would arrange to get this sorted out. They said that the person who normally attended to this had not been in work. It was unclear why no other staff member had seen to it that this person received the care they needed to maintain their nails in a satisfactory condition.

We saw that people's care files were no longer stored in an unlocked cupboard in communal areas which were accessible to unauthorised persons. However, we did find personal information and records left out in the communal hallway on two occasions. This meant that people's confidentiality was not always maintained.

During our visit, we observed that staff had little time to talk to people in any meaningful way as they were too busy supporting people with their personal care needs. We saw one person in a wheelchair sitting at the bottom of a ramp because they were unable to push themselves up the ramp. A number of staff walked past the person and did not stop to offer help or ask if the person was ok. This did not demonstrate that staff were attentive to people's well-being.

During our visit, some people's call bells range for over ten minutes before they were answered. We observed that some staff simply ignored the call bell, they did not check the call bell panel to see who was ringing for help and they did not check on the person's welfare. They simply walked past the call bell panel without looking. Other staff members checked the call bell panel to see who was ringing for help but then simply carried out with what they had been doing previously without going to check on the person's welfare. The acting manager and support manager were both in the building at the time people's call bells were ringing for long period of time. Yet no-one seemed to take any action to ensure people's needs were met promptly. This did not show that staff members cared about people's welfare.

We also observed a staff member ask a person a very personal, intimate question in the corridor which was a communal area and in our hearing. This did not respect the person's privacy or dignity.

These examples demonstrate a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to dignity and respect.

We asked residents if they now got a shower or bath regularly. As the provider had told us this was happening at least weekly, we asked people, "Do you have a shower or bath weekly?"

One resident said, "Weekly? You got to be joking. It can take three weeks easily." We clarified with the person whether this had improved or got worse recently. The person told us, "It has got worse recently."

Another resident confirmed, "We do not get them [showers or baths]. [I] have to wait months to get a shower or bath."

A third resident told us, "[I get a shower] when they can, not very often. Maybe once a month."

We saw that people who lived at the home were comfortable and relaxed in the company of staff and there were times during the day when we heard them laughing and joking with people. But these interactions were limited. We noticed on this inspection that interactions between visiting staff providing hairdressing and residents were more dignified and respectful.

Inadequate

Is the service responsive?

Our findings

At our previous inspections in July 2017 and February 2018, people's care was not always centred on their individual needs and wishes. At this inspection, we found the same. This meant there was a continued breach of Regulation 9 of the Health and Social Care Act as the provider had failed to take appropriate action to address this.

We viewed the care files of six people. We saw that some people had person centred profiles in their care file. In some cases these were incomplete and had the name of a different care home on the top of the document. We saw that some additional information about the person's preferred daily routines had been added to people's care plan since our last inspection. This was an improvement but other aspects of people's care planning remained generic. This meant there was general information about people's needs but none specific to the individual concerned to enable person centred care to be delivered.

For example, people's end of life care plans were insufficient and generic. People's end of life wishes and preferences were not documented. Plans contained generalised information that had been written by the consultant or other staff at the home on the person's behalf yet there was no evidence that these plans had been discussed with people or that they had been involved in their development. This meant that people could not be assured they would receive end of life care in line with their wishes. End of life care planning was noted as poor at our previous inspection and at the last two inspections staff had not received training on how to support people who were at the end of their life. At this inspection, records showed that staff had still not received training in end of life care. Despite this the provider had failed to take any action to address this which meant there remained a risk that staff may not know how to support people appropriately at the end of their life.

We saw that people's needs were reviewed regularly but information about the person's progress remained limited. It was difficult to see if any changes in the person's needs and care had occurred since the person's last care plan review that staff needed to be aware of. We saw that some people had care plans for conditions that no one knew anything about. For example, one person had a care plan for epilepsy but nothing in the care plan indicated when they had last had a seizure and the acting manager knew nothing about this aspect of their care or when it was last reviewed. This was concerning, especially as we had raised concerns about this at our last inspection with both the acting manager and provider.

At our last inspection in July 2017, the activities co-ordinator had left the employment of the provider and no activities were being provided. We asked about this at our February 2018 inspection and were told the same. At this inspection there were still no activities being provided yet on the home's noticeboard, a full activity planner was displayed promoting a range of activities in July 2018. We asked the acting manager about this, they confirmed no activities were taking place in accordance with the activity planner. This was misleading as it led people to believe that a number of social and recreational events were taking place at the home when they were not.

A person told us, "We need someone to come in who is very good. We need someone who comes in and

keeps us stimulated, "while pointing to their head, "'up here' with activities. Just someone to read to us even, to keep us stimulated. We used to have someone come and do that. But that has not been the case for a long time."

Other people confirmed this. One person showed us their word search book, "That is my 'activities', there is nothing else on."

Another person said "There are no activities. Ages ago we had them" and another person told us "We have got none (activities) at the moment. We used to have an entertainer. [Manager's name] found someone, but they have not been for a while. They are so short-staffed and there is no one to take over."

We found during our observations that staff were still in and out of the lounge and at times there were no staff present. At times there was one member of staff in the lounge handing out medicines, but no one else. Staff came into the lounge to speak to other staff, but did not always greet residents or interact with them. There were some interactions when staff handed out drinks. During our observations, we found that if there was a member of staff present, they might sit in a far corner of the room by the door. Managers had noted in an action plan that activities for people and interactions did not have to rely on a dedicated activities person, but should be for all staff to do. We did not see this in practice.

These incidences were a continued breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the planning, design and delivery of people's care was not person centred.

On reviewing people's care records we saw that people had access to routine healthcare. For example GP's, dentist, opticians and chiropody. Where people needed specialist support we saw that this had been organised for example district nurses, tissue viability services, speech and language therapy, dieticians and special mental health teams. Information in respect of these visits or appointments was difficult to understand and often had not been considered in the monthly review of the person's care or included in their care plan.

The provider had a complaints policy in place. We saw that there had been one complaint since the last inspection from a relative and this had been responded to appropriately.

People's views on being listened to were mixed. We asked a resident if they had a complaint who they would go to. We also asked if they felt their complaint would be taken seriously. "I would go to [manager's name] or [senior staff name], but it would not be taken seriously."

Another person told us, "I have had no complaints so far. I would tell them, but I have not had any."

We observed a staff member asked one person, "Do you want the doors open, to get some air in?", they then opened the doors. A person we were speaking at the time this took place told us, "That is the one thing, it is not nice and warm here." We asked if staff asked whether everyone was happy with the door open. The person told us, "I would say something, but I do not want to interfere."

We asked people who lived at the home if residents' or relatives' meetings took place. They told us there were no residents' meetings. One person told us, "There are no resident meetings. Staff have meetings, we do not."

We asked one person if they had ever completed a satisfaction survey about the service. They told us, "I

cannot remember having done a survey".

Inadequate

Is the service well-led?

Our findings

At our inspections in November and December 2016, July 2017 and February 2018 there was no registered manager in post. There was still no registered manager in post at this inspection. This meant there had been no registered manager for a number of years. 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 provider's failure to ensure a registered manager was in post meant that the provider's conditions of registration with CQC were breached.

The acting manager in post at our last inspection was still in post at this inspection. The acting manager was supported by a consultant contracted by the provider to help improve the service. At this inspection the acting manager was also supported by a support manager. Despite these management arrangements we found that no sufficient improvements had been made. The provider had commissioned another different consultant to audit the quality and safety of the service. This consultant had identified that a significant number of improvements to the home still needed to be made.

For example, the consultant identified that improvements to the management of medication, staffing levels, staff recruitment, care planning, the implementation of the mental capacity act, end of life care planning, the delivery of care and the management of the service were needed. The consultant also concluded that "Concerns raised by CQC had not been fully addressed so the provider must work with the managers and external companies to make sure the home is fully compliant". An action plan for improvement was provided by the consultant but at the time of this inspection none of these actions had been met.

At this inspection concerns were identified again with the accuracy and completeness of people's care records. This was because some of the information about people's needs and risks was confusing and difficult to follow. People's care plans did not cover all of their needs and risks and staff lacked adequate guidance on how to care for people safely or in the way they preferred. This meant there was a risk that people would not receive the care and support they needed. Only four care plan audits had been completed since the last inspection and there were 21 people in the home. The care plan audits that had been carried out did not identify any concerns with the care plans. All of the six care plans we looked at had serious concerns. This meant that the audits were ineffective.

The governance system in place to ensure medication was administered as prescribed required improvement. We saw that there were medication audits in place for tablet or liquid based medication. These were somewhat effective in terms of determining whether the balance of medication in the home matched what had been administered. We found however that the audits had not picked up on the fact staff were not recording the time that people's medication was given in order to ensure that time specific medication or medication with a specific time interval between doses was given safely. The audit also did not check that the administration of topical ointments, creams and gels or the administration of thickening agents had been given as prescribed. This meant that the checks in place had not picked up that staff

lacked sufficient guidance on when and how to administer this medication or that people's medication records showed that these prescribed creams continued to be applied inconsistently. These exact issues were found at the last inspection and brought to the acting manager's and provider's attention.

The governance arrangements in place to ensure the premises and its equipment were safe and suitable remained ineffective. This was because areas of the home remained in need of repair. Parts of the building which were unsafe were still accessible to people who lived at the home placing them at risk of injury and harm. The outside area of the home was unsafe as it was littered with broken tiles that had fallen off the roof. The provider's governance arrangements had not ensured that the provider's fire risk assessment had been updated or that the fire alarm panel was working properly. The home was not secure. People who were not safe to leave the home of their own accord were able to access areas that areas that were not in use and able to open doors that were not sufficiently alarmed for staff to be alerted to the location of the alarm to check on people's welfare. The home's health and safety audit had not been completed since April 2018, the last completed audit showed incorrect information and had not picked up on issues. The maintenance person had carried out monthly safety checks, but we noticed that in their absence these had not been completed since May 2018.

The provider's governance systems continued to fail to ensure that staff recruited to work at the home were recruited robustly. The management system in place to monitor the supervision and appraisal of staff was also haphazardly completed. This meant it was impossible for the acting manager or provider to know which staff members had received adequate support in their job role. The provider's training schedule was also out of date.

Records showed that people did not always receive the care and support they needed to maintain their health and well-being. Personal care records showed that people did not receive adequate support with their personal hygiene, people's skin integrity care was not always provided in accordance with risk management plans and people's support needs were not always met in a timely manner by staff. All of these concerns were brought to both the manager and provider's attention at the last two inspections so it was extremely alarming at this inspection to find once again that no action had been taken to address this.

We spoke with the acting manager and the support manager at the end of our inspection. We explained that we still had serious and significant concerns about the service and people's care. There was little evidence of the provider's commitment and involvement with a programme of sustained improvements and there was no evidence that they had any oversight of the service in line with their legal duty as a registered provider with CQC. We asked about the acting manager about this and they told us that the provider did not complete any audits or checks at the service.

The consultant's involvement was also vague and some of the changes they had made to the service were insufficient and inadequate. There was no adequate improvement plan and there were no available audit records or action plans from the consultant's visits to evidence their involvement. We asked about the acting manager about this. The acting manager told us there was no documentation with regards to the checks undertaken by the consultants and that there was no documented improvement plan in place that they would show us how the consultants intended to bring about positive change. It was clear that the support provided by the consultant and the provider to improve the service was inadequate.

These examples clearly demonstrate that the service continued to be poorly led and people continued to be placed at serious risk by the standard of care at the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The latest inspection report was not displayed in the home. The previous out of date inspection report was displayed. We pointed this out and it was rectified whilst we were at the home.