The Cottage Nursing Home Limited

# The Cottage Nursing Home Limited

**Inspection report**

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## Ratings

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

## Overall summary

The Cottage Nursing Home Limited is registered to provide accommodation and care for up to 53 older people, ranging from frail elderly to people living with dementia. On the day of our visit, there were 44 people living in the home.

The inspection was unannounced and took place on 10 November 2014.

The service has not had a registered manager for three weeks. 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.

# Summary of findings

People's safety had been compromised in a number of areas; not all staff were able to demonstrate that they knew how to identify or respond to abuse appropriately; parts of the home had not been adequately cleaned or maintained and there were poor arrangements for the management of medicines that put people at risk of harm. Bedroom doors that had been wedged open and this put people at risk if there was a fire in the home.

We had concerns about the arrangements in place for obtaining and acting in accordance with the consent of people. Steps had not been taken to ensure each person was protected against the risks of receiving care that was inappropriate and unsafe.

Records did not demonstrate that people had access to health care professionals to meet their specific needs. Care records and risk assessments did not accurately reflect people's current care needs or offer guidance for staff as to how people should be cared for and supported.

People were not provided with choices of food and drink and meals were rushed. Staff support for people in relation to their nutritional needs was not carried out with sensitivity and they showed little respect towards maintaining people's dignity.

We observed that some staff were not always patient and many did not take time to listen and observe people's verbal and non- verbal communication. Throughout the day of our inspection we observed some poor interactions between some staff and people using the service.

Through our observations and by talking to staff we found there was a deeply embedded culture which included a lack of respect, dignity and compassion for people. We found that care was not based around the involvement of the individual, but was task focused, and we observed people's safety was compromised by poor practice.

Records we looked at demonstrated that people's concerns and complaints had not been dealt with appropriately. We were unable to find any information in a format that was suitable for people who were using the service to use in relation to making a complaint.

The provider was not adequately monitoring the quality of the service and therefore not effectively checking the care and welfare of people using the service.

We identified that the provider was not meeting regulatory requirements and was in breach of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Systems for the management of medicines were unsafe and did not protect people using the service.

People were being put at risk because the premises had not been adequately maintained and cleanliness and hygiene standards had not been upheld.

Staff did not have an appropriate level of understanding of their roles and responsibilities to safeguard people in the home.

**Is the service effective?**

Inadequate

The service was not effective.

People were not provided with choices of food and drink to meet their diverse needs. Staff did not support people with eating and drinking with sensitivity and respect for their dignity and respect.

The service was not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and people using the service could not be confident that their human rights would be respected and taken into account.

Staff were not provided with regular training to develop their skills and knowledge to enable them to perform their duties effectively.

We found that people's care and support was not planned and delivered in a way that consistently ensured people's health and well-being.

**Is the service caring?**

Inadequate

The service was not caring.

We found that people were not always treated with compassion, kindness, dignity and respect.

People were not supported to express their views and be actively involved in making decisions about their care, treatment and support.

Care was mainly task focused and did not take account of people's individual preferences and did not always respect their dignity.

**Is the service responsive?**

Inadequate

The service was not responsive.

People did not receive care and support that was responsive to their needs because staff did not have a good knowledge of the people who used the service.

Systems were not in place so that people could raise concerns or issues about the service. People told us that their concerns were not listened to.

# Summary of findings

Relatives we spoke with confirmed they were not kept informed about issues affecting their family members.

**Is the service well-led?**

**Inadequate**

The service was not well led.

The service did not have a registered manager in place and this was having an impact on the leadership and direction for people living in the service and staff.

We found that staff were not supported to question practice and we were unable to find how people who raised concerns, including whistle-blowers were protected.

People were put at risk because systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment were not effective.

# The Cottage Nursing Home Limited

**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.'

The inspection was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed information we held about the service. We also contacted the local authority. We identified a number of concerns about the provision of care within the service and used a number of different methods to help us understand the experiences of people living in the service. We saw how the staff interacted with the people who used the service. We observed how people were supported during their breakfast, lunch and evening meal.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people who used the service. We also spoke with the interim manager, deputy manager, nine relatives of people who used the service, and three nurses, two team leaders, six care workers, the cook and two members of the housekeeping team.

We looked at 10 people's care records to identify if the care they were receiving reflected their identified needs. We also looked at four staff recruitment files and further records relating to the management of the service including quality audits.

# Is the service safe?

## Our findings

People had differing views on whether they were safe. One person using the service said, "I'm alright here. I get looked after." A relative told us, "My [relative] has lived here for one year and they seem happy and safe." Another relative said, "Oh yes my [relative] is safe here. We can speak to anyone if we have concerns and there is a new manager." One person who used the service had concerns for their safety. They said, "I do feel threatened here, I accept what they tell me. I don't like to use my call bell at night because the staff get cross."

We were concerned about staffs' level of understanding of their roles and responsibilities to safeguard people in the home and the action that they should take if they had any concerns about potential abuse or people's safety. We spoke with 10 members of the care staff and found that there were significant gaps and inconsistencies in their understanding and awareness. Three care staff told us they would, in the first instance, confront a staff member if they saw them behaving inappropriately to a person using the service, but said that they would not report it to the manager.

Although other staff were aware of the different types of abuse, they did not have a clear or consistent understanding of how to report or raise any concerns appropriately

We looked at the staff training matrix and found that out of the 50 care staff employed at the time of our inspection, 37 had not received 'Safeguarding of Vulnerable Adults' training. This meant that the provider had failed to take appropriate action to ensure that staff understood signs of abuse and knew how to appropriately report their concerns. This exposed people to unnecessary risks and a lack of protection.

We found that the manager had not taken appropriate action to ensure that incidents or safeguarding concerns were reported to the relevant authorities for consideration and potential investigation. Required alerts and or notifications had not been made to the Local Authority or to the Care Quality Commission. One staff member told us they had reported an incident of abuse to the previous manager but, "nothing was done about it."

We found that the registered person had not protected people against the risk from abuse and improper treatment. This was in breach of regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not safely or appropriately managed. Staff explained that they gave some people their medicines crushed and hidden in their food. We found that 27 people were given their medicines crushed and mixed with yoghurt. Although staff said that this was in the person's best interests, covert administration of medicine is not acceptable practice unless a best interests assessments have been completed, relevant professionals and people had been involved and this method of administration agreed. We found that these requirements had not been fully met.

We observed a medication round taking place and saw staff using a pestle and mortar to crush peoples' medicines. We saw that the equipment was not cleaned between medications being crushed and that residue in the bottom of the mortar was mixed with the next persons' medicines. This exposes people to unacceptable risks of having their medicines contaminated with other medicines.

We looked 12 Medication Administration Records (MAR) and found there was no information recorded to guide staff how to give medicines which were prescribed "when required" or as a variable dose. We asked the deputy manager if this information was available and they told us it "might be in the care plans." However she was not able to find this information for us. We looked in 10 care plans and were unable to find any information that would guide staff in the administration of these medicines.

The MAR charts showed gaps and omissions in the recording. We checked the gaps identified and looked to see if these medicines had been given. We found the tablets corresponding to the omissions had been removed from the Monitored Dosage System (MDS). However, we found no evidence in the care records that people had received their medication and there was no record in the disposal record book to confirm that these tablets had been disposed of

We found that controlled drugs were not stored securely. We looked at the controlled drugs cabinet and found that there was a number on the lock of the cupboard. We also found that the keys were numbered and correlated the

# Is the service safe?

numbers on the locks. This meant that the controlled drugs were not secured as required. We examined the Controlled Drugs register and looked at the records for one person who was prescribed a controlled medicine. We found omissions in the controlled drugs register where two staff are required to sign for each transaction. We found only one staff signature on four occasions in October and November 2014.

We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our visit we found that people were not protected against the risks associated with unsafe or unsuitable premises. We observed 13 bedroom doors wedged open with door wedges and bedroom furniture. These were fire doors with a self-closing mechanism which enables the door to close when the fire alarm is raised. Wedging the fire doors open meant that people may be put at risk if there was a fire in the home.

We found that the registered person had not protected people against the risk of unsafe premises. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the cleanliness of the home. One person said, “The cleaners’ clean all the time, my room is clean.” A relative said, “My [relative’s] room is clean.” However we were concerned about the poor level of cleanliness that we observed and the impact this had in relation to the management of infection control within the home. We found that carpets and furniture in the home were stained. There were a number of chairs in the lounge which were heavily stained and had not been cleaned. One chair appeared to have dried food matter stuck on it. The carpets in the main lounge and hallways were also stained and had not been cleaned and there was a strong smell, of what appeared to be urine, throughout the home.

We looked at toilet areas in the home and found broken radiator covers and rusty radiators. There were broken tiles, that were cracked and falling off the wall near a basin for hair washing. The grout around the tiles was discoloured and we saw that toilet brush cleaners were soiled with what appeared to be faeces. We found that appropriate hand washing facilities were not available and that there was a lack of antibacterial gel in communal areas for people to use. In addition the laundry facilities did not have soap dispensers to allow staff to wash their hands and prevent the risks of infection

Infection control training records showed that out of the 50 care staff employed, infection control training for 23 staff had expired and the remaining staff had not completed the training; this included housekeeping staff.

We found that the registered person had not protected people against the risk of, preventing, detecting and controlling the spread of infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Most people told us that there were enough staff on duty throughout the day and night to meet their needs. However, one relative told us, “They are always short of staff.” A staff member also told us, “I don’t think the care here is effective as there are not enough staff.”

The deputy manager told us that they did not use a specific tool to assess dependency levels of people’s needs when calculating the required staffing numbers. They confirmed that staffing arrangements included two trained nurses and eight health care assistants on duty throughout the day. These numbers were reduced to four health care assistants on duty at night along with one trained nurse. We found that the staffing numbers were consistently maintained at this level and did not see any days on the rota where there was a shortage in staffing numbers. We found that the staffing numbers provided were adequate to meet people’s identified needs.

We looked at four staff recruitment files. They contained evidence that checks had been undertaken to ensure staff employed were suitable to work with people living at the home.

# Is the service effective?

## Our findings

Six relatives felt their family member was well cared for. However one relative told us "The care could be better. I feel I need to visit every day to take care of my [relative]" Another relative said that their family member had sustained injuries due to poor moving and handling procedures and said, "The staff need more training."

The training and development systems in place were ineffective and failed to ensure that staff received the training they need to care safely and appropriately for people in the home. There was little evidence to confirm that staff received a comprehensive induction and we found that most had not received or been enabled to keep up to date with the providers mandatory training program.

One staff member commented, "The training is not regular and I need most of my training to be updated." Another staff said, "Staff need more training in hoisting and transferring. There are a lot of new staff and they are not trained properly, so we as staff feel vulnerable as well as putting the service user at risk."

We found that 22 out of 50 staff had not completed moving and handling training. This put people who use the service at risk of unsafe moving procedures. We observed one person being hoisted by two staff members. We noted the sling on the hoist was not secured properly and the brakes were not put on the on the wheelchair, allowing for movement. This exposed this person to unacceptable levels of risk

The staff training program also failed to take account of the needs of people in the home and to ensure that staff had the skills and competencies required to appropriately care for people living with dementia. We found that staff had little knowledge of caring for a person with dementia care needs and this was confirmed through our observations of care practices. The training matrix confirmed that out of 50 care staff, 13 had not received training in caring for people with dementia. A staff member commented, "We definitely need more training in this area."

We found that the first aid training for 13 staff members had expired and this training had not been completed by the remaining staff working at the service. This meant there were no qualified first aiders working in the home. In addition we found that 38 staff had not completed food hygiene training and 33 staff had not received fire training. Therefore staff were not adequately supported to acquire and maintain the skills and knowledge to meet people's needs effectively.

Some staff felt they had not been supported by the management of the home and one staff member commented, "My mandatory training is up to date. I wanted to gain another NVQ to allow me to do care planning and more services but I was told no." Staff said that they would benefit from further training.

We were informed by staff that they had not received supervisions on a regular basis and records we looked at confirmed this. One staff member commented, "The previous manager did not deal with issues we raised at staff meetings or supervisions." Staff we spoke with felt there was poor communication which made them feel unsupported.

We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that the human rights of people who may lack mental capacity to make particular decisions are protected. DoLS are required when this includes decisions about depriving people of their liberty where there is no less restrictive way of achieving this

Care files we looked at demonstrated that the provider was not following the MCA Code of Practice because assessments relating to people's capacity in relation to specific decisions had not been completed appropriately. For example, the care file for one person highlighted that they became aggressive while receiving personal care. We saw that a MCA assessment and best interest documents had been completed by a senior staff member to allow staff to restrain the person while providing personal care. We were unable to find any evidence that anyone else had been involved in this decision or that this was the least restrictive practice. We were also unable to find any evidence of the type of restraint being used for this

# Is the service effective?

individual or that staff had received training to use appropriate restraint safely. This meant that the person may be at risk of serious harm from inappropriate use of restraint by staff.

We found that 27 people were receiving their medicines covertly. We looked at the care files for five of these people. We saw that Mental Capacity Assessments and best interests' documents had been completed by a senior staff member. However, we were unable to find any evidence of any other people being involved in this process, such as a health care professional, an advocate or a person who knew and understood the person.

The care file for another person contained a 'Do not attempt cardiopulmonary resuscitation' (DNA CPR) form that had been transferred with them from a previous placement. However, we saw a written statement in the same file stating that the person was of sound mind and wished to fight for life. This had been signed by the person using the service and by a witness. This conflicting information meant that the person was at risk of receiving inappropriate treatment and their human rights may not be taken into account.

Staff told us they had not received any training in the Mental Capacity Act 2005 and training records we looked at confirmed this.

We found that the registered person had not protected people against the risk of unsafe care and treatment because the systems in place to obtain consent were not effective. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with seemed happy overall with the food provided by the home. One person said, "The food is very nice." Another person commented, "The kitchen staff are nice they get me quorn as I like to eat vegetarian. They know I like lasagne so they do a vegetarian one. The food is good." However a relative said, "My [relative] is not asked what they would like for dinner. They like fish and chips from the chip shop but never get them. Also, they used to have a cooked breakfast every day, but they are lucky if they get one on a Sunday now." Another relative commented, "I visit every evening to support my [relative] with their evening meal. I dislike how staff feed people; it's too fast and too rough."

The chef and an assistant cook that we spoke with demonstrated a good knowledge of people's likes and dislikes and said they would always prepare something different for people if they didn't like what was on the menu.

We made observations over the breakfast, lunch and evening meal periods. When we arrived at 07:30am for our inspection there were 18 people sitting in the lounge waiting for breakfast to be served. One person told us, "I have been up early and I have not had breakfast." The time was 08:30am. We observed three people calling out for food and at 08.40am there were still 12 people who had not received their breakfast. This meant that people did not receive appropriate care and support to make sure they had enough to eat and drink and enjoy mealtimes without feeling rushed.

We saw that people in the large lounge were seated in arm chairs and small tables were used so people could eat their meals from them. A member of the housekeeping staff was cleaning the lounge where people were eating. Staff handed out food to people with little or no interaction and people were not offered a choice. We observed one member of staff roughly waking up a person to give them their breakfast. We observed people who required assistance with feeding were rushed by staff. We noted one staff member take 2 minutes to feed a person a bowl of porridge. This person then ended up with porridge down their clothing. During breakfast the atmosphere was hectic and there was no structure or organisation with the distribution of food.

We looked at the menus' and found there was only one choice of meal available. This was shepherd's pie on the day of our inspection. We saw a lot of pureed meals which had been served in individual portions. However we saw staff then mix these together when supporting people to eat their meals. This meant that people's meals were not served in an appetising way to encourage enjoyment.

We saw that care plans were in place for eating and drinking, however people's dietary preferences were not identified. Care files contained some information about people's nutritional screening such as a nutritional assessment and a record of their weight. However, we saw gaps in people's dietary records. For example, in one file for a person who had been identified as being at risk of not eating or drinking enough, a record of their food and fluid

# Is the service effective?

intake had not been fully completed. This meant that an accurate record was not available of this person's dietary intake and this placed them at risk of receiving inadequate nutrition and hydration.

We found that the registered person had not protected people against the risk of inadequate nutrition and hydration. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The environment was not supportive for people with dementia care needs. There was no signage for toilets and bathrooms to make them recognisable for people using the service. There were no features for interest, different settings or welcoming dining areas and the furnishings were sparse. We observed several soft sponge chairs which made it difficult for people to get out of and some windows in the main lounge area were cloudy and obscuring the view. In the older part of the home the bedrooms were cold and dark. We saw one bedroom in this area which had large holes in the walls, fluorescent lights, a sink but no toilet. The sink had a label over it which said, 'Not drinking water'. The mirror over the sink was damaged, the wall paper was torn and the ceiling had patches of discolouration. The formal dining room in this area of the home was unused and tables were covered with plastic table cloths which were sticky. There was office equipment and filing cabinets stored here. There was a toilet near the dining room and we found the toilet seat was brittle and the edges sharp. This does not ensure people are safe and secure in a well maintained environment.

We found that the registered person had not protected people against the risk of an unsafe and inadequately maintained environment. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with people and their relatives about how their health care needs were met. One relative told us, "When my [relative] is ill I prefer for them to be in hospital as they are more professional. They leave it too long before getting the GP." Relatives told us they were not always kept informed of changes in their relative's health needs. One relative said, I am not informed if there are any knocks or bruising that occurs or any unexplained marks to my [relative]. I have not seen my [relatives'] care plan."

One staff member we spoke with said, "I don't get told anything and would not know if anyone had been poorly over a weekend." Another staff member told us, "Communication is not very good." This meant that people, or those acting on their or behalf, were not always involved in making decisions about their care and meant that some people did not feel listened to, respected or have their views acted upon.

Staff told us that they supported people to attend required appointments when needed. They also told us that they made referrals to relevant healthcare professionals should the need arise. We saw a record of visits made by doctors and district nurses. However records showed that people did not regularly access other health care professionals such as dentists and opticians.

# Is the service caring?

## Our findings

People gave us varied responses when we asked about how they were supported by staff. One person said, “Some staff are lovely, but some treat me like a rag doll.” A relative told us, “I have noticed one or two staff that are not very good. I have had issues about attitudes of nurses but I have now resolved this. It could be better.” Another relative commented, “The staff make time for my [relative], they can have a coffee any time they like and the staff are caring.”

We spoke with the activities co-ordinator who told us, “The home does not provide newspapers for some of the gentlemen and one person likes lemon sweets so I buy them for him. I sit with some people at end of life lifting their spirits."

Throughout the day of our inspection we observed some poor interactions between some staff and people using the service. We saw several staff that were abrupt when talking to people and we noted that some staff were “tutting” during the lunchtime meal. We also saw a staff member snatching some porridge away from another person. This meant that people’s diverse needs were not always met in a caring way.

We spoke with nine relatives and five told us they had not been involved in the care planning process with their family member. We saw that people were not always offered choices about their care and were not involved in decisions about their care routines. Throughout the day we saw that people were not given choices about the food they ate or the activities they took part in. Daily routines were not person centred but task-led. For example, staff commenced getting people up at 06:00am whether they wished to get up or not. Many people were left in the lounge throughout the day with little or no interaction.

We were unable to find any information available about advocacy services. Advocates are independent of the service and support people to communicate their wishes. We were told that no one who lived in the home currently had an advocate. They also told us they did not have any information to give to people about how they could find one. This meant people may not be aware of advocacy services which were available to them.

During this inspection we found that people’s privacy and dignity were not always respected. One person told us, “Sometimes the staff get very cross and they say “SIT DOWN” and I ask them not to shout at me, I am not a dog.” One relative commented, “Some staff are very rude. They say things in front of my [relative] which is not right.” Another relative said, “My [relative] is treated with dignity and respect most of the time.”

Throughout the day of our inspection we heard staff address some people as ‘Granddad’ and ‘Mamma’ and we heard staff say to people, “Good boy” and “Good girl, well done.” Many interactions between staff and people using the service were not respectful and people were not always treated with dignity. We observed that most people were not toileted throughout the day. As the day went on we noticed that some people had developed an odour of what appeared to be urine.

We observed several female service users with a lot of facial hair and dirty nails which did not promote their dignity. We observed two staff members who were supporting people with a meal, talking to each other about another person using the service and an on-going medical issue. This meant that some staff did not have an understanding of how to promote respectful and compassionate behaviour towards people using the service. In addition people could not be confident that information about them was treated confidentially and respected by staff.

There were no quiet spaces or lounge areas for visitors to meet with their family members. We saw numerous relatives visiting on the day of our inspection and observed that there was no privacy for them when talking with their relative and we overheard people’s conversations with their family members. This meant that people could not be assured that their privacy was maintained or that staff knew how to promote peoples dignity and confidentiality.

We found that the registered person had not protected people against the risk of receiving care that did not maintain their privacy and dignity. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We saw that people were not supported to be independent and to do as much for themselves as they were able to. For example, we saw that on occasions staff moved people’s walking frames out of their reach. People then had to call for assistance which was not provided in a timely manner.

# Is the service caring?

We saw that people were not supported to use the toilet throughout the day. On one occasion we saw a staff member take the spoon out of a person's hand who was attempting to feed themselves. They then proceeded to feed the person. We did not observe any special cutlery in place for people who required support to eat their meals. This meant that people's independence was not promoted.

# Is the service responsive?

## Our findings

People did not receive personalised care that was responsive to their needs. People told us they had to wait for assistance from staff. During our inspection we saw numerous occasions where people's needs were not met. For example, people were left throughout the day without being supported to use the toilet, some people were left hungry and calling out for food and we observed poor support to assist people to eat their meals. A relative told us, "I don't know if they did a full assessment before my [relative] moved here from the hospital. I ironed out a lot of things as I had an issue with a nurse and I reported her to the manager." Another relative said, "They did a full assessment before my [relative] came here and the staff tell me if there are any incidents but I have no involvement with care planning."

We found that the provider had not always considered the needs of other people who lived at the home before offering a place to someone. For example, we observed one person who, we were told, slapped people. We observed this person being verbally abusive to other people close by and a relative told us the person had pulled people out of their chairs. Prior to our inspection we received concerns from a relative that a service user had entered their family member's room and slapped them around the face. This meant that the needs of people were not always regularly reviewed and where necessary reasonable adjustments made to make sure they received the support they need.

People had not been fully involved in discussions about how their care was assessed, planned and delivered. We saw that people's goals and aspirations had not been documented in their care plans. Care records were not personalised and lacked detailed information about people's background, personality and preferences. They did not demonstrate that people were able to make decisions about what time they got up, went to bed and how they spent their day. All care records we looked at lacked evidence of people's involvement of planning for their care.

We found that the registered person had not protected people against the risk of inappropriate care and treatment. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

During this inspection we found that the service did not routinely listen and learn from people's experiences, concerns and complaints. In addition we were unable to find any evidence that concerns and complaints were used as an opportunity for learning or improvement. One person using the service said, "I don't like to complain because some staff get cross." Relatives had different opinions about raising a concern. One relative said, "**I** would not know who to complain to but I have no complaints." Another relative told us, "We can speak to anyone if we have concerns and there is a new manager." A third relative informed us that they had raised numerous concerns with the previous manager but, "nothing had happened."

We were unable to find any information in a format that was suitable for people who were using the service, to use in relation to making a complaint. We looked at the minutes of the previous two staff meetings and found information about two complaints that had been made by relatives. Neither of these complaints had been recorded in the complaints log and we were unable to check if they had been addressed. This meant that concerns raised by people who use the service or others had not been investigated thoroughly and recorded.

We found that the registered person had not protected people by failing to ensure complaints received were investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Is the service well-led?

## Our findings

The service did not have a registered manager in post on the day of our inspection. However, there was an interim manager and it was their first day at the service.

We found that staff had not been supported to question practice and we were unable to find how people who raise concerns, including whistle-blowers were protected. Staff had poor knowledge in relation to reporting safeguarding vulnerable adults from abuse and we found that many staff had not been trained to understand the aspects of the safeguarding processes relevant to their role. A staff member said, "I witnessed a staff member being rude to a resident so I reported it. Nothing was done." Another staff told us, "I don't think the old manager listened and they didn't deal with things such as complaints."

One relative said, "We have not been made aware there is a new manager, but I have heard the new manager is on the ball." Staff told us they were unaware who the new manager was. We saw that the provider introduced them at a staff meeting on the afternoon of our inspection.

We observed many instances throughout the day of poor interactions between staff and people who use the service. By talking to staff we found there was a deeply embedded culture which included a lack of respect, dignity and compassion for people. We found that care was not based around the involvement of the individual, but was task focused, and we observed people's safety was compromised by poor practice.

We found that there were no formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. We found that people, relatives and staff were not consulted regularly about the delivery of service. Quality assurance records we looked at were not fully completed. Where audits had been completed we found that areas of concern had not been addressed. For example, audits in relation to infection control and cleanliness had not been completed fully. We were provided with an infection control audit that had been undertaken of the home This had not been dated so we were unable to determine when it had been completed. The results of the audit found that carpets, chairs and cushions were 'grubby'. There was an action plan in place, however this only recorded the problem and not the action taken. During our inspection we observed that the areas of concern identified by the audit had not been addressed. This meant that the outcome of the audits had not been acted upon and were not effective.

Staff we spoke with felt there was poor communication within the team and one staff member told us, "With the previous manager there has always been an excuse not to implement new ideas." We were unable to find any evidence of recent relative and service user meetings or how the service gains the views of people. We saw that staff meetings had taken place regularly and records we looked at confirmed this.

Care records were not person centred, and we were unable to find information about how staff communicated with people who were unable to communicate verbally.

We found that documentation did not demonstrate a clear record of accidents and incidents. Concerns raised by staff and relatives of people using the service had not been dealt with appropriately and reported to the relevant authorities, and had not been properly recorded and analysed to identify any patterns. People and/or their relatives and staff had not been encouraged to share their views and experiences on how any concerns and complaints had been managed. People we spoke with did not feel that they were responded to properly and whether anything had changed in light of any concerns they had raised. This meant that the service was failing to listen and learn from people's experiences, concerns and complaints.

We found there were no suitable arrangements in order that staff were appropriately supported to deliver care and treatment to an appropriate standard by receiving essential training and development.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br>**People were not provided with a choice of suitable nutritious food. Staff did not provide support to to people in a sensitive and respectful manner to eat and drink sufficient amounts for their needs.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>**The registered person had not made suitable arrangements to manage and respond to complaints.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**The registered person had failed to ensure that people were protected from risks associated from unsafe or unsuitable premises.** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>The registered person had not made suitable arrangements to ensure that people were enabled to make, or participate in making decisions relating to their care and treatment. Staff did not treat people with respect and dignity. |

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<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The registered person had not protected people against the risk of unsafe care and treatment that included the unsafe management of medicines, inadequate systems in place to protect people against the risk of the risk of, preventing, detecting and controlling the spread of infections and by failing to ensure persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The registered person did not have a formal system in place to effectively assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Personal care<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>People were not protected against the risk of unsafe care and treatment because the systems in place to obtain consent were not effective. |