

Countrywide Care Homes (2) Limited

Argyle House

Inspection report

The Avenue
Dallington
Northampton
Northamptonshire
NN5 7AJ

Tel: 01604589089

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19 September 2018

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Ratings

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

Summary of findings

Overall summary

This unannounced inspection took place over three days on 13, 18 and 19 September 2018. The first day of the inspection was unannounced, we carried out announced visits on the second and third days.

Argyle House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Argyle House is registered to provide accommodation, nursing and personal care to up to 87 people in one adapted building. The home is set out over four floors, with each floor set up as a separate unit providing a particular type of care; these are residential dementia care, nursing care, dementia-nursing care and residential care. At the time of the inspection there were 60 people living in the home.

There was a registered manager in post. 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 previous comprehensive inspection on 3 and 4 April 2018 the service was rated 'Requires Improvement'. We found concerns in relation to the governance of the service, record keeping and the measures in place to ensure that people's personal information was stored securely. We also found concerns with staff deployment in the home. The provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make improvements in relation to the governance of the service, confidentiality, record keeping and staffing levels. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations.

At this comprehensive inspection, we have found that the required improvements have not been made. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling

their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

Many of the people using the service were extremely vulnerable, and highly dependent on the care and nursing staff supporting them. Our observations of peoples' needs, during our inspection showed that they were not always receiving the necessary support to ensure risks to their health, safety and wellbeing were being effectively managed. There was a lack of care delivered to meet people's individual needs and maintain their dignity.

We found there to be insufficient numbers of staff working at the service to keep people safe. People had experienced and were at risk of experiencing unsafe care and treatment as a result.

Care was not always planned and delivered to ensure people's safety. People at nutritional risk and those at risk of developing pressure sores had experienced unsafe care and treatment and there was a lack of monitoring in relation to people's nutritional intake. We found that medicines were not always safely managed and that medicines records were not completed accurately.

People's dignity was not being maintained at the service and their privacy was not always respected.

People's personal preferences in relation to their care was not always considered and people lacked stimulation and choices about how they spent their time. People did not feel listened to by the provider, as they had raised concerns about the service they received but no action had been taken.

There were elements of environmental safety that needed to be addressed to ensure that the environment people lived in was safe. Risks posed by the environment had not been identified and as a result had not been resolved. Where risks had been identified insufficient action had been taken to mitigate these risks. We found that some areas of the environment were malodorous and the principles of infection control were not consistently adhered to. Food hygiene measures had not been effectively implemented and this posed a risk that people would be provided with food that was not safe to eat.

There was a lack of effective monitoring in place at the service and this had resulted in poor outcomes for people using the service. Ineffective quality monitoring systems had failed to pick up and address the failings we identified during our inspection. There was a lack of clinical leadership within the home.

We found individual staff to be caring and compassionate towards people, however, due to staffing levels at the service they lacked time to be able to spend with people. Care being delivered was often task focussed.

Staff were provided with appropriate training, however did not always put this training into practice, due to time constraints when providing people's care.

People were supported to maintain good health. Staff had the knowledge and skills to support them and there was prompt access to healthcare services when needed.

The principles of the Mental Capacity Act 2005 were followed at the service and people had assessments and best interest decisions documented when needed.

At this inspection we found breaches of five regulations of the Health and Social Care Act 2008 (Activities) Regulations 2014. The breaches we identified posed a significant risk to people who used the service due to the complexity of their care needs. Full details regarding the actions we have taken are added to reports after any representations or appeals have been concluded.

Due to the breaches of regulation we identified during our inspection and the risk that these posed to people, we made a number of safeguarding referrals to the Local Authority as we were concerned about people's safety and well-being.

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.

There were insufficient numbers of staff, which put people at risk of unsafe care and support.

The provider had failed to identify and address serious risks to people's health and well-being.

Medicines were not being managed safely and people could not be assured that they would receive their prescribed medicines.

People were not always protected from environmental and infection risks, as measures in place to identify and reduce these risks were not always sufficient.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People were not adequately supported to have enough to eat and drink.

Staff had access to supervision but this process had not enabled them to raise concerns they had regarding some aspects of the service.

Staff received appropriate training, but did not always put this training into practice.

People were supported to access relevant health and social care professionals to ensure they received the care and treatment that they needed.

The principles of the Mental Capacity Act (MCA) 2005 had been applied appropriately.

Is the service caring?

Inadequate ●

The service was not caring.

People's dignity was not maintained and their privacy not always

respected.

Staff lacked time to spend with people.

People did not have choice in how they spent their time due to low numbers of staff working at the service.

Is the service responsive?

The service was not always responsive.

People did not always receive care to meet their individual needs and there was lack of consideration around how people would like their care delivered to them.

Complaints were logged when these were identified, however, people and relatives, we spoke with felt that issues they had tried to raise had not been adequately responded to.

People's care plans were reviewed with them on a periodic basis.

The provider had appropriate systems in place to support people's communication needs.

Requires Improvement ●

Is the service well-led?

The service was not well led.

Appropriate systems to monitor the quality of care that people received had not been implemented.

Areas identified at the previous inspection in relation to the deployment of staff and governance of the service had not been resolved by the provider.

The provider had not deployed appropriate strategies to address previous breaches of regulation to drive continuous improvement.

Inadequate ●

Argyle House

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 checked 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 prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

This comprehensive inspection took place on the 13, 18 and 19 September 2018 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor, and an expert by experience. A specialist advisor is a person with professional expertise in care and nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of co-ordinating care services for relatives.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us; a statutory notification is information about important events that the provider is required to send us by law. We reviewed information sent to us by other agencies, including the local authority and clinical commissioning group, who commission services from the provider. We also requested information from Healthwatch; an independent consumer champion for people who use health and social care services.

During our inspection, we spoke with seven people who lived in the home and five people's relatives. We also spoke with the registered manager, deputy manager and ten members of staff including care staff, nursing staff, and catering staff. We also spoke with two health care professionals who were visiting the service during the inspection. We looked at eighteen records relating to people's care needs and eight staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, quality surveys that had been carried out by the registered manager, training information for staff and arrangements in place for managing complaints.

Is the service safe?

Our findings

At the last inspection in April 2018, we rated 'Safe' as 'Requires Improvement' and the provider was in breach of Regulation 18 (1) Staffing. We asked the provider to take action to make improvements in relation to staffing levels. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations. They stated that they would be compliant by 31 August 2018.

At this inspection, we found that the provider had not taken sufficient action to meet the breach in regulation and comply with the action plan. The provider continues to be in breach of Regulation 18 (1). This is because they have continued to fail to ensure that staffing levels are maintained to meet people's needs. This ongoing failure has contributed towards the rating of 'Inadequate' in the 'Safe' domain.

People continued to tell us that there were not sufficient staff on duty to meet their needs. During the inspection we spoke with seven people and five people's relatives. Five people and four people's relatives raised concerns about staffing levels. People told us that they often had to wait for support to meet their personal hygiene and health needs, because there were not enough staff on duty. One person said, "The staff try their best, they are so busy with other people and they are so under staffed, no they are not quick to respond to the bell, I am sat here now saturated, my catheter is leaking, I have rung six times, the manager has been once to tell me someone will come." While we were with the person, the registered manager came to tell them that staff would be with them when they could. Another person's relative said, "They are short of staff most of the time, weekends are not very good."

We spoke with care and nursing staff to check whether they felt staffing levels were sufficient. Feedback was mixed, depending on the area of the home where staff were deployed. Staff working in the two areas of the home that provided nursing care raised concerns about staffing levels in these areas. Comments included, "Today, and everyday we washed and dressed ten people, plus pad changes, repositioning and helping people to eat and drink. The pad changes get missed as we do not have enough time to get around to everyone." Nursing staff told us that they didn't have time to complete care documentation and that "there is no time to spend with the residents and I think loneliness is a real issue." People were at increased risk of receiving care that did not meet their basic care needs or address risks to their health and well being, because adequate numbers of staff were not deployed.

In one area of the home that provided nursing care, sixteen people were being cared for. All had care needs associated with dementia, including confusion and behaviours that may place them at risk. All required high levels of supervision to keep them safe. Some people regularly needed two staff to ensure safe movement and handling and to ensure that their personal care needs were safely met. On the second day of inspection we saw that three care staff and a nurse were working in this area. We observed that care staff were often engaged in caring for people in their rooms and that other people in the unit were regularly left unsupervised or waiting for their care to be delivered. We saw that no staff were visible in communal areas for prolonged periods and people who had been identified as at risk of falls or behaviour that may affect others were left without support or supervision.

We saw that low staffing levels were affecting most aspects of care provision and there were a number of areas where the quality and safety of the care provided were being compromised. In the nursing units we saw that people were only having their very basic personal care needs met and that at times they had to wait significant periods of time to be attended to. Due to the lack of staff; people were not receiving care that adequately met their needs; this posed a risk to their health and wellbeing.

This was an ongoing breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care that ensured their safety. We found that risks to people's health had not always been adequately planned for and this put people at risk of harm. For example, where people had been identified of being at risk of pressure sores, we found that the care and treatment being provided did not protect people from the risk of developing pressure areas. We saw one person required support to change their position in bed every three hours to minimise the risk of them developing a pressure sore. During the inspection we saw that this person remained in the same position for nine hours. We also saw that on another occasion the document in which staff recorded this support had not been completed overnight for eleven hours.

One person had bed rails in place and was assessed as at risk of entrapment in these. An incident had occurred where this person had been found trapped between the mattress and the bedrails and sustained bruising. Measures had been put in place including changing the air mattress to a foam mattress, and the use of wedges in the bed to prevent further entrapment and regular visual observations. During the inspection, we observed the wedges were not securely in place in the bed and staff were not regularly checking that these were in place. The person remained at risk of entrapment. as staff were not following the system in place to reduce this risk.

Another person was at risk of choking. Their speech and language therapy assessment stated, 'Staff to continue to try and sit [person's name] as upright as possible for all meals and drinks.' During the inspection we observed a member of care staff use the electric bed to sit the person up for their meal. The person was not sat up as advised in the speech and language therapy assessment. Staff mixed all of the pureed food into one mass and proceeded to spoon large spoonfuls of food into the person's mouth, with no explanation of what they were doing. The person was at risk of choking as they were not sitting in an upright position and had not been made aware that food was going to be placed in their mouth.

People did not receive the support they required to mitigate their risk of falls. For example, one person's care plan stated that they required thirty-minute visual observations and two crash mats to be placed by their bed. We observed that the thirty-minute observations were not taking place, or recorded adequately. The chart from 17 September 2018 had three entries after 4.30pm which were unreadable, the next entries made were at 8am on the 18 September. During the inspection we also saw that the crash mats were not in position to break any fall, as one was propped up against the wall by the window and the other mat was under the bed. The person had experienced numerous falls leading to multiple bruises to their head and arms; insufficient action was being taken to mitigate the risk of falls.

Risks associated with people's health had not been identified in their care documentation or acted upon. Care plans were not implemented until this was identified by inspectors during the inspection. For example, we saw that people with diabetes, epilepsy and specific dietary needs did not have care plans in place to guide staff in how to meet their needs.

People could not be assured that they would receive their medicines as prescribed by their doctor. For

example, one person was prescribed an injection to be administered every three months. This was due to be administered on the 12 September; on the first day of inspection we saw that it had not been administered. We brought this to the attention of staff who contacted the GP for advice and this was referred as a safeguarding alert. Staff had not identified the error, which put the person at risk of harm as they had not received their prescribed medicine.

We saw that the service was relying on agency nurses to cover night shifts and that there had been an increase in the number of medicines errors that people experienced on these shifts. People were at risk of harm due to not receiving their prescribed medicines and the provider had insufficient measures in place to mitigate this risk.

Medicines records were not consistently completed. There was not always a signature on the medicines administration record (MAR) to confirm that creams had been applied at the frequency prescribed. One person had a barrier cream prescribed to be applied twice a day; on the MAR from the 20 August 2018 to the 16 September 2018 this was only signed once a day; it was not signed for at all on the 7 September 2018. This placed the person at risk of harm as it was not clear whether prescribed creams had been applied.

This is a breach of Regulation 12(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

There was a plan of regular health and safety audits in place. We saw some areas where improvements were required to the safety of the premises and equipment. One person showed us that they had to lay down towels when they had a shower, as their shower did not drain properly and leaked water over their bathroom floor. They found it difficult to pick up the wet towels and there was a risk that they would fall. In one of the toilets the bracket on the support rail was broken and there was no anchorage point on the floor making it unstable and a falls risk. In another area of the home a portable air-conditioning unit had exposed pipework and a toilet had a broken seat. Actions required in response to some health and safety checks had not been undertaken as needed. For example, regular legionella checks were carried out but no action had been taken on three occasions when water was below the safe temperature. The failure by the provider and registered manager to take timely action upon known risks put people at increased risk

Procedures for the prevention and control of infection were in place to mitigate the risks to people's health and well-being; however, these had not been implemented consistently. One person's relative told us that staff did not always clean the person's catheter site thoroughly and they had to remind them that it should be cleaned daily. They also told us that they had to remind staff that the person's catheter bag required emptying regularly. Some areas of the home were not visibly clean and hygienic. The shower in one area of the home was malodorous and the paint work was flaking off the wall. One person's bedroom and parts of the communal space in another area of the home were malodorous.

The service was relying on agency cooks and we saw that they were not recording basic food hygiene checks to ensure the safety of the kitchen and food served. There were kitchenette areas in each unit of the home, bread and cereals in these areas were not stored in appropriate pest control containers. Some of the kitchenette areas were dirty and fridges had spilt milk on the shelves. There was a risk that people would not be adequately protected from the spread of infection.

People provided mixed feedback regarding how safe they felt in the home. Two people told us that although they felt safe with staff support they were affected by the behaviours of other people who lived in the home; we discussed these concerns with the registered manager. Other people told us that they felt safe; comments included, "Oh yes, I feel safe here, I have never doubted my safety, I feel safe as houses, I can

leave my door open at night without any concerns." And "I do feel safe, because I'm not on my own, my family come every day and visit me."

During our inspection we identified people who were at risk and made safeguarding referrals as a result. People were not consistently protected from the risk of abuse as the registered manager was not aware of all incidents that occurred at the service where people were at risk of harm. We saw that staff had received training in this area and information regarding safeguarding was displayed at the location. Where the registered manager was aware of safeguarding incidents, they had submitted safeguarding alerts to the local safeguarding team and had worked with the local authority in completing investigations as required.

Staff were safely recruited, although action was required to ensure that records relevant to the nursing and midwifery council register were amended to reflect staff's current status. Pre-employment checks were carried out to ensure prospective new staff were of good character. These checks included criminal records checks for staff. This meant that the registered manager could be sure that staff were of good character and fit to work with vulnerable people.

The provider and registered manager failed to learn from previous breaches in regulations and this resulted in people continuing to receive unsafe and neglectful care.

Is the service effective?

Our findings

At the last inspection in April 2018, we rated 'Effective' as 'Good', at this inspection 'Effective' is rated as 'Requires Improvement'.

People were not supported to have sufficient amounts of food and drink. There were several people who were underweight and at nutritional risk during our inspection. People were regularly weighed where possible and these records showed some people consistently losing weight. People's relatives raised concerns about how their family member's nutritional needs were met. One person's relative told us about their family member's food and fluid records saying, "They [staff] have written that [family member] has drank 200ml of tea at for example 11.25am, I have come in at 11.45am and the cup is still there with stone cold tea in it." Our observations confirmed that people were not provided with the support they needed to eat and drink sufficient amounts and that the amount of fluids that people had consumed had been incorrectly recorded which put people at risk of malnutrition and dehydration.

In one area of the home we saw several occasions where people who had been identified at risk of weight loss were not provided with the support they needed to meet their nutritional needs. People were in bed and could not help themselves to food and drink; they were left with meals and drinks they could not manage themselves. Staff recorded on people's food and fluid charts that people had eaten and drunk. However, we saw that the food and drink was left to go cold and then removed by staff without the person eating or drinking anything. For example, on the second day of inspection, we observed that one person did not eat their breakfast and spilt the drink that had been left with them as they were asleep. The person was not offered a mid-morning drink and did not eat their lunch as they were still asleep. Staff did not prompt or assist the person to eat their meals or provide any more drink. The person did not receive support from staff until teatime when they were supported to eat some soup. Staff recorded that the person had received food and drink, but this was not accurate.

We saw that where people had been identified as at risk of weight loss and care plans implemented to support their nutrition, staff did not provide this support. For example, one person's care documentation instructed staff to provide fortified milk shakes and prescribed supplements. On the second day of inspection we observed that the person did not receive these, food and fluid records for previous days also showed these were not being provided as directed for the person.

We observed lunch service in one of the residential areas of the home. We saw that staff did not know what one of the main meal choices was and that people who needed a modified diet because of swallowing difficulties were not given a choice. Before lunch one person was sitting at the table with a bowl of cereal in front of them. They had not eaten the cereal and as lunch was served staff swapped the cereal for their lunch meal, which they then required support to eat. We observed throughout the lunch service that there were not sufficient staff to provide people with appropriate support to eat their meal. Staff moved between people, giving a few spoonfuls of food at a time and had to stop supporting one person to serve the next course. Some people were left with food in front of them for prolonged periods and the food became cold and unappetising because they could not feed themselves and staff were already helping others.

This is a breach of Regulation 14(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

There was a plan for staff supervision and appraisal in place, but staff feedback about the support provided to them was mixed. Some staff said that they felt supported and that supervision gave them the opportunity to discuss any concerns and receive feedback about their performance. Other staff felt that the process had not been effective in enabling them to raise concerns regarding staffing levels. Staff told us that they were concerned about the deployment of staff, but did not have confidence that these concerns were being addressed. Supervision meetings were used to assess staff performance and identify on-going support and training needs; however, staff did not find these effective in addressing their concerns and supporting them to carry out their roles and responsibilities.

Supervision and appraisal records showed that although a plan was in place, there was no regular pattern of supervision for staff. Some staff were receiving supervision regularly, other staff had only received one supervision this year.

People could not be assured that their needs would consistently be met by staff who acted with appropriate knowledge and skills when providing their care. Staff had received training that was relevant to their role, however staff did not always put this training into practice. One person's relative told us, "They train staff, but they don't train them in specialist cases like dementia where they can't think for themselves to drink and eat." Staff had received dementia awareness training but this had not been effective in ensuring people's needs were met.

Staff told us that they were encouraged to attend training and that training was of a good quality. One member of staff said, "We get a lot of training, we've recently done seizure and epilepsy training, including rescue medication and diabetes training, [registered manager] has pushed for this, it's good because it's face to face, practical training." Records showed that staff had accessed training in key areas such as health and safety, mental capacity and manual handling on a regular basis. Nursing staff were supported to access training appropriate to their role including wound care, emergency first aid and clinical skills training.

Staff carried out pre-assessments of people's care needs to ensure that the service was able to meet their needs prior to them receiving care. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their needs. Staff visited people and assessed their needs with family members present to support the person where appropriate. However, the initial assessment had not resulted in care plans and risk assessments that covered all the areas necessary to guide staff in providing people with appropriate care; for example where people had specific health conditions.

The service worked and communicated with other agencies and staff to facilitate a co-ordinated approach to people's care needs. We saw that people had input from a variety of professionals to monitor and contribute to their on-going support. A chiropodist was visiting the home during the inspection and told us, "They [staff] are very good at following up on things." We saw that one person had ongoing support from a specialist nurse, at their last care review they had asked to be referred to a physiotherapist and staff had arranged this referral on their behalf.

People's healthcare needs were monitored and prompt referrals were made when people's health needs changed. One person's relative told us, "[Person's name] has lost some weight, the staff have had the GP out and they're having blood tests, they [staff] keep an eye on [family member]." A district nurse was visiting the home during the inspection and they told us, "They [staff] are on the ball ringing through any issues, for example if people need equipment or blood tests."

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The registered manager and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom. Best interest decisions were recorded in care plans where people were unable to consent to their care. Choices and preference were clear in people's care plans including where people had varied capacity. People told us that staff asked for their consent before carrying out any care. One person said, "They [staff] always ask before doing anything."

Is the service caring?

Our findings

At the last inspection in April 2018, we rated 'Caring' as 'Requires Improvement', at this inspection 'Caring' is rated 'Inadequate'.

People's experience of care was affected by the insufficient staffing levels in the home. The provider had not taken account of people's views, needs and preferences when allocating staffing levels. As a result, people's dignity was not sufficiently maintained. People were left in an unkempt state, in wet beds and were not provided with personal care as often as they wished. One person said, "Some [staff] leave me in my nightie, depends who is on duty, but I don't mind, I know how busy they are." Another person's relative told us, "I came in one day and [family member] was saturated, it was lunch time and all their bedding was wet." The person's relative explained that staff had told them this was because another person had needed support and no staff were available to help their family member.

Our observations confirmed that people were not provided with dignified care. For example, we saw that one person had spilled their drinks in bed. Staff had been into their room, but they did not support the person to change their clothing and bedding; the person was left lying in the drink that had spilled for a long period of time.

We heard another person calling for help to go to the toilet. There were no staff present to hear the request and the person continued to shout. Staff came to the person's room to serve their meal, the person again asked to go to the toilet, the member of staff told them that they would change them, after the meal. The person was aware they required the toilet, however, staff did not provide any facility except for an incontinence pad, and did not ensure they were not left in a soiled pad whilst they ate their meal.

We found evidence that people were not having showers or baths as often as they wished due to a lack of staff. One person told us, "They [staff] don't seem to have time to shower me, I'm lucky if I get one once a month." Another person's relative said, "[Person's name] doesn't have a shower very often... sometimes they have smelled." We looked at the person's daily record and saw that from the 15 August to the 13 September staff had recorded that they had received one shower.

People's belongings were not always treated with respect. People consistently told us that they were unhappy with the laundry service. People's clothing was damaged during the laundry process, their clothing was returned to other people and the labelling of clothing was not dignified. One person said, "They [staff] have marked numerous items of clothing with a pen on the back of my t-shirts with the words [room number], this is not even on the label, it is visible on the back of my neck, it's like being in a prison camp." The person showed us a white blouse and the room number was clearly visible on the outside of the garment. Another person's relative told us that their family member had been bought a new jacket two months ago, they had worn it once, but since then they had seen another person wearing it on several occasions.

This is a breach of Regulation 10(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

2014, Dignity and respect.

Two people using the service had belongings which had gone missing during their time at the service. One person told us, "I have had so many things taken, little trinkets and photo frames, things like that but the carers try to get back what they can, I think they know the [person] that wanders in and out of my room, but my clothes have gone missing and I haven't been able to get those back." Another person told us that their toiletries had gone missing, they said, "I have to lock all my toiletries away in a cupboard because so many of them were going missing. I did report it but it carried on so the only alternative was to put them under lock and key. Staffing levels meant that it was difficult to manage people going into the rooms of others and that people's privacy was not always respected.

At the last inspection we found that people's personal information was not consistently stored in a confidential manner. At this inspection we found that all records were stored appropriately and people's confidential information was treated appropriately by staff.

People were positive about the way individual staff supported them. Comments from people included, "The staff have been very helpful, yes they are respectful, they will always knock on my door and say [person's name], hi, are you ok?" And, "I love my carers, they want to help me but they don't have time." And, "The staff are nice, I can't think of one I don't like, they're all nice," One person's relative said, "They are kind, I get on well with the staff." However, the lack of suitable staffing levels meant that staff were stretched and prevented from consistently providing people's support in a caring and dignified way.

Is the service responsive?

Our findings

At the last inspection in April 2018, we rated 'Responsive' as 'Requires Improvement', at this inspection 'Responsive' is rated 'Requires Improvement'.

People's personal preferences were not always respected at the service and this meant that people did not consistently receive care that met their choices and needs. One person's relative told us that they felt staff often got their family member up too early and when they visited later in the day the person was tired. They had discussed this with staff and agreed with the person that they would get up later. They told us, "Night staff get [family member] up to save the day staff. I come in and [family member] is tired. They [staff] say [family member] will have a lie in, this happens once and then they get them up early again." The person's relative believed that this was because the person's care needs meant it was more convenient for the routines of the service for them to get up early.

People told us that they often had to wait for their care and support and that staff were too stretched to provide a responsive service. One person said, "I do ring my call bell for different things, it can be a good while before they come."

People's relatives also told us that there were not enough staff to provide prompt, personalised support. One person's relative said, "I have been here when [family member] has rung the bell and it has been nearly forty minutes before someone has arrived." And, "Sometimes when [family member] needs the loo, they have to wait because they need two to hoist them. At weekends there only seems to be two on, if I say to the staff [family member] needs the toilet, they say there's only two of us on can they wait a minute." Staffing rotas and allocations reviewed at the time of inspection showed that there were more than two care staff allocated to day shifts on this unit. However, the experiences of people and their relatives reflected that staff were not available to meet their needs in a timely manner

Staff knew people well and were able to tell us people's individual routines, likes and dislikes, past occupations, hobbies and interests. One member of staff said, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right." We observed staff interacting with people on an individual basis in a person-centred way. However, a lack of staff meant that they were unable to consistently provide personalised support.

People were involved in their care planning and reviews of their care needs. The reviews provided updated information about people's needs and preferences. One person's relative said, "We have a review with the [staff] every six months." However, we found that some people's care plans did not provide staff with sufficient information on how their health needs should be met.

People told us that they enjoyed the activities that were provided but recently the activity team had been depleted and this had resulted in a lack of activities. One person's relative said, "They're a bit stuck for going out at the moment as the staff who drives the bus is off. We have a knitting circle, reminiscence and a quiz but [activity staff] is often called upon to fetch shopping." This affected the amount of time available for

activities to be provided. We observed during the inspection that a plan of activities was taking place. However, care staff did not have time to help people to the activities and a lot of the activity staff's time was spent supporting people to and from the area where activities were held.

Complaints had been logged by the registered manager and there was a system in place to ensure that the complaints which were identified and dealt with were adequately recorded and responded to. However, throughout the inspection people and their relatives raised concerns about their care that they had spoken to staff about. The registered manager was not aware of these concerns as it had not been recognised that these people may wish to make a complaint and have their concerns formally investigated.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded bodies to ensure people with a disability or sensory loss can access and understand information they are given. Care plans contained detailed information regarding people's communication needs. Information such as the service user guide was available in different formats.

People were supported at the end of their life to have a comfortable and pain-free death. No one currently living at the home was receiving end of life care but records showed people had been involved in discussions about the end of their life. An end of life care plan had been developed and it was recorded how people wished to be supported at this stage of their life.

Is the service well-led?

Our findings

At the last inspection in April 2018, we rated 'Well led' as 'Requires Improvement' and the provider was in breach of Regulation 17 (1) Good governance. We asked the provider to take action to make improvements in relation to the governance and oversight of the service. The provider submitted an action plan detailing the improvements that they would make to comply with the regulations. They stated that they would be compliant by 31 August 2018.

At this inspection, we found that the provider had not taken sufficient action to meet the breach in regulation and comply with the action plan. The provider continues to be in breach of Regulation 17 (1). This is because they have continued to fail to take sufficient action to effectively monitor and improve the quality of care and support people receive. This ongoing failure in the leadership and governance of the service has contributed towards the rating of 'Inadequate' in the 'Well-led' domain.

The registered provider had failed to implement effective governance systems or processes and had not effectively assessed, monitored or driven improvement in the quality and safety of the care being provided in the home. Although the provider's own internal processes had identified some concerns about the adequacy, safety and quality of care they had failed to take the necessary action to drive improvement and secure compliance in relation to the regulatory requirements. This meant that people living in the home were exposed to unnecessary and unacceptable levels of risk.

People could not be assured of safe care and treatment as this was not being effectively monitored. There was a lack of clinical oversight in the home. Where risks to people had been highlighted, it had not been identified that staff were not following the systems in place to reduce this risk. The systems in place for medicines management had not resulted in people's medicines being managed safely. Medicines audits had not resulted in the improvements required to medicines administration and record keeping. This placed people at ongoing risk of harm.

People who were at nutritional risk were not being provided with care that met their needs and their nutritional needs were not adequately monitored. We found that people using the service who should have had their food and fluids monitored were having very little to eat and drink, despite them being identified as being at risk. Records were inaccurate as staff recorded people had eaten and drunk when they had not; as a result, clinical oversight of people's nutritional needs was ineffective.

Staffing levels weren't assessed or monitored to ensure people's safety. Although a dependency tool was in place, this had not effectively measured staffing needs as we found staffing levels to be inadequate during our inspection. Staff were unable to deliver safe care and support due to the staffing numbers, however, this had not been identified as an issue.

There was insufficient oversight of the recruitment of nurses. During the inspection we saw that a member of staff had been recruited to work as a nurse, we checked the nursing and midwifery council register and there was no record of this member of staff under the name they had provided. The provider explained that the

person had married and had not updated the register with their married name. The recruitment systems in place had not highlighted that the member of staff's details was not correct on the register and the need for further investigation. The lack of an effective recruitment system put people at risk of receiving care from people not suitable to be employed at the service.

The systems in place to monitor the environment and infection control had not resulted in a safe environment where infection control risks were adequately managed. The registered manager was aware that a lack of permanent staff in the kitchen was affecting the quality and safety of food provision, but insufficient action had been taken to improve this. We were told by staff that sufficient amounts and variety of food was sometimes not provided to people. We saw kitchen audits that identified food hygiene checks were not being recorded, but no action was taken to rectify this. At the time of inspection, a new floor was being laid in the kitchen and we saw that staff were having to provide meals in a chaotic environment. No risk assessment had been undertaken or plan put in place to manage how people's meals were provided whilst this work was on going.

During our inspection we identified several incidents which had occurred at the service that posed a risk to people's health and well being. Some of these incidents the registered manager had been aware of but others they did not have any knowledge of. These incidents involved a lack of adequate care and support to people who used the service. There was a lack effective oversight in relation to staff performance and the safety and quality of care being delivered.

Regular meetings took place for people and relatives. Some meetings were chaired by senior staff, others were chaired by activity staff. People and relatives, we spoke with felt that although they were able to raise their concerns about the service, there had been no improvement in response to their concerns. One person said, "The activity person takes the meetings, they're a nice person, they take notes and write things down at the meetings and say they will pass on our comments, but things are the same. If I could change anything it would be more outings, more staff and more atmosphere in here and the food, something a bit different for a change." We saw minutes of residents' meetings for July, August and September 2018 that reflected they were chaired by activity staff. Minutes also reflected that people had raised concerns about staffing levels, the laundry and food. No action had been taken in response to these concerns.

We saw that regular staff meetings were held covering a variety of topics such as nutrition and health and safety. However the discussions that took place during these meetings had not resulted in the improvements that were required to people's care.

Although the provider had a number of quality assurance processes in place at the service, these had not been effective in identifying the number of widespread and significant shortfalls in safety and quality. Where issues had been identified they had failed to make improvements. These failings posed serious risks to people using the service. The oversight in place had not been effective.

This is an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Most people we spoke with knew who the registered manager was and were positive about the registered manager and management team; they described being able to approach them should they need to. One person said, "I think there might be more than one manager, I think one is called [registered manager's name], she is very approachable, I am confident in asking for anything, I don't feel I can't speak."

We found that where the registered manager had been aware of the incidents which needed to be notified

to CQC and other agencies such as the safeguarding team, they had done so. For example, ongoing monitoring of falls and accidents was in place. However, we were not assured that all incidents which had taken place at the service had been notified to us due to the lack of management oversight we found at the service.

The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People did not receive care that respected and maintained their dignity.

The enforcement action we took:

Imposed positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to identify and address serious risks to people's health and well-being. Medicines were not being managed safely and people could not be assured that they would receive their prescribed medicines.

The enforcement action we took:

Imposed positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People were not adequately supported to have enough to eat and drink.

The enforcement action we took:

Imposed positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Appropriate systems to monitor the quality of care that people received had not been implemented. Areas identified at the previous inspection in relation to the deployment of staff and

governance of the service had not been resolved by the provider.

The provider had not deployed appropriate strategies to address previous breaches of regulation to drive continuous improvement.

The enforcement action we took:

Imposed positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were insufficient numbers of staff, which put people at risk of unsafe care and support.

The enforcement action we took:

Imposed positive conditions on the provider's registration.