Mr & Mrs F Barrs

Alton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Alton House on 30 August and 4 September 2018.

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."

Alton House is a care home, providing accommodation and support for 23 adults including people who may have a diagnosis of dementia. At the time we inspected there were 22 people living at the service.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. This service provides personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had 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 our last inspection on 5 and 6 January 2017 the service was rated 'Requires Improvement' overall. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not manage and administer all medicines, safely. The lack of detailed and specific information about people's needs placed them at risk of not consistently receiving the care that they required. The service did not have adequate governance systems in place to ensure people were receiving a service that safe, effective or responsive to their needs.

At this inspection, we rated the service as now being 'Inadequate'. We found that these previous breaches

had not been addressed and we found further breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of the Registrations Regulations Act 2009. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
The service did not oversee people's medicines in a safe way. Covert medicines and PRN medicines were not managed in a way that was safe and in line with best practice. Individual risk assessments were not detailed and not kept up to date. People's changing support needs were not reviewed and staff were not provided with enough information about how to keep people safe from potential harm. The service had not been adapted in a way that kept people safe from hazards and the home was not always cleaned sufficiently which meant people were at risk of cross-infection. In particular, the service did not manage the moving and handling of people in a safe way and people were being moved incorrectly which put them at risk of harm or injury. Staffing levels were not sufficient and therefore impacted on the safety of people who had high level care and support needs. The service did not have safeguarding systems in place which meant that people were not protected from potential abuse.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. At the time of the inspection, applications for DoLS had been made to the local authority in relation to all people who lived at the service. The service had not followed the principles of the MCA correctly and some DoLS applications had been incorrectly applied for. This meant people's legal rights were not protected.

Staff did not receive an induction into the service. We found that training was not always well managed and systems were not in place to ensure all staff received regular support through supervisions and appraisals from their managers. This meant staff were not equipped with the necessary skills and tools to practice in a safe and caring way. People did not always have a varied choice of food they could eat and were not supported to eat in a way that was responsive to their needs and preferences. The service did not engage well with other health and social care professionals, which meant holistic care and support was not being provided and people were at risk of becoming more unwell.

People did not always experience meaningful and caring interactions from staff. This meant people were at risk of social isolation which in turn impacted on their wellbeing. People were not made to feel involved in their care. We found the service did not support people in a way that respected their privacy and dignity, and people were not encouraged to live independently.

Individual care plans were not detailed and not kept up to date, and as a result people did not receive personalised care and support. People were not being supported to engage in activities and their individual social needs were not being met. People did not feel happy living at the service. The service did respond to complaints received. However, the complaints procedure was not made available for people living with dementia or other sensory communication needs and therefore people may not have always felt able to make a complaint. The service was unclear about their approach to supporting people at the end of their life and not all staff knew who needed end of life care.

The service was not well managed: the leadership of the home was not strong and the management team evidenced inconsistencies in their approach. We found that previous breaches had not been addressed and the quality assurance systems in place did not identify the concerns we found during our inspection. People, relatives, staff and the wider community were not asked to provide feedback about the service and there was no evidence of lessons learnt or plans to make improvements. Statutory notifications, required by law, were not always sent to the CQC.

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 home was not safe.

People told us they did not feel safe living at the service.

The service did not have adequate systems in place to manage medicines.

Individual risk assessments were not detailed and did not support staff to protect people from potential harm.

There were no safeguarding systems in place and the service had not identified incidents of potential abuse.

Staffing levels were not sufficient which meant people were not receiving adequate care and support.

People were not protected from the risk of cross infection.

The premises was not adapted to keep people free from potential harm and people were not supported to be moved and handled in a way that was safe.

Is the service effective?

Inadequate

The home was not effective.

People told us they did not feel happy living at the service.

Staff did not understand the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. Restrictive practices were in place without evidence of consent.

Staff did not receive an appraisal, detailed supervisions, an appropriate induction or regular training so they did not have the up to date skills and knowledge to provide effective care.

People did not always have a choice about the food they ate.

People did not receive ongoing assessments of need alongside health and social care professionals.

Is the service caring?

Inadequate

The home was not caring.

People did not always feel staff supported them in a kind and compassionate manner.

People were not given opportunities to express how they wanted to be cared for and supported.

People did not have their privacy and dignity respected.

People were not encouraged or supported to be as independent as possible.

Is the service responsive?

Inadequate

The home was not responsive.

People did not receive personalised care and support.

People's care plans were not detailed or up to date.

The service did not always support people to engage in activities.

The service did not support people living with dementia or other sensory communication to make a complaint.

The service did not provide sufficient end of life care to people.

Is the service well-led?

Inadequate

The home was not well-led.

People, relatives and staff did not always feel supported by the registered manager.

Robust quality assurance systems were not in place to regularly assess and monitor the service, identify areas of concern and where improvements were required.

Systems were not in place to seek the views of people who used the service or gather feedback from relatives, staff and other health and social care professionals.

The service did not always work in partnership with other health and social care professionals.

The registered manager did not understand their legal obligations to submit specific notifications and documents relating to the service to the CQC.	

Alton 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 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.

We carried out a scheduled inspection of Alton House on 30 August and 4 September 2018. This inspection was unannounced and carried out by three inspectors.

Before the inspection we reviewed relevant information that we had about the provider from the local authority and Healthwatch.

The provider had not submitted a Provider Information Return (PIR). A PIR 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.

During the inspection we spoke to seven people living at the service. We spoke to ten staff members including care workers and maintenance staff, the chef, the deputy manager and the registered manager and the owner. We also spoke with seven relatives and two health and social care professionals. We inspected the premises and spent time observing people at lunch time. We also observed ongoing interactions between staff.

We looked at seven people's care plans and other documents relating to their care including their risk assessments and medicine records. We looked at other documents including six staffing files, health and safety documents and quality monitoring audits.

Inadequate

Is the service safe?

Our findings

At our last inspection on 5 and 6 January 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not being managed safely. The service had no guidance for staff about the administration of PRN medicines. PRN medicines are to be taken as needed instead of on a regular schedule. Some medicines were administered without people knowing (covertly). The service was not assessing staff competency around medicines. During this inspection we found that this previous breach had not been addressed.

We found there were no PRN protocols in place. When PRN medicine was administered there was no mechanism for recording why or if it had been effective. One person told us, "I want co-codamol. I am in a lot of pain and I can't seem to get it here." When we asked staff about this they told us, "[Person] is fine". This demonstrated that staff did not understand PRN medicines.

The registered manager confirmed that one person continued to receive medicines covertly and they had a letter from their GP on file to confirm this. However, there was no capacity assessment or rationale recorded as to why this person's medicines were crushed. There was no evidence of involvement with family, no best interest meeting had been held and there was no communication with other health and social care professionals to make sure it was safe. Therefore, the system for managing covert medicines was not robust and did not ensure that people's rights were protected.

During the inspection the registered manager told us they did not do any competency assessments of staff administering medicines. After the inspection we received a chart to indicate most staff had been assessed. We also saw a competency assessment for one staff member administering medicines. However, this was completed through talking to the staff member rather than observing them and therefore did not demonstrate staff were assessed in a sufficient manner to ensure they were administering medicines safely. One staff member confirmed they received medicines training. They said, "Yes, we do long distant training, we do this at home, in our own time. There isn't enough time at work. I found it very long, loads and loads of writing. Time consuming. Not really helpful." This showed that the service could not be sure that staff were adequately trained to manage medicines safely.

We found in one person's bedroom that prescribed medicines were not locked away. For people living with dementia there is a risk that they could misuse their medicines and be at risk of harm.

There were no medicines reviews, or actions taken when medicines were refused. One service user was prescribed Cosmocol 13.8g sachets, one twice a day. Between 13 July 2018 and 30 August 2018, they had refused these 26 times. There was no record of why this was refused or if this had been discussed with the GP.

We observed staff on their medicines round. Twice a loose tablet was found and the staff member returned this to the packaging instead of disposing of it securely. We found that medicine stocks balanced but not all errors were identified by staff. We found that medicines were administered and stored safely. We found that

while one medicine storage cupboard had a thermometer, the main cupboard did not. There were no records of medicines storage temperatures.

Medicines records were up to date and accurate, and signatures and codes were used appropriately. There was a system in place to count medicines, which was completed daily for all medicines given which were not in blister packs. Those which were not given PRN were checked on a weekly basis. Medicines cover sheets were in place for people, however these included people's admission medicines, not their current ones.

People had individual risk assessments. Staff did not always recognise the importance of reading and understanding risk assessments. One staff member said, "We need risk assessments." However, another staff member told us they had not read all the risk assessments and said, "Staff show me [what to do]." Risk assessments looked at how to support people in various aspects including mobility, skin and personal care. We found that overall, the risks to people were not assessed or managed safely as the risk assessments did not guide staff or provide sufficient information about a person to ensure they were kept free from potential harm.

Risk assessments assessed the level of risk in a particular area, but then provided no guidance about how to mitigate those risks. Risk assessments were not regularly reviewed by care staff or management. For example, two people were diabetic but there was no risk assessment in place about how to manage this. Three people had the highest level of risk for falls but there was no guidance available about how to reduce the risk and safely support the person. Another person's risk assessment on moving and handling said, "Hoist is used if [person] is having a bad day." However, on their falls risk assessment their notes said, "[Person] needs the assistance of one person." This risk assessments had not been updated since 3 August 2017 and there was not enough information for staff to know when and why it would be appropriate to use a hoist.

The service supported people with moving and handling by using a hoist and a standing hoist. A hoist is used for people who are unable to weight bear to support them to move around the home. A standing hoist is used for people who can partially weight bear, to assist them to transfer between places. People should be assessed to determine what size sling they would need for the relevant hoist. The registered manager and the deputy manager confirmed that there were no systems in place for people to be assessed by health and social care professionals to ensure the correct sling size or hoist was used and there were no records in people's care plans. This was confirmed by staff who told us, "We only use the standing hoist to support people, there is only one sling used to support each person. [People] do not have their own slings." There was no evidence to show how this moving and handling equipment had been specifically checked for safety.

One person told us, "I have been falling all over the place," and when as asked them if staff were helping they said, "No." One relative said, "Hoists should never be used the way they are. Staff are picking up others in bad way, it upsets me the way they use the hoists. One [person] is transported around in it." One health and social care professional told us, "They lifted a person under their arms rather than with equipment. Also with moving and handling we are getting a lot of people with skin tears and we don't have that with other homes we visit. It wold be good if they had training on that."

Staff told us they received training on moving and handling. One staff member said, "We have regular updates. Yearly training. Just make sure you are doing it in a safe environment." Another staff member said, "Yes, it was e-learning and practical. We learnt with the hoist and the [trainer] was speaking to us. I can't remember when we last had it." When we asked the registered manager how they assessed staff

competency in moving and handling they said, "We are quite often in the lounge so we are watching them all the time." We were advised that the moving and handling training was completed annually, however the service had not had training since March 2017.

The concerns above demonstrated a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not feel safe. When we asked people if they trusted staff to keep them safe, one person said, "No I don't think so." We spoke to relatives who had concerns about people's safety. One relative said, "The only risk is the staff, if [person] died I wonder how long it'd be before they found [person]." This shows that the service was not always able to support people in a way that made them feel safe. However, one relative told us, "Yes I do feel [my relative] is safe."

Staff we spoke to were aware of their responsibilities in relation to safeguarding people. One staff member said they would, "Go to the manager and if nothing is done go somewhere else like the CQC." The service had a safeguarding policy in place but there was no evidence that that this had been regularly discussed with the team. One staff member said, "Yes, I would think [there is a safeguarding policy], I haven't read it in a long time." The registered manager told us that staff received annual safeguarding training, however the training matrix did not reflect this and staff were not always able to confirm this. One staff member said, "I have never had safeguarding training."

There was no information available about safeguarding available within the home for people to access. The service did not have a safeguarding system in place to log incidents that could have led to a safeguarding alert. We reviewed records and found that there had been one potential safeguarding incident whereby people within the home were at risk of abuse and this had not been acted upon to ensure the person remained safe.

People were therefore not safeguarded from potential abuse or improper treatment. This demonstrated a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked six sets of staff recruitment records. These showed that nearly all required checks had been carried out. These included criminal background checks, employment history and references and proof of ID. However, for one staff member who had recently been recruited there were unexplained gaps in their record of previous employment history. The registered manager told us they could not recall any further details. This meant recruitment procedures were not robust.

People, relatives and staff felt the service did not have sufficient numbers of staff. When we asked people if they felt there were enough staff to support them, one person said, "Not really, I am sat around waiting to die." When we asked one person if they could have a cup of tea when they wanted they said, "No, only between 8.30-9.00 and after 11.00 I suppose and after that 3.00 I suppose." One relative told us, "I know they are very busy [staff]. As family members we all try and help out, staff are doing other things all of the time." Another relative said, "I think they are shorthanded on occasion and do not have much time to have any exchanges with their clients." One staff member said, "At times we need more. Weekends is harder as they are just us. We don't have management in at the weekends." Another staff member told us, "Worse at the weekends. No management. No cleaner. Just three members of staff and a cook. If we are bathing someone that could take two people, that leaves one person to oversee the other 20 or so people. It is too much."

During our inspection we observed there were not always enough staff to support people. During lunch two people were sat together and needed help with their food. There were no staff available and so the other

person cut up their food for them. The staff rota required three care staff to be on duty during the day, and we found the required number of staff were available. However, the service had not completed any dependency assessments and advised they were not looking to recruit any additional members of staff. The service was unable to evidence they had enough staff employed to support people to stay safe and meet their needs. This demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that most equipment was serviced to ensure that they were safe to use. Gas, electric and water services were also maintained for safe use. Internal and external maintenance checks were in place. However, these failed to highlight areas in need of repair, such as the broken washing machine and there were no recorded actions because of this check. Staff had completed training on fire safety and first aid and were aware of what to do in an emergency. One staff member told us, "All the doors would shut automatically. Those that need hoisting we would help first. Fire drills happen every 6 months. They test every single room."

At our last inspection on 5 and 6 January 2017 the registered manager advised us they would complete all individual personal emergency evacuation plans (PEEP). During this inspection we reviewed seven PEEP and found that four had not been completed.

By each fire door the service had completed an 'emergency evacuation plan' that gave details about people living at the service to support fire officers with a safer evacuation. The deputy manager advised these were reviewed monthly. However, we found that these documents were not up to date. For example, there was information about a person who had oxygen cylinders in their room. We were told this person hadn't lived at this service for a long time. This suggested that although regular audits of risk assessments were being completed they weren't effective.

We saw sign in the hallway close to a door stating, 'please do not leave the wheelchairs here' and we saw two walking frames in front of this sign. We found a walking frame in one person's bedroom, even though this person was now using a wheelchair. For people living with dementia there is a risk that they could forget they are unable to walk and try to use this walking frame which would put them at risk of harm. We also saw their call-bell cord and their light switch cord were tangled and were not within reach for the person when they were in bed. We could not see evidence of this having ever been appropriately secured and the maintenance staff did not know how long this call-bell cord had been out of reach. This meant people were not protected from harm in the event of an emergency.

There were garden sheds used for storage, which were unlocked. These sheds contained confidential information, COSSH products and gardening tools. Other COSHH products were stored securely inside the laundry room. However, the door to the laundry room was locked by a bolt from the outside, which meant that people could access the laundry room without staff supervision.

We saw wheelchairs that were unclean and broken and were told that these had not been serviced or cleaned. We observed a stand aid being used to support one person to the toilet and the same sling was used for another person, without being cleaned. We saw a pile of used incontinence pads in one person's bathroom. The cleaners oversaw most of the cleaning during the week and there was a cleaning rota in place for care staff, for other tasks. This was not completed on 15 days between 28 June and 29 August. The registered manager said, "If it hasn't been ticked it is because it hasn't been done, we prioritise caring for people." People were therefore at risk of cross infection.

An environmental health officer visited the service in March 2018. They were given a 4-star rating and a list of

recommendations. There was no evidence to support that these had been acted upon. For example, there was a suggestion that areas of the kitchen be cleaned, but there was no cleaning schedule in place for the kitchen. We also found that the food was not always labelled with opening and expiry dates and not all opened food was sealed.

Relatives told us they felt the home was clean. One relative said, "[Person's] room is 100% clean. I see it every day." Staff told us they were provided with protective clothing and equipment. One staff member said, "We wear gloves, especially when giving personal care. We have aprons." Observations confirmed staff were using protective clothing and equipment. The service had a dress code policy which stated all staff were supposed to wear uniform and closed shoes. We saw that staff were wearing open toe shoes rather than supportive, closed toed shoes.

Accidents or incidents were recorded. These forms had a section to record the details of the accident or incident as well as immediate action taken. We looked at 12 forms and on only three of them had the review section been completed. We noted that there were five forms completed for the same person, four of which related to falls. None of these had the review section completed. A referral had not been made to other health and social care professionals and their risk assessment had not been updated because of these falls.

The premises and equipment were not safe for supporting people. This demonstrated a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The service was not effective. During our inspection we found that the service did follow the principles of the Mental Capacity Act 2005 (MCA) and consent for care and treatment was not gained. This demonstrated the service was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked if the service followed the principles of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and the deputy manager advised they had applied for DoLS for every person in the home, as they thought this was the process. This was not in line with best practice. However, records did not confirm this. There was an audit sheet to track DoLS which showed 17 out of 22 people had applications in place. It was unclear why five people had not had a DoLS applied for. The audit sheet stated that one person had a DoLS applied for on 30 May 2018. The registered manager told us they did not know why the DoLS had been applied for, as they felt that the person had capacity. The registered manager and the deputy manager told us they weren't sure about MCA and DoLS processes and hadn't had any formal training in this area. They told us they did not carry out any mental capacity assessments of people or best interest's decision-making meetings.

One person told us, "It feels like a prison with four walls. It's too depressing." Another person said, "I am down. It's no life I want to live." Staff did not always know about MCA or DoLS. One staff member said, "No, I haven't got a clue what that is." Another staff member said, "Nobody here has capacity. If they don't have capacity they would have an advocate." The registered manager told us nobody had access to an advocate.

Staff did not always understand the meaning of consent. When we asked one staff member how they gained consent from people to provide care and support they said, "[Registered manager] does that. [Registered manager] has the forms I think." The deputy manager could not find any completed consent forms and said, "I don't know where they are, I don't even if know if we have them all."

We observed one person being force fed their food. The staff member did not talk to the person or ask for their permission before putting food to their mouth. We observed one staff member go in to a person's bedroom without knocking first. The person was in their room at the time.

During this inspection the service could not evidence their staff were supported or suitably competent to

meet the needs of people living at the service. This demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 5 and 6 January 2017 we found the registered manager was not able to provide any staff training records or tell us when staff had last received training. They did not have a system in place to identify when training needed to be updated.

The registered manager could not find all staff training records. We were shown a training matrix that had not been kept up to date and did not identify when training needed to be refreshed. There was no guidance about how often training should be done. The training matrix we reviewed showed inconsistencies amongst staff training. The registered manager told us the pharmacist visits the service annually to give medicines training, but there were no records to confirm this. The training matrix showed us that six members of staff had not had dementia training, including the registered manager and the deputy manager. The registered manager told us, "This is being set up, we have a lot overdue." One relative told us, "I got a feeling staff aren't trained in dementia." We spoke to one health and social care professional who said, "About pressure sores, we think they could do with more training around that." We spoke to staff about training. One staff member told us, "We do get regular training. I can't remember the last training I did."

The service did not have a policy on staff supervision and appraisal. Records showed staff had one to one supervision every two months. One staff member said, "The supervisions are fine." This consisted of them being observed carrying out a task and feedback was given about how they performed the task. Supervision records showed that staff were asked if they were happy with the training provided. That was the extent of the recorded discussion, and details were limited. We discussed this with the registered manager and the deputy manager who agreed supervisions could be more comprehensive in the scope of their discussions.

Records showed that staff had no annual appraisals. The registered manager said, "Not very often, some have them, some don't. I know they are supposed to be yearly." They told us, "To be honest we have not been good at that [staff appraisals], but staff don't like doing them." One staff member had been employed less than a year so was not yet due an appraisal. One staff member last had an appraisal in 2007 and there was no record of the other four staff ever having an annual appraisal.

The service did not have a policy for inductions. The deputy manager told us, "We have no system. We had one and stopped using that as it was too long winded. We are trying to develop a new system." There was a new member of staff working on the day of our inspection. We asked the registered manager and the deputy manager how they were supporting this new staff member and overseeing their competency they said, "We have gone through the process of telling [staff member] everything, where the care plans are and where things are. They shadow, not left on their own." The registered manager and the deputy manager confirmed they had not booked any training for this new staff member and there were no records of any conversations had.

We spoke to this staff member about their induction. They said, "I have never done care work. I am learning all of the time. I shadowed during my first week. I have a list of the residents and what they like and their preferences with sugars and stuff. I learnt to do the bathing." We asked them if they had read people's care plans and they said, "No, I haven't had the time. I haven't read anybody's folders at all yet." We asked if they had done any training before supporting people and they said, "I have not done any training yet. If there is something I don't know someone will show me."

At our last inspection on 5 and 6 January 2017 we recommended lunchtime arrangements be reviewed to ensure that everyone is fully supported in a timely manner. At this inspection we observed people waiting at

the table for up to 35 minutes before their dinner was served. We found that staff interaction at mealtime was inconsistent. We observed the registered manager and the deputy manager having their lunch away from the dining area and they did not support staff or interact with other people. Some staff were observed to be on their mobile phones during lunch. We observed one person receive support to eat and they were given time to finish mouthfuls.

People had mixed feedback about the food. One person said, "The tea tastes like hot water. And the coffee too," and another person told us the food was, "Edible, that's the main thing." However, another person said they always get, "Something hot. We have a very good chef. "

People were provided with a choice of food and drink for their evening meals for five days of the week. We were told by one member of staff, "The only days they have no choice is Thursdays and Sundays. They get a roast then." When we asked this staff member what people would eat if they didn't want a roast dinner we were told, "They could have a sandwich." We asked the chef if people had individual preferences and they were not able to give any examples. One person was eating potatoes and said, "I don't like potatoes but I will eat a few. I don't care anymore. I have given up." We found that there were no vegetarian options. We explained that it is important for people to have a varied choice even if they are not vegetarian.

The tables were pre-set with cutlery and a small glass of orange squash for each person. No choice was offered about what people would like to drink. We also saw there were no napkins or other table dressings and people were observed to use their clothes to wipe their mouths during lunch.

We asked the chef if they knew about people's allergies or dietary needs, and were told, "The carers tell me." We saw a chart with a tick box for who was on pureed and finger food. For people who needed support to manage their weight, the chef said, "I will try and add fat to their meals, like cereal with cream, extra yoghurt." However, the chart with tick boxes on did not record who this applied to. One person was eating finger food and the majority of the food was fried. We spoke to the registered manager about the importance of a healthy diet and they said, "They are fried vegetable sticks."

We also saw one person served their food all mixed together and staff were unable to tell us why, or if this was in the person's care plan. On the second day of our inspection this food had been separated by colour. We observed one staff member ask another staff member, "Do you reckon [person] needs the banana mushing up?" The other staff member said they did not know, and this person was given a whole banana. This demonstrated that staff did not always know people's preferences or dietary needs and did not know how to keep them safe from potential risks.

During the inspection we did not see people being encouraged to engage in activities to promote a healthy lifestyle. The service had a large, accessible patio and garden area but people said they did not go outside. The registered manager told us, "The back door is open so they can come out if they like." One person said, "I am puzzled how people are over or underweight, why aren't they being helped? It's serious. It's about people's psychology here."

Records showed some people had access to health care professionals including the GP, district nurses a chiropodist and optician. When we asked relatives if the service liaised with other professionals one relative said, "No, not really." However, another relative said, "[Person] had a chest infection and they encouraged [person] to sit up in the lounge for [person's] lungs." Another relative told us, "[Person] did have a psychiatric nurse visit a few months ago." We spoke to health and social care professionals about the service. One professional told us, "We have had a few issues about staff not knowing when to alert us." However, another professional said when they visited the home, "Staff knew patient and history." Staff told us they worked

alongside other health and social care professionals to provide effective care and support. One staff member told us, "We work with the district nurses every day. [Person's] legs were really swollen and ulcerated. It was interesting and helpful and now it has mended. We all worked together it was nice."

Pre-admission assessments were in place. They asked questions about what people enjoyed doing, end of life and medicines. However, there was no evidence of the service completing a holistic assessment of need with other professionals. One person's pre-admission assessment said they enjoyed meeting new people. When we asked the registered manager if this person was supported to meet other people they told us they weren't. Another person's pre-admission assessment said, "Needs supervision," with their mobility but there was no further information available. It was unclear how these assessments ensured the service, and staff could provide adequate care and support.

Inadequate

Is the service caring?

Our findings

The service did not demonstrate it was caring. During our inspection we observed that the care and support provided was poor. We found that that there was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's and relatives' comments about the quality of care provided at this service was mixed. One person told us, "I am miserable here, I am on my own." Another person said, "[Staff] aren't worth the light of day." A relative we spoke to said, "The way staff talk to people. It's not the way I would. I'm not qualified but I know there are certain ways you talk to people." Another relative told us, "I know it isn't a nice place, I see a lot of things that make me sad but that's homes for you."

One person gave positive feedback about the service, stating, "I've got nothing to complain about. They [staff] ask if there is anything they can do for me and its done." One relative said, "They are very nice, I think they are very kind." Another relative told us, "Yea they are okay. Mostly they seem caring. Sometimes they are a bit sharp. I know it can be difficult caring for people with dementia."

Staff told us, "The care is focused on a person here." One staff member told us, "We know [people's] personalities. [Person] loves head being scratched. We know if [person] is sad by body reactions and facial expressions. If you scratch [person] head or back or sing to [person] it can make [person] happy."

However, we saw that staff supported people in a way that was not always compassionate and kind. Staff were observed providing personal care in the form of shaving to one person in the main lounge, in front of others. The registered manager told us this person didn't mind. They then said usually this person would be shaved in their bedroom but staff did not have time that morning due to another person's personal care needs taking longer than usual. We also saw one staff member say to a person, "Your jumper needs changing tonight it is yuk." Another person was woken up by staff shouting their name in their face. This person awoke suddenly and appeared startled. Here people were not treated in a caring way and people's rights to engage in conversation or express their choices around care and communication were not considered. During lunch we observed two people sat at a corner table, facing a wall with no lighting. Both people closed their eyes and did not engage with other people or staff until their food was served.

During afternoon tea we observed one staff member wake up a person who was sleeping by forcing a banana into their mouth without their consent. As the person awoke, staff told the person, "It is yum" before walking away and letting the banana fall into the person's lap. Throughout afternoon tea the person did not respond and the banana fell into their lap before it being thrown away by staff. When we spoke to the registered manager about this incident they said, "If that was [person] it is okay as [person] doesn't pay attention really." We advised the registered manager that this was not the same person we observed. This person may have felt disrespected as they were not communicated with about their individual preferences and choices. Furthermore, this incident could have put the person at risk of choking.

We did not see any examples of people being supported to live independently. One person told us, "I can't

have my own opinion." Another person said, "They [staff] make rules in this club and they get violated." A different person told us, "I have to adjust to their systems." Staff were not able to give specific examples of how they supported people to be independent. One staff member told us, "If they can do things themselves we encourage it. If they need help, we help them."

We found that the service did not have any male carers. When we asked the registered manager what they would do if someone preferred a male carer they said, "Most men don't care, most women want women. If that is what they wanted we wouldn't be able to accept them. What are we going to do, employ a male just for one or two men to be happy and then those staff can't touch the women, no thanks?" Here the service demonstrated that they did not ensure people's preferences and wishes were respected. Throughout our inspection we found that the overall culture of the service did not respect people's dignity and people were not supported in a way that meant they felt comfortable or independent.

People's privacy was not always maintained, even where people were asleep or not in the room their privacy was being breached. We observed the registered manager speak openly in the communal lounge about a person who was eating by themselves, despite care staff advising the registered manager that this person wanted to join other people at the table. The registered manager said, "We are keeping [person] away from the table and if we pretend like we are ignoring [person] we can be sneaky and get an idea of what [person] is eating." Here, this person's wishes were not considered or respected and the conversation could have been overheard by many people. We also saw one person was waiting outside of an occupied bathroom and asked staff for support. Staff appeared busy and told this person they would have to wait until after dinner to go the bathroom. This person waited on their own for over 6 minutes and suggested they required more immediate support to go to the bathroom. They appeared distressed. There was a lack of respect and dignity shown to this person. We then observed staff speak openly about this person's care and treatment in the communal lounge. Feedback from one relative said, "There is no privacy when discussing clients and their needs." Discussions about people's care and treatment should not be held in a place where it can be overheard as it breaches confidentiality and can cause people to feel disrespected and uncomfortable.

We found that the service did not work in line with best practice in relation to EDHR. We did not see any examples of people's cultural backgrounds being explored or discussed and support was not tailored to meet these needs. The registered manager and the deputy manager advised there were, "No different cultures." Staff application forms asked questions to prospective staff about their date of birth, ethnicity, nationality and religion. This meant that staff were not protected from potential discrimination with regards to recruitment and may have been at a disadvantage. We discussed this with the registered manager who told us they would amend the application form to ensure it asked relevant questions only.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 5 and 6 January 2017 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, we found that individual care plans were not detailed and did not contain specific information about people's needs. This placed them at risk of not consistently receiving the care that they required.

During this inspection we found that this breach had not been addressed. Care plans were in place but these were not person centred and not sufficient in their detail. It was therefore difficult to know how to support people appropriately and line with their personal preferences. One staff member said, "The care plans are okay but there is a load more to do on them. It feels like sometimes we have to write the same thing so many times. It is hard. Things go on it and get lost or we forget where to put the information. They are helpful but also a hinderance because we have to write so much."

The care plan for one person stated, "[Person] has help from one carer in all aspects of their personal care." However, there was no more detail provided, setting out how this person liked their personal care to be delivered or what elements this person could manage independently. The same care plan said, "[Person] now has a catheter." There was no more detail about how to provide support with this was given. The persons care plan on mouth care simply stated, "[Person] needs help now."

We saw that one person's care plan said this person preferred to wake up between 6.30am and 7.00am but in another document, it said they preferred to wake up at 8.30am. When we asked the registered manager about this they said they did not know what this person preferred.

In each care plan, people had a "This is me" document that had a photograph of the person and information about their support needs. One person's care plan asked, "How can we communicate" and the notes advised staff to, "Speak to me loud and clear." Under mobility the notes said the person is a "Bit shaky, prone to falls" and for their personal care the notes said, "Carers help me wash and dress." There was no further information or details provided.

Another person's care plan for sight, hearing and communication said, "[Person] needs help putting in their hearing aids." However, there was no further information or details available for care staff. It was therefore not clear how these hearing aids should be cleaned, inserted or removed and there was no evidence of this person having had a check up with a relevant health and social care professional.

One person had a care plan in place for their skin management. Their records said, "Sacral area needs to be creamed when [person] needs it creamed." There was no further information or details about what the person needed this cream for, what cream needed to be used, when this person should have their skin creamed, and there had been no update for over 12 months. When we asked the deputy manager about this they told us this was no longer a problem and they had overlooked the auditing of this care plan during their quarterly checks.

Another person had care plans in place for their mental state and behaviour and physical and mental health but they were blank. Therefore, we did not know what support this person needed with their mental and physical health.

Care staff did monthly care plan audits. Of the files we looked at we found that all individual care plans had been reviewed in time. However, these reviews did not provide detail about a person's changing needs. For example, for one person between May and June 2018 their nutrition assessment changed from, "No [person] eats well," to, "Yes, [person] has pureed food now." There was no information in this audit or in the persons care plan about what had changed during this month i.e. why they were on pureed food, how this was being managed and there were no records to confirm this person had been referred to other health and social care professionals. Another care plan review for mobility changed from, "Not walking very well, needs 1 carer," to, "Not walking at all, needs wheelchair." Again, there was no detail in this audit or in the persons care plan about what changed and their falls and environment risk assessment had not been updated.

Care plans did include details of what people preferred to be called and some information about their past life history, such as where they grew up, their employment and their family.

People did not feel they were supported to participate in activities. One person told us, "I sit here in the morning. I always do the same thing. In the afternoon I do the same." Another person said, "I am not happy I am bored." Another person told us, "All I am doing is sat down doing nothing." When we asked people what they were going to do on the day of our inspection one person said, "I will have lunch. I don't know what else I will do. I am not sure what else we do." One person told us, "I haven't lived here long enough for them to plan anything. Maybe they will." Records confirmed this person had lived at the service for approximately 10 weeks.

Relatives were mixed in their feedback about people being supported to engage in activities. One relatives feedback said, "As a dementia care facility I do not see, in the times I've visited, much going on for the clients except television." Another relative said, "I am not happy at the level of activities, seeing most of the clients just sitting in chairs with arms folded." Another relative told us, "Main concern is interaction. Staff talk to themselves, not to the people. I don't see any interaction. They [staff] all sit around the table." However, one relative told us, "They do activities. Sometimes they have music on. I have come in before and they play bingo with those that can participate."

Some staff told us activities did not take place. One staff member said, "I haven't seen any going on. They watch the television." Another staff member said, "We don't have the time." However, one staff member told us, "We play games, there is a pet therapy dog. Residents love a dance, we often put music on and have a dance." During the inspection we saw photographs of people holding a dog. The deputy manager showed us photographs on her phone taken of a trip with people to a local park on 16 July 2018.

One person's care plan on daily routines said, "[Person] would like to give board games a try." When we asked the registered manager if this person was supported and encouraged to play games they said, "Not really no, you can only play games with one or two people and anyway [person] wouldn't play, trust me." We also read in one person's care plan that they wanted to participate in listening to music, listening to the radio, singing and watching television. During our inspection we observed this person to be sat in a chair facing away from the television so they would be unable to watch it. Daily records confirmed this person had not participated in any activities.

On the first day of inspection we observed a ball-game being played for a short time in the morning. The service had an activities policy in place and a weekly activities timetable. On the second day of our

inspection there was to be a sing-a-long and bingo. We did not see either of these activities take place. At 4.15pm we saw some music being played. Throughout our inspection we witnessed some members of staff sometimes talk to people. However, this was not regular and conversations with people were short. We did not see any people access the garden. When we asked one person if they used the garden they told us, "No".

We saw one person reading newspapers written in their first language. The registered manager told a staff member who had been on holiday bought these newspapers for this person so they could, "Keep up to date with their home." However, when we asked if they would keep purchasing these newspapers the registered manager said, "No, it's only because [staff member] went on holiday."

Overall, we found that the service did not produce detailed care plans for people and this meant staff could not adequately respond to people's needs and provide care and support that was tailored to individuals. Furthermore, people were not supported to participate in activities of their choice and their wellbeing was not maximised. This demonstrated a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy in place. We reviewed 3 complaints that the service had received and we found that all had been dealt with by the service. People and staff were not able to tell us about the complaints policy. One relative told us, "I don't know the procedure but I would take their complaint I would take them to [registered manager]."

We found that the service was not working in line the Accessible Information Standards (AIS). Organisations that provide NHS or adult social care must follow the AIS by law. The aim of the AIS is to make sure that people that receive care have information made available to them that they can access and understand. The information will tell them how to keep themselves safe and how to report any issues of concern or raise a complaint as well as explain their care and support.

The registered manager confirmed that there were not any accessible versions of the complaints policy available for people. This meant that people living with dementia or other sensory communication needs would not always be able to raise a complaint or a concern about the service.

The service supported people who were approaching the end of their life. The deputy manager told us they had received training from a hospice. We were shown a folder that contained 'Thinking Ahead' forms, listed the names of people who were receiving palliative care and individual reviews of their support needs. However, the deputy manager could not locate the monthly updates from July and August. When we asked the registered manager and the deputy manager how this paperwork informed their practice they said, ""It doesn't really help it's just a record."

When we asked the deputy manager to provide us with a care plan of someone on palliative care they told us they didn't know who was approaching the end of their life. We found that there was no end of life care plans for people. Staff did not always know if people were on end of life care. One staff member said, "Don't know anything about that. Don't know if anyone is on palliative care." However, another staff member told us, "[Person] has cancer and there is not much time left. Palliative care plans have been put in place. We know [person] is coming to the end of [person's] life. Meds are in place to apply and [person] has stronger painkillers. We have had training on this." The training matrix showed us that staff had received recent palliative care training. However, they were unable to put their training into practice.

This therefore demonstrated inconsistencies amongst the management team and the care staff about who needed end of life care and support, and how they should be supporting people appropriately.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 5 and 6 January 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that there was a lack of robust management and monitoring which placed people at risk of not receiving safe, effective and responsive care.

During this inspection we found that this breach had not been addressed and the quality assurance standards had declined.

We reviewed the management quarterly care plan audits and saw care plans were last reviewed in December 2017. We were advised that this was not correct as the registered manager and the deputy manager had different auditing formats. The registered manager made their notes directly into care plans whereas the deputy manager showed us a spreadsheet which showed care plans had been reviewed in June 2018. However, these audits had failed to pick up insufficient notes and incorrect details. For example, in one person's care plan under 'admission to other healthcare services' we saw this had been reviewed by the deputy manager on 13 May 2018 but we found that throughout this person's care plan they had 3 different contact details for GP's. This demonstrated that the audits were inefficient as people's support needs were not fully explored and inconsistencies were not identified. Staff would not know how to deliver safe and effective care.

At our previous inspection, we found that there was no record of provider visits or audits. During this inspection the registered manager told us these were now happening. We found there were no regular detailed quality assurance records available. From the visits that had taken place by the provider there was no action plan in place to advise how identified problems would be resolved. For example, the last visit which recorded any care plans looked at was dated 3 October 2017 and there was no information to confirm which care plans were looked at. When the provider did conduct a visit, they failed to record key details, e.g. who they spoke with (person, family, staff) and only gave very general feedback. We spoke to one of the owners and asked for examples of improvements made because of their checks. They said, "I spoke to [maintenance staff] about the windows in [person's] room, the warm weather is affecting the gap in them. We have ordered a draft excluder." Records confirmed that on some occasions there were specific checks of bedrooms and evidence that areas for improvements were noted, however; there was no plan in place to address these.

At our last inspection on 5 and 6 January 2017 we recommended that meetings be held for staff, relatives and people using the service in order for them to feel supported and encouraged to provide feedback. This recommendation had not been implemented.

People, relatives, staff and other professionals had mixed responses about the support they received from the registered manager. One person said, "They're getting money for nothing." One relative said, "I don't deal a lot with [deputy manager]. [The registered manager] always has an answer. It's not a good answer. There is no point talking to them." A member of staff told us, "It's a tight family run business. If we disagree

with something it can be hard because it's a family." One health and social care professional told us they found the management to be, "Quite abrupt."

Other feedback was positive. One relative said, "The [registered manager] is lovely. A staff member said the registered was, "Great, they are very easy to talk to. If there is a problem they will sort it out."

Meetings for people using the service were not held. The service had no surveys that had been completed by people using the service. The registered manager confirmed that there were not any accessible versions of feedback forms available for people. We asked one member of staff if they gathered feedback from people about whether they enjoyed their food or if they had any suggestions for new meals and were told, "There is no point. They can't remember what they ate."

We saw a file that contained surveys sent out to relatives in October 2017. We found that only 10 relatives had been contacted and there was no evidence of how the surveys were used to drive improvements because no meetings were held with relatives. The registered manager told us they spoke through the issues with people's families instead. There were no records to confirm these conversations had taken place. They explained that there were several comments about activities, but told us those relatives regularly visited at times when activities were not scheduled, such as immediately after lunch. Some feedback from relatives on surveys included, "I have never seen any activities, I am here three times a week." Other responses said, "I would like a bit more feedback without having to ask."

One staff member said team meetings were not held. They said, "No not really, if I had concerns I would speak to [registered manager]." Although another staff member said team meetings were held, they confirmed they were not regular. They told us, "Yes we do. They vary. [Registered manager] calls them whenever needed. We might have 2 or 3 a year." When we asked the registered manager if they held team meetings, they said "We are getting there, we talk all the time, we are a small service so it's not like the big companies that have to have them." There were no records to confirm team meetings were being held. The registered manager did show us some hand-written notes from the last team meeting, but they were not detailed, did not always make sense and were not filed away appropriately. There was no evidence of surveys being sent to members of staff. Staff we spoke to confirmed they have never provided feedback about the service.

We spoke to the registered manager and the deputy manager about if they liaised with other professionals for advice and guidance and they told us they did not. They told us they often found it, "Too difficult and unhelpful." The deputy manager said, "It's a competition out there so other homes won't help us. The local authority doesn't help. We get told too many different things." There was no evidence of surveys being sent to health and social care professionals. Health and social care professionals we spoke to confirmed they had never provided feedback about the service.

One person had moved to the service approximately five weeks ago and came with a new 'red bag'. A red bag is used to transfer paperwork, medicines and personal belongings for people throughout their transitions between their home and hospital. The 'red bag' ensures everyone involved in the care of a person will have necessary information about their health. This had been emptied as the registered manager and the deputy manager did not know what had to go in the bag. They told us they had contacted the CCG for more information in relation to the red bag scheme. However, there were no records to confirm that they had sought training for them and their staff in this area. This meant the service was not effectively working with other health and social care professionals to support people in staying well and safe.

We asked the registered manager and the deputy manager if they felt supported by the other providers and

owners. The deputy manager said, "Yes very. If we need new things they get us things. They help us make choices."

The service had a business continuity plan that had been updated in April 2018. However, this was unfinished. Many of the sections were blank, including the areas that looked at what essential processes should be taken in the event of an incident and there were no staff details available.

These concerns evidenced that the service did not assess or mitigate risks to people. Quality assurance processes were not in place to identify the concerns we found to help improve the service. This demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to comply with Registration regulations. At this inspection we found that the provider was not compliant with two of the regulations.

Regulation 12 requires the registered person must keep the statement of purpose under review and give the Commission a statement of purpose. The CQC had not received a copy of the statement of purpose. The registered manager and deputy manager advised they did not know they had to submit a statement of purpose to the CQC. We were provided a copy of their updated statement of purpose during the inspection. We discussed some of in the information in this.
Firstly, the statement of purpose said, "Care plans are reviewed once a month in the presence of the client and/or their representative." We were told this is incorrect. Instead, care staff reviewed the care plans monthly. The registered manager told us, "Some relatives we don't see or involve, if they come in we will show them the updated care plan. We don't involve them really."

Secondly, the statement of purpose said, "We hold monthly meetings with our clients." The registered manager told is this is incorrect and said, "Dealing with dementia makes this hard they don't ask questions or anything."

The statement of purpose also said, "Any client who wishes to continue going to clubs or other outside activities will have arrangements for transport made for them." We saw no evidence of people accessing community activities or the service having transport arrangements in place. The registered manager said this is incorrect and said, "A lot of clubs won't take them when they are in homes."

Finally, we found that the statement of purpose said, "Clients may receive visitors at any time, there are no restrictions." This contradicted with a sign in reception that gave visiting times. The registered manager told us this is also incorrect and said, "Because of respecting people's privacy and dignity visitors will not be visiting at lunch time."

This demonstrated a breach of regulation 12 of the (Registration) Regulations 2009.

Regulation 18 says that the registered person must notify the Commission of any incidents which occur whilst services are being provided that affect a person or the providers ability to continue to carry out their regulated activity.

When we spoke to the registered manager about their legal responsibility to notify the CQC of DoLS authorisations they told us, "I didn't know that." The registered manager was unclear about what was considered a serious injury and did not know this would include notifying us of people who had pressure sores of Grade 3 or above. They also advised they were unclear what type of falls they had to notify us of. The

deputy manager did not know of any notifications that needed to be submitted to the CQC. On the 29th August a person was admitted to hospital following fall with a suspected broken hip. The service had not notified the CQC of this. We saw an email from deputy manager to the local authority, who places people to live at this service, on the 9 August 2018 that said, "I recently been informed that I have to notify you when someone passes away which I was not aware of." This email confirmed two people had passed away on the dates of 12 May and 22 May 2018.

The registered manager and deputy manager advised they did not know they had to submit a PIR to the CQC. The CQC had sent two previous requests and the deputy manager had failed to pick these up. They advised they would complete this following the inspection. We did not receive a PIR.

This demonstrated a breach of regulation 18 of the (Registration) Regulations 2009.