GCH (Kent) Ltd

Baugh House

Inspection report

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Date of inspection visit:
05 April 2017
06 April 2017

Date of publication:
06 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 05 and 06 April 2017 and was unannounced. At our last comprehensive inspection of the service in May 2015 the service was rated 'good'. Baugh House is a home providing nursing and residential support for up to 60 people. At the time of our inspection there were 46 people living at the home.

Since the last inspection there had been a series of changes within the management team at the service. At the time of our inspection there was no 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. The current manager explained they had been in place as an interim measure since March 2017, following the recent departure of the previous manager. They told us the provider was in the process of recruiting for the registered manager post.

At this inspection we found significant concerns amounting to a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not always been adequately assessed, and where areas of risk had been identified, action had not always been taken to manage them safely. Medicines were not safely managed because we found issues in the way medicines were recorded, stored and disposed of. Staff responsible for medicines administration had not always been assessed to ensure they were competent to do so, and were not always up to date with training relating to the safe management of medicines.

People were not always protected from the risk of abuse, because potential abuse concerns had not consistently been reported to the local authority safeguarding team, in line with local protocols and the provider's safeguarding procedure. Sufficient staff were not always appropriately deployed within the service to safely meet people's needs. There was also a high level of agency staff usage which meant staff did not always have detailed knowledge or experience in supporting the individual needs of the people living in the home.

Staff were not always up to date with training considered mandatory by the provider. People told us staff did not always seek their consent when providing them with support and we found there was a risk that care and treatment may be given to people against their wishes. The provider had not always complied with the Mental Capacity Act 2005 (MCA) in making decisions on people's behalf where they had been assessed as lacking to do so themselves. People were not always lawfully deprived of their liberty under the Deprivation of Liberty Safeguards.

People had care plans in place, but these were not always up to date and accurate. People's preferences in the way they received care were not always met. The provider's systems for monitoring and improving the

quality and safety of the service were not always effective and had not addressed the issues we found at this inspection. Audits undertaken by senior staff did not consistently identify or address areas of concern. The provider's systems for seeking and acting on people's feedback were not effective in driving improvements.

You can see the action we have asked the provider to take in respect of these breaches at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We also identified areas that required improvement. Complaints were not consistently managed and responded to in line with the provider's complaints procedure. Whist we observed a number of caring interactions between staff and people, we also noted interactions which were not caring or staff failing to interact with people when they were in distress. People were not always involved in day to day decisions about their care and treatment. A range of activities were on offer to people at the service but improvement was required to ensure appropriate social stimulation was offered to all of the people living at the home.

The overall rating for this service is 'Inadequate'. Immediately following the inspection the provider GCH (Kent) Ltd applied to cancel its registration. This application has been granted and a new provider, GCH (South) Ltd has been registered to provide the regulated activities 'Accommodation for persons who require nursing or personal care' and 'Treatment of disease, disorder or injury' at this location. CQC decided that we could only permit GCH (South) Ltd to operate this service subject to a number of conditions to address the concerns found at this inspection and to ensure the continued monitoring of the safety of the service. GCH (South) Ltd agreed to accept those conditions on its registration.

There were also some areas of good practice at the service. Appropriate recruitment checks were made on new staff before they started work. People were supported to access a range of healthcare professionals when required and we received positive feedback from visiting healthcare professionals about the support people received during our inspection. People told us their nutritional needs were met and that staff respected their privacy.

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.

Risks to people had not always been accurately assessed and action had not always been taken to manage risks where they had been identified.

Medicines were not managed safely. There were issues with records relating to the management of medicines as well as storage and disposal procedures.

People were not consistently protected from the risk of abuse because potential incidents of abuse had not always been reported to the local authority safeguarding team.

Sufficient experienced staff were not always appropriately deployed within the service to safely meet people's needs.

The provider undertook appropriate recruitment checks on staff before they started work.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received training in areas considered mandatory by the provider.

Staff did not always seek consent from the people they supported and there was a risk that people may receive treatment against their expressed wishes.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA) where people lacked capacity to consent to their care and treatment.

People were not always lawfully deprived of their liberty in line with the requirements of the Deprivation of Liberty Safeguards (DoLS).

People told us their nutritional needs were met but systems used to monitor and mitigate risks associated with low fluid intake

were not effective.

People were supported to access a range of healthcare services when required.

The manager had taken action to improve the frequency at which staff received support in their roles through supervision.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we identified some caring interactions between staff and people, we also found that staff did not always respond to people when they displayed signs of distress.

People did not always feel involved in decisions about their care and treatment and relatives told us staff did not always treat people with dignity.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People had care plans in place but these were not always accurate or up to date. Care was not always provided in line with people's individual preferences.

Improvement was required to ensure complaints were consistently managed and addressed in line with the provider's complaints policy.

There were a range of activities on offer to people but improvement was required to ensure appropriate social stimulation was provided to all of the people living at the service.

Is the service well-led?

Inadequate

The service was not well-led.

We identified significant concerns with the provider's systems for monitoring and improving the quality and safety of the service which amounted to multiple regulatory breaches. Audits conducted by senior staff did not always identify issues or result in service improvements.

The provider's systems for seeking and acting upon people's

feedback to drive improvements at the service were not effective.

There was no registered manager in place and there had been significant management changes at the home which had impacted negatively on the running of the service.

Staff spoke positively about the current manager of the service although the manager confirmed they were only in post as an interim arrangement.

Baugh 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 brought forward in response to information of concern we received which indicated potential concerns about the management of risk at the service.

This inspection took place on 05 and 06 April 2017 and was unannounced. The inspection team consisted of two inspectors on the first day and one inspector, an inspection manager and a specialist advisor completing the inspection on the second day.

Prior to the inspection we reviewed the information we held about the service and the provider. This included notifications from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. We also contacted a local authority responsible for commissioning services at this location to seek their feedback. We used this information to help inform our inspection planning.

During the inspection we spent time observing the care and support being delivered by staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people, ten relatives, and two healthcare professionals to gain their views on the service. We also spoke with twelve staff, including the current manager, two maintenance staff, the chef and three nursing staff. We looked at records, including 12 people's care plans and risk assessments, 14 staff recruitment files, staff training records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Risks to people had been assessed but action had not always been taken to mitigate risks where they had been identified. People's care records contained risk assessments which covered areas including skin integrity, malnutrition, moving and handling, and falls. Records showed that most people's assessments had been reviewed on a monthly basis to ensure they remained up to date. However we found that risks were not always safely managed.

For example, we noted that two people who were identified as suffering from diabetes had not had their blood sugar levels monitored for over six months, placing their health at risk. In another example we saw risk management guidance to regularly reposition four people who had been assessed as having risks to their skin integrity but records showed they had not been supported to reposition at the required frequency to support them safely.

We also found risks to people had not always been adequately assessed. For example one person's skin integrity risk assessment had been reviewed on a monthly basis but the reviews had not taken a change in risk factor relating to their mobility into account which meant the overall risk assessment had been scored incorrectly. The incorrect use of assessment tools at the service placed people at risk of not having risks properly identified and managed safely. In another example we found that one person's care plan identified that they may exhibit some challenging behaviour when being supported by staff with their personal care. However, there was no risk assessment or guidance in place for staff on how to manage this safely.

Risks associated with the use of equipment had not always been assessed. For example, one person had bedrails in place on their bed, one of which was in use during our inspection. The risks associated with the use of bedrails had not been assessed for this person to ensure they were safe to use. We raised this with staff on the first day of our inspection and they told us they would arrange for the bedrails to be removed at that time. However, we found the bed rail was still in place and being used during the following day of our inspection.

We also found concerns with the provider's arrangements to deal with emergencies. For example we noted that personal emergency evacuation plans (PEEPs) were in place to provide information to staff and the emergency services on the support people required to evacuate the service in the event of an emergency. However, one person's PEEP incorrectly identified the bedroom they were accommodated in, placing them at risk if an evacuation of the service was required.

Additionally, we identified issues with regard to assessing, detecting and controlling the spread of infections. For example, one person's infection control care plan identified that their urine should be checked on a weekly basis due to their history of urinary tract infections but these checks had not been carried out. In another example the inspection team noted concerns relating to the cleanliness of the service. Chairs on the residential unit smelt strongly or urine and we found a soiled incontinence pad had been left in a bag on the floor of one person's bedroom after staff had supported them to change.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). Following the inspection we wrote to the provider highlighting our concerns and they provided us with an action plan identifying how they would promptly address the issues we had identified.

Medicines were not always safely managed. Medicines were stored in secure medicines trolleys in locked clinical rooms which only authorised staff had access to. Where people had been prescribed Controlled Drugs (CDs) we saw these were also stored securely in line with regulatory requirements and medicines which required refrigeration were kept in lockable refrigerators in the clinical rooms. Records showed that checks had been made on the temperatures of storage areas to ensure medicines remained safe and effective. However, we found medicines refrigerator temperatures had not been recorded for 10 days over a 3 month period which meant we could not be assured that medicines had been consistently stored within a safe temperature range so as not to affect their effectiveness.

We also found concerns relating to the recording, storage and disposal of CDs at the service. For example, staff had recorded that doses of a CD prescribed to one person had been destroyed in February 2017 although the service's CD register and separate records of destroyed or returned medicines contained contradictory information as to the number of doses and dosage which had been destroyed. We also found doses of the CD prescribed to the person were still in stock and held by the service which could not be accounted for whilst doses of the same CD prescribed to another person were unaccounted for, having been recorded as being in stock on the 24 February 2017 and no longer in stock on 25 February 2017. Whilst this issue had been identified by staff and statements had been recorded regarding the discrepancies, there was no record of any investigation and the provider had not taken action to inform the appropriate authorities in line with their medicines policy.

We looked at 14 people's medication administration records (MARs) which listed people's medicines and doses along with space to record when doses had been administered by staff. Ten of the MARs had been completed correctly, confirming people's medicines had been administered as prescribed. However, we found four people's MARs contained omissions where prescribed medicines had not been administered but the reasons for these omissions had not been documented by staff. This was not in line with guidance from the Royal Pharmaceutical Society which states, "Records must be complete, legible, up to date, written in ink, dated and signed to show who has made the record."

We also found that some staff who administered medicines had not received medicines training and competency assessments on an annual basis, in line with the provider's training policy, to ensure they were competent to undertake this task. One staff member told us they had received medicines training but had not had their competency assessed and this was confirmed by records we reviewed. Records showed that a further three staff did not have documented medicines training and three staff did not have documented assessment of their competency. We requested that the manager provide us with evidence of competency assessments having been competed for staff following our inspection but they confirmed they were unable to do so. This meant we could not be assured that all staff responsible for administering medicines at the service were competent to do so safely.

These issues were a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). In response to the concerns we raised with the manager during our inspection, they ensured the appropriate authorities were informed of the discrepancies relating to CD concerns we identified following our inspection.

People and relatives we spoke with had mixed views on the care they received at the service and whether they felt safe. One person told us, "I'm quite happy here; the staff do their best." Another person said, "I feel

more secure here now than I did when I first moved in, as I've got used to things." A relative told us, "We come every day and feel [their loved one] is safe." However another relative commented, "We've had a number of problems in the last several months and I don't feel [their loved one] is safe."

Staff told us they had received training in safeguarding adults. They were aware of the types of abuse that could occur and the action to take in reporting any suspected abuse. The manager was aware of the procedures to follow in reporting any allegations of abuse to the local authority safeguarding team and notifying CQC in line with regulatory requirements. We saw examples of appropriate safeguarding referrals having been made in response to concerns identified by staff at the service. However we also found one recorded example of unexplained bruising sustained by one person at the service during the month prior to our inspection. Whilst this had been referred to the person's GP, there was no evidence of this incident having been raised as a safeguarding concern with the local authority for their consideration as a potential incident of abuse.

This issue was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). The manager confirmed they would make a referral relating to this incident to the local authority following our inspection.

People and relatives had mixed views on whether sufficient levels of suitably skilled and experienced staff were appropriately deployed at the service to meet people's needs. One person told us, "I have a call bell and staff will come if I use it." A relative told us, "It can be hard to find staff when you need them." Another relative said, "There's a lot of agency use. We see some familiar faces but there's a lack of continuity in the staffing." We spoke to the manager about this and they confirmed there had been a high level of staffing changes. They told us where agency use was required, they attempted to use the same staff so that they could familiarise themselves with people's needs. However, they acknowledged that this was not always possible.

The manager explained that planned staffing levels were based on the level of dependency of people at the service in order that their needs could be safely met. However, records showed, and staff and the manager confirmed that on one of the days of the weekend prior to our inspection the service did not have the planned number of staff covering the shift during the day because staff members had called in sick at short notice and cover for the shifts could not be arranged. This meant there were two care staff fewer than had been planned on the residential unit and one care staff fewer on the nursing unit. The manager told us that care staff would have been supported in their duties by the chef and an activities co-ordinator although senior staff on duty on the day in question told us these two staff members were unable to support in the provision of person care as they were unable to do so. This mean there were insufficient staff on duty to meet people's needs in a timely manner.

On the first day of our inspection we also found concerns with the level of experience of the staff supporting people. Half of the care staff on duty at the service were agency workers, although the manager was unable to identify which staff had worked there on more than one occasion. We observed a handover between two agency nursing staff on the morning of the first day of our inspection. Both the nurse from the night shift and the nurse starting the day shift confirmed that these were their first shifts at the service and that they had limited information or knowledge about the people they were supporting. The nurse starting the day shift also confirmed they had not received any form of induction prior to starting their shift. This meant we could not be assured that the nursing staff were sufficiently experienced in providing support to the people living at the service to safely meet their individual needs.

We also found concerns in the way in which staff were deployed within the service. One person described an

incident where staff had been recently been supporting them with their personal care. They explained that after they had got undressed, the staff member was called away to do something else, leaving them under a bed sheet and without the support they needed at that time. We also spoke to a relative who told us they had visited on the day prior to our inspection during which they said that staff had not provided appropriate continence support or repositioned their loved one during a five and a half hour period.

On two occasions during our inspection we observed staff failing to attend to people promptly when they requested support using their call bells. In the first occasion we found one person had pressed their call bell because they needed support to go to the toilet. This call bell was cancelled remotely by staff without a staff member checking on the person to see what they needed. The person then pressed the call bell again and continued to wait before we brought this issue to the attention of staff on the floor. In total they waited more than 10 minutes before a member of staff checked on them to see what support they needed. On the second occasion we found a person waiting for a response to their call bell for fifteen minutes without response before staff checked on them. These examples demonstrate that staff were not appropriately deployed within the service to meet people's needs in a timely manner.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Appropriate recruitment checks were made on staff before they started work at the service. We looked at 14 staff recruitment files and found appropriate background checks had been conducted. These checks included details about each staff member's qualifications and experience, their employment history and reasons for any gaps in employment, references, a criminal records check, health declaration, proof of identification, and registration of qualified nurses with their professional bodies. This meant people only received care from staff who were suitable for their roles.

Inadequate

Is the service effective?

Our findings

Staff had not always received or were not up to date with training in areas considered mandatory by the provider. Staff we spoke with confirmed they had received an induction when starting work at the service which included time familiarising themselves with the provider's policies and procedures, a period of orientation and shadowing more experienced colleagues. They also confirmed they were required to undertake training in a range of areas including moving and handling, safeguarding, fire safety, first aid and infection control in order to develop the skills to effectively meet people's needs.

However records showed that 17 of 46 staff had not received or were overdue moving and handling training, and we observed an example of poor moving and handling practice during our inspection. Records also showed 31 of 46 staff required training or refresher training in safeguarding adults and we identified a breach of regulations in regards to protecting adults from the risk of abuse.

Additionally we found further significant shortfalls in training in areas including control of substances that are hazardous to health (COSHH), fire safety, first aid and food hygiene. The manager provided confirmation of planned training dates for staff covering some of the overdue training requirements we had identified. Following the inspection we contacted the manager to request confirmation as to whether training had gone ahead as planned but we did not receive a response. Therefore we could not be assured that the manager's plans for ensuring training had gone ahead or had been met.

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

We also noted that staff had not always been supported in their roles through regular supervision during the previous year, in line with the provider's policy. This issue had been identified by the manager who told us they were in the process of making improvements in this area. Records confirmed that this was the case, and that most staff had undergone a formal supervision session over the previous two months. The manager told us they were confident that those staff who had not been supervised during this period would be picked up by the end of April 2017, although we were unable to check on this at the time of our inspection. Staff we spoke with told us they felt sufficiently supported by the manager to undertake their roles competently.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they were aware of the importance of seeking consent from people when offering them support. One staff member told us, "I would always respect people's wishes- we can't force people to do things." However, not all of the people we spoke with felt their consent was sought by staff. For example, one person told us, "Some staff are very good, but others don't ask me [about my support]; they just tell me what to do."

Records showed that plans had not always been in place to ensure people's expressed wishes were met. For example, one person's care plan included their recorded preference not to be resuscitated in the event of a cardiac arrest. However we found that there was no Do Not Attempt Resuscitation (DNAR) documentation in their file. This meant that in the event of a cardiac arrest staff or the emergency services may have attempted resuscitation without the person's consent to do so.

We also found that the service had not always complied with the requirements of the MCA Code of Practice, where people had been assessed as lacking capacity to make decisions for themselves. For example, we found a decision to use bed rails had been made in one person's best interests, but there was no evidence of a mental capacity assessment having been conducted beforehand to demonstrate they were unable to make the decision for themselves. In another example we found a mental capacity assessment had been conducted for one person covering a range of decisions relating to activities of daily living. However, there was no accompanying best interests decision information and the sections of the form available for family members or advocates to sign had been left blank.

These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

People were not always lawfully deprived of their liberty. The manager confirmed that at the time of our inspection they had identified a number of people living at the service whose DoLS authorisations had expired. They confirmed they were in the process of seeking new authorisations to ensure people were only legally deprived of their liberty under DoLS. We also found conditions placed on people's DoLS authorisations had not always been met. For example, one person's DoLS authorisation included a condition that the service implement a care plan to demonstrate that they were monitoring the authorisation for its duration, but this had not been put in place.

In another example we found that the provider was unable to demonstrate that monitoring forms requested by one local authority as a condition of two people's DoLS authorisations had been submitted. This meant the provider was failing to meet legal requirements where people had been deprived of the liberty.

These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). Following our inspection the manager wrote to us confirming that they had reviewed all of the people living at the service to ensure that any outstanding DoLS applications had been submitted to the relevant local authorities.

People told us they received enough to eat at the service although we received mixed feedback from relatives about the support people received to drink. We also found that the systems used to monitor risks associated with low fluid intake were not effective. With regards to the meals on offer at the service, one person told us, "Overall the food is fine, but a bit repetitive." A visiting relative said, "[Their loved one] enjoys the food here." However one relative we spoke with raised concerns around the lack of availability of drinks

in their loved one's room during the day and another relative told us they believed their loved one was regularly dehydrated when they visited.

Systems for monitoring the risk of low fluid intake were not effective. We reviewed a sample of fluid charts completed by staff for people at the home and found these had not always been completed clearly to demonstrate whether people were provided with sufficient support with their fluid intake. For example we found the fluid charts of three people for the week during our inspection had been completed to show that their intake was less than half of their recorded daily intake target.

This issue was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We observed a lunchtime meal during the inspection and noted a number of positive staff interactions with people on the residential unit. The dining room atmosphere was relaxed and friendly. There were enough staff on duty to assist people where needed, and we saw examples of staff providing appropriate support to people who needed help to eat and drink. Staff held meaningful conversation with people, and helped those who ate slowly, encouraging them to finish their meals. We also observed staff were on hand to support people on a one to one basis where required on the nursing unit when supporting people to eat.

Kitchen staff were aware of any specific mealtime requirements people had for example who required soft or pureed diets or which people suffered from conditions such as diabetes. Records also confirmed that advice had been sought from healthcare professionals such as a dietician or speech and language therapists where this was required to ensure people's nutritional needs were safely met.

People and their relatives where appropriate told us they were supported to access healthcare services where required. One person said, "I see the GP when I need to; they visit regularly." A relative told us, "As far as I'm aware staff have sorted out any appointments when they've been needed." Records showed people had access to a range of healthcare professionals including a GP, community nurse, occupational therapist and speech and language therapist. We noted any external appointments people had were discussed during daily meetings with the manager to ensure staff were aware of the support people required.

We spoke with a visiting healthcare professional who was visiting the service during our inspection and they told us they felt any guidance they provided staff was appropriately shared and acted upon. They said, "There's been a difficult period here but things seem to be settling down. The residential team have been proactive in seeking our support when needed."

Requires Improvement

Is the service caring?

Our findings

Staff we spoke with described the actions they took to ensure people's privacy was respected, for example by knocking on doors before entering and ensuring any support they provided to people with personal care was undertaken behind closed doors. However, staff did not consistently treat people with dignity. For example, one relative explained that their loved one was incontinent and required regular support in this area. They told us that they had overheard staff arguing openly in the corridor about who should provide the support as none of them wanted to do it.

Inn another, we observed three staff in a communal area failing to respond to a person who was displaying clear signs of distress and had to draw this issue to their attention before any form of support was offered. We also noted a poor interaction from one staff member who was silently supporting someone to eat without making any attempt to engage or consult with them about the support they were providing.

These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

People's privacy was respected. People and relatives told us their privacy was respected. One person said, "I think the staff respect my privacy as much as they are able to in a home." Another person told us, "I don't have any concerns regarding privacy." A relative commented, "Staff always pull the curtains and shut the door when they caring for [their loved one]."

We received mixed feedback on whether staff were caring in the way that they treated people at the service. One person told us, "The staff seem caring and I get the support I need." Another person said, "Some staff are very kind and understanding, but others are less so; they rush and can be rough." A relative said, "I think the staff are caring but they need to spend more time getting to know the people here." However, another relative told us, "Some of the staff are lovely, but others do not care. You never know what you're going to get from them." A member of staff on the nursing unit also commented that they did not think all staff had a caring attitude.

We observed some friendly and caring interactions between people and staff. For example one staff member displayed consideration and patience whilst encouraging one person to accept support with their personal care and it was clear from their interaction that they knew the person's needs and preferences well which helped to put them at ease.

Staff told us they consulted people with regards to their preferences in the way they were supported wherever possible by giving them choice around their daily routines. People and relatives confirmed that they had been involved in some decisions relating to their support. For example, one relative explained how they'd requested their loved one only be supported by female care staff and this had been arranged. However improvement was required to ensure people were consistently involved in decisions around their care and treatment. For example, one person described how staff had not involved them in deciding what they wore that day and that their preference would have been to wear a different outfit.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us they had been involved in making some discussions around their care needs. One person said, "Staff talked to me about the support I needed when I moved in." Another person told us, "I've talked to staff about my care planning." A relative said, "We know [their loved one] has a care plan and we can access it any time." However one person commented that "Nobody has talked to me about what I want from my support." One relative also told us, "We have looked at the care plan once in the last two years; this was in May or June 2016. We've had not had any involvement in any further reviews."

The manager confirmed that people were assessed prior to admission to the home to ensure the service was suitable to meet their needs. This assessment was used as the basis upon which people's care plans were developed in consultation with them and their family members, where appropriate. Records showed that care plans had been developed for people in areas including mobility, continence, communication, nutrition and the management of people's skin integrity.

However, care plans were not always complete or accurate and had not always been reviewed on a monthly basis, in line with the provider's policy to ensure they remained up to date and reflective of people's needs. For example, we found sections in one person's care plan used to summarise their life history, hobbies and interests had not been completed by staff. Another person's care file didn't contain an end of life care plan to demonstrate that their end of life needs and preferences had been considered. In a third example we noted one person's care plan identified their preferences in the manner in which they wished to practice their faith but when we spoke with staff to determine whether they were supported accordingly, they told us the care plan was no longer accurate and needed updating.

We also found that people's individual preferences regarding their care and treatment were not always met. For example, one person's care plan identified their preference for a weekly bubble bath but the daily notes for the month prior to our inspection made no reference to the person being offered a bubble bath during this period. In another example one relative told us that their loved one's expressed preference to be washed every day had not always been met which had led them to raise a complaint which was confirmed by records we reviewed. Another relative told us that they had requested that a previous manager arrange a haircut for their loved one but this was not acted upon.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

People were supported to maintain relationships that were important to them. The manager confirmed that visitors were welcome at the service whenever they wished and this was confirmed by relatives we spoke with. One relative told us, "I'm able to visit every day." Another relative said, "We can visit when we want; there are no restrictions."

The service employed two activities co-ordinators who encouraged people to engage in a range of meaningful activities. We spoke with one of the activities co-ordinators who told us that activities were not

arranged every day due their limited working hours and because the number of activities staff employed at the service had reduced. The manager confirmed that one activities co-ordinator had left the service but told us they were in the process of looking to increase the frequency of organised activities at the service, although we were unable to check on this at the time of our inspection.

Activities available to people at the service included chair based exercises, arts and crafts, pamper days and bingo. However, improvement was required to ensure the activities on offer covered people's diverse needs. For example, one person's care plan noted that they were unable to participate in activities due to dementia, but contained no further information about how their need for social stimulation should be met.

The provider had a complaints policy and procedure in place which was accessible to people and relatives at the service. This gave guidance on what people could expect if they raised a complaint, including details of the timescales for any response and how concerns could be escalated if they remained unhappy.

People and relatives told us they knew how to complain, but did not always express confidence that any issues they raised would be appropriately investigated or responded to. For example, one relative told us they had complained but not received a response a few months prior to our inspection after they had found their loved one in the same clothes they were wearing on the previous day. We reviewed the service's complaints log and confirmed that this issue had been raised formally with the previous manager, but there was no record of any investigation having been conducted or the complaint having been responded to.

However, despite this issue we also found that complaints made more recently to the current manager had either been investigated and responded to appropriately, or were in the process of being investigated prior to a response being sent out. Therefore improvement was required to ensure all complaints were consistently investigated and responded to appropriately, in line with the provider's complaints procedure.

Inadequate

Is the service well-led?

Our findings

At this inspection we found significant concerns with the provider's systems for monitoring and improving the quality and safety of the service, and for mitigating risks relating to the health, safety and welfare of people living at the service. The failings of these systems to address issues at the service contributed to the multiple breaches of regulations previously referred to under the other key questions of this report in addition to the concerns identified below.

Senior staff conducted a range of checks and audits in areas including care planning, medicines and checks on kitchen processes. However these audits did not always identify issues or drive improvements. For example we reviewed a care plan audit conducted in January 2017 which identified gaps in the information contained in one person's care plan and that the care plan was overdue for a review. We reviewed the person's care plan during the inspection and found the gaps in care planning had not been addressed. We also found that whilst the person's care plan had been reviewed once since the audit, it had taken more than a month before this took place. The care plan was also again overdue a review at the time of our inspection, to ensure it remained up to date and reflective of the person's needs and preferences. This demonstrated that the audit process was not effective in driving improvements in people's care planning. The manager also acknowledged that only a limited number of care plan audits had been completed on the nursing unit and that further work was required to ensure all care plans have been audited and any issues addressed.

Staff were not always aware of the correct details of the provider's systems for contacting senior on-call staff if required in the event that management support was required to help address concerns at the service which had the potential to put people at risk. This had led to an incident over the previous weekend where a member of staff had left a message for a member of the management team who was not on-call to contact them because they were short staffed during the shift. This message was subsequently not picked up and acted upon at that time, resulting in the shift operating with fewer staff than had been calculated by the provider as being required to meet people's needs.

In another example, we found the provider's systems for monitoring and mitigating risks to people's skin integrity were ineffective because two staff we spoke with were not aware of how repositioning charts should be accurately completed, despite confirming that they were responsible for completing the charts. This meant that in some cases, we could not be assured that information regarding the repositioning of people had been correctly recorded.

Whilst the manager was in the process of acting to address issues where people's Deprivation of Liberty Safeguards (DoLS) authorisations had expired, the provider had no system in place to monitor people's DoLS authorisations or identify when action may be required to ensure any conditions placed on authorisations were met. This had led to a breach a breach of regulations previously identified in this report.

We also identified concerns with the provider's systems for ensuring the maintenance of complete and accurate records relating to people's care and treatment. We found gaps in some of the daily notes recorded

by staff about the support people received, or examples of daily notes lacked adequate detail about the person's current condition or the care that staff had provided them in order to demonstrate their individual needs had been met.

Additionally, we found the provider's systems for seeking and acting on feedback from people for the purposes of improving the service were not effectively operated. The manager confirmed that a survey had been completed during 2016 but the results had not been analysed and no action had been taken as a result. They told us a new system had been designed to seek feedback from people but this would not be implemented until June 2017. Therefore they were unable to provide examples of how feedback from people had been used to drive improvements at the service.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

There was no registered manager in place. At the time of our inspection, an area manager for the provider had day to day responsibility for the management of the service and had been in place as the acting manager since March 2017. They told us this was an interim arrangement and that the provider was seeking to recruit a new registered manager at the time of our inspection.

People and relatives told us there had been a lot of management and staffing changes at the service over the last year which had impacted negatively on the management of the service. They told us that previous managers failed to retain what they considered to be good quality staff many of whom had left due to issues with the way in which they were treated, which had led to an increase in the use of agency staff who were not always aware of their loved one's needs. This was confirmed by staff we spoke with. For example, one staff member told us, "It has been a very challenging period as staff have left this home; they have not been replaced by as skilled or as competent staff."

Not all of the people and relatives we spoke with were aware of who currently had responsibility for the management of the service and some relatives were not aware that the previous manager had permanently left. We received some positive feedback about the current manager. For example, one relative told us, "I think the new manager is trying to get things on track." Another relative said, "The current manager is more realistic; the last manager was hopeless and never responded to my emails." However despite this positive feedback, relatives told us they were not assured that any improvements would remain embedded at the service due to the high frequency of management changes and in light of confirmation that the current manager was only in post as an interim measure.

The manager told us that relatives had raised a series of wide ranging and serious concerns about the current situation at the service. These issues had previously been raised during relatives meetings but the manager told us that it was difficult to conduct these effectively due to the scope of issues raised. We saw that they had subsequently arranged for a series of open door sessions for relatives to attend around the time of our inspection to discuss any concerns they had about the service and these sessions included times when representatives from the local authority would be available for relatives to speak to if they preferred to speak to someone external from the service.

Staff told us that staff the manager had also arranged weekly drop in sessions if they had any concern they wished to discuss. One staff member told us, "The new manager is ok and seems to be getting things done. We had high turnover of managers but the current manager is sorting things out and things are settling down." Another staff member said, "The current manager is very firm and thorough, and wants things done properly. They are really trying hard to improve things."

The manager held daily meetings with senior staff to discuss the running of the service and ensure that relevant information was shared with the staffing team. We sat in on these meetings during our inspection and noted that the areas of discussion included the current occupancy of the home, staffing levels and agency use, any appointments people had that day as well as any housekeeping and maintenance issues. We noted that these meetings were effective in addressing day to day issues at the service. For example, during one of the meetings we attended staff raised concerns regarding a blocked sink at the service and we found that this issue had been addressed when we checked the sink later that day.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not always up to date and reflective of their individual needs. People's care and treatment did not always reflect their preferences. Regulation 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Sufficient action had not always been taken to prevent, detect and control the spread of infections. Regulation 12(1)(2)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably experienced staff were not always deployed at the service. Regulation 18(1).

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 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the Mental Capacity Act 2005 where people lacked capacity to consent to decisions regarding their care and treatment. Regulation 11(1)(2)(3).

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people were not always assessed or action taken to mitigate them. Medicines were not always safely managed. Regulation 12(1)(2)(a)(b)(g).

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse because the provider did not effectively operate systems established to investigate any allegation of abuse. Service users were deprived of their liberty without lawful authority. Regulation 13(1)(3)(5).

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes established to monitor and improve the quality and safety of the service, and to assess and mitigate risks to service users were not operated effectively. Systems established to maintain a complete an accurate record in respect of each service user and for seeking and acting on feedback for the purposes of continuous improvement were also ineffective. Regulation 17(1)(2)(a)(b)(c)(e).

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate training and professional development, as necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1)(2)(a).

The enforcement action we took:

We served a warning notice on the provider.