Willowbank Rest Home Limited

Deansgrove Residential Care Home

Inspection report

38 Blue Bell Lane
Huyton
Merseyside
L36 7XZ
Tel: 0151 489 1356
Website: www.example.com

Date of inspection visit: To Be Confirmed
Date of publication: 24/07/2015

Ratings

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

Overall summary

This was an unannounced inspection, carried out on 15 and 18 May 2015.

Deansgrove Residential Care Home is registered to provide accommodation and personal care. It is a privately owned care home which accommodates up to 29 adults. The service is located in the Huyton area of Knowsley and is close to local public transport routes.

Accommodation is provided over two floors and the first floor can be accessed via a stair case or passenger lift. At the time of our inspection there were 16 people living at the home.

The service does not have a registered manager. 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'.

Summary of findings

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. A manager had been appointed by the registered provider to manage the service.

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

The last inspection of Deansgrove Residential Care Home was carried out in November 2013 and we found that the service was meeting the regulations.

People who used the service were not fully protected from potential abuse. Staff did not have access to relevant safeguarding policies and procedures and their understanding about how to respond to allegations of abuse was limited. Incidents of potential abuse which had occurred at the service had not been appropriately dealt with. Staff did not have confidence in the provider's whistleblowing policy and procedure. They told us they were afraid to raise any concerns they had with the manager.

People's health and safety was put at risk because parts of the environment were unsafe and unclean and infection control practices were not being appropriately followed. Potential risks to people had not been considered or planned for in relation to their care.

People's medication was not managed safely. Staff administered medication without appropriate guidance and there was excessive quantities of medication which could result in confusion and expired stock.

Training provided to staff was ineffective and some staff had not received training relevant to their roles and responsibilities. Staff did not have access to guidance such as codes of practice in relation to the work they carried out. Staff did not feel supported and they had not been given the opportunity to discuss their work, training and development needs.

The manager and staff had not completed training in relation to the Mental Capacity Act 2005 and they lacked knowledge in relation to this. They failed to apply the principles of the law when making decisions for people who lacked capacity and needed their liberty restricting for their safety.

There was no evidence to show that care plans were developed and reviewed with the involvement of the person they were for, and significant others, such as family members and health and social care professionals. Review records lacked detail about how the reviews took place, who was involved and the outcome.

People were not always respected because of the lack of maintenance and suitable facilities to ensure people's privacy, dignity and independence. There was an unpleasant smell throughout the environment and people's bed linen was tatty and faded. The storage of people's personal records in communal areas undermined their privacy and confidentiality.

The leadership of the service was unsupportive and did not promote a culture whereby staff felt able to openly discuss any concerns they had. Systems were not in place to check on the quality of the service and ensure improvements were made. These included a lack of regular audits on aspects of the service and obtaining people's views and opinions about the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Parts of the environment were unsafe and posed a risk to people's health, safety and welfare. Risks to people were not assessed and planned for.

Staff were unsure of the process for responding to allegations of abuse. Incidents of potential abuse which had occurred were not appropriately responded to.

Medication was not safely managed. Staff did not have access to procedures and best practice guidance for managing medication.

Parts of the service were not clean and hygienic and staff failed to follow appropriate infection control procedures.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked knowledge of and they failed to apply the law when making decisions for people who lacked capacity.

Staff had not received the necessary training and support to enable them to effectively meet people's needs.

Good relationships with visiting professionals and family members were not maintained had not been established in the best interests of people who used the service.

Is the service caring?

Inadequate

The service was not caring.

The environment failed to promote people's privacy, dignity and independence due to a lack of maintenance and the provision of suitable facilities for people.

People and their family members told us that the staff were kind and caring. Staff spoke about people in a caring way and they were patient and caring in their approach when providing people with care and support.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had not been updated to include a change in people's needs and they did not reflect people's preferences with regards to how they wished their care to be provided.

People's complaints had not been investigated in line with the provider's complaints procedure. The complaints procedure failed to inform people of the correct process to follow if they needed to escalate a complaint.

Recommendations from outside professionals had not been acted upon to ensure improvements were made to the service.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager. Staff and family members described the manager as unsupportive and unapproachable.

The leadership of the service was not inclusive and did not promote an open culture.

There was no attempt to establish relationships with visiting professionals in the best interest of people who used the service.

There was a lack of effective quality assurance systems which resulted in people receiving inadequate care and support.

Deansgrove Residential Care Home

Detailed findings

Background to this inspection

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

Our inspection was carried out over two days on 15 and 18 May 2015. The inspection was unannounced and the inspection team consisted of two adult social care inspectors.

During our visit to the service we spoke with five people who used the service, two family members and seven staff. We also spoke with the manager, the provider and four visiting healthcare professionals. We looked at four people's care records and observed how people were cared for. We toured the inside and outside of the premises including people's bedrooms. We looked at staff records and records relating to the management of the service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection and information we received from members of the public and local commissioners. Following the inspection we contacted a number of other health care professionals who visited people at the service.

Inadequate

Is the service safe?

Our findings

Before our inspection we received some concerns related to the safety of the service. We looked at these concerns as part of the safe domain.

People told us they felt safe and that the staff had treated them well. People's comments included; "I'm fine here, the staff treat me good" and "Yes I feel safe".

People were not protected from abuse or the risk of abuse. Staff did not have access to important information about safeguarding procedures and they had limited understanding of how to respond to abuse. We asked staff how they would respond if they were told about, witnessed or suspected abuse. Staff comments included; "I would tell the person [alleged abuser] to stop it and probably call the manager to tell her", "I would go and question the carer to see if it was true. You don't always know if people are telling the truth", "I would tell the carer not to do it again" and "I'm not really sure". The provider had a safeguarding policy and procedure, however staff found it difficult to locate. One member of staff eventually located it in a file which they took from a cupboard kept in an area outside the office. Several other members of staff told us they were not sure where the policy could be found and that they didn't remember seeing it. A file containing the local authority's safeguarding policy and procedure was kept in a cupboard in the office. None of the staff we spoke with knew about this and had no idea where to find it. Staff told us that the office was kept locked whenever the manager was not on duty, the manager confirmed this. This meant staff did not have access to important information about safeguarding procedures, such as who to contact if they witnessed or suspected abuse. Some staff told us they had not received safeguarding training and others said they had. We saw records which confirmed this. However, staff that had completed the training said that the training consisted of watching a DVD which lasted 20 minutes and that they were given a list of questions to answer following the DVD. They said they did not receive any feedback regarding their progress. One member of staff commented that the training was ineffective and that they would benefit from further safeguarding training.

People were not protected from abuse or the risk of abuse because incidents of suspected abuse were not responded to appropriately. Entries recently made by staff in a communication handover book detailed four incidents which were potential safeguarding matters. For example, unexplained bruising and a physical altercation between two people who used the service. We discussed these with the manager and she did not consider that any of the incidents were safeguarding matters and therefore they had not raised them with the relevant safeguarding team for investigation.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were at risk of abuse because systems and processes were not in place to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

People were not protected against the risk of the spread of infection. Practices at the service increased the risk of the spread of infection. The provider had a policy and procedure for infection control; however this was not being followed. On entering the service we noted a strong smell of urine. We entered a bedroom near to the entrance of the service and found an overpowering smell of urine. The manager told us that it was the provider's intention to deep clean the room, however this had not been done. A number of other rooms we entered also smelt of urine and one person's bed had been made over a dirty mattress. We brought this to the attention of the manager, however, several hours later we returned to the room and saw that the bed had been re made over the same mattress which remained dirty. There was a soiled incontinent pad in a drawer in a vacant bedroom. We brought this to the attention of the manager and when we later returned to the room the pad was still there. The pad had been removed on the second day of our inspection. Slings for lifting hoists were hung on the back of bathroom and toilet doors. We brought this to the attention of the manager on the first day of our inspection; however they were still hung up in the bathroom and toilet on the second day of our inspection. This increased the risk of the spread of infection.

We saw stains on carpets and bathroom floors, dirty arm chairs, dusty furniture, dusty skirting boards and window ledges in people's bedrooms. The manager told us that there should be two members of staff undertaking domestic duties working at the service at different times throughout the week. However, she said that there was currently only one domestic worker as they were recruiting for a vacant post. The domestic worker in post, worked four

days a week and no arrangements were in place to cover the other three days. The manager told us it was the responsibility of the care staff to carry out cleaning and laundry duties to fill this gap. There was a cleaning check list on the back of each person's bedroom door. The record included cleaning tasks which were required to be carried out in people's rooms, daily, weekly and monthly. The relevant member of staff was required to sign the record on completing the task.

We observed a member of staff rolling up a quilt on the floor in a corridor outside people's bedrooms. The member of staff told us that they had removed the quilt from the person's bed because it was wet with urine. The member of staff was not using any personal protective equipment such as disposable gloves and apron. This increased the risk of the spread of infection.

The laundry was cluttered. There were two plies of laundry on the floor, one pile was in front of the dryer and the other pile was close by in front of the washing machine. A member of staff confirmed that the washing in front of the dryer had been laundered and that the pile in front of the washing machine was dirty. There was no clear system in place for separating clean and dirty laundry. For example, there were no colour coded bags or containers available for storing clean and dirty laundry. The manager told us that there was no dedicated laundry assistant and that it was the responsibility of the cleaner on duty or care staff to manage people's laundry. This increased the spread of infection.

An audit carried out by the local authority's community infection control team in April 2015 highlighted a number of concerns and gave recommendations regarding infection control at the service. We found that although some of the concerns had been addressed others had not. For, example, strong urine odours were evident across the service, care staff did not have access to PPE at the point of care and the laundry room remained cluttered. An audit of the service carried out on 01 and 08 May 2015 on behalf of the provider reported on infection control, however it failed to identify any of our findings as described above.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care was not provided to people using the service in a safe way. People were not protected against the risk of the spread of infections.

Areas of the service posed a risk to the safety of people, staff and visitors. On our arrival at the service at 9:30 am we saw a paper napkin taped over a light switch outside a bathroom. There was a hole in the centre of the napkin which suggested someone had attempted to use the switch. When we removed the napkin we saw that the switch was broken and wires were exposed. We immediately brought this to the attention of the manager who advised us that the switch had been broken for approximately one week. However, other staff told us it had been broken for several months. The manager told us she had reported the broken switch to the provider and had requested it to be repaired, however there was no record of this and no further evidence to show any attempt had been made to repair the switch. The manager refused to contact an emergency electrician to repair the switch and told us that she was unable to do this without consent from the provider. Following our advice the area close to the switch was cordoned off and an electrician arrived at 6 pm that evening and repaired the switch.

We identified a number of hazards which had the potential to cause harm to people who used the service. There was a trailing telephone wire on the floor directly outside a bedroom and bathroom and loose wires running across the floor in the hallway, this posed a trip hazard to people who used the service, staff and visitors. The lift flooring was very sticky and it had a gapping split through the centre, therefore increasing the risk of falls. Staff told us the lift floor had been damaged for several weeks and that they had reported it to the manager. We brought this to the attention of the manager who advised she was aware that the lift floor had split some time ago and she confirmed that it had been glued down. There were no records to show that the damage to the lift floor had been reported or that any action had been taken to repair it. The flooring in the lift was replaced during our inspection.

There were three unlocked rooms at the service being used for storage. Items stored in the rooms included; broken and unused wheelchairs, beds, furniture and pots of paint. One of the rooms housed a central heating boiler and had exposed pipes running up the wall which were very hot. The boiler was mounted on a wall and the floor boards underneath it were missing, exposing more hot pipes. People were at risk of entering the rooms and falling, without the knowledge of staff. Following our inspection we were assured that the room had been locked.

Inadequate

Is the service safe?

The garden at the back of the service which was accessible to people who used the service had not been maintained posing a risk to people. The lawn was overgrown causing a potential trip hazard. There were two sheds at the side of the garden which stored gardening tools, garden substances and broken equipment such as wheelchairs and old furniture. The sheds were unlocked which posed a risk to people who entered these areas.

Risks to people's safety had not been assessed or planned for. We asked to view risk assessments in relation to the environment. However, the manager only provided us with two. One was for infection control and the other was for the use of the lift. Both risk assessments had been initially completed in September 2012. The only information added to the risk assessments since they were first completed were; the manager's initials and a date of 20 February 2015. This was despite a number of environmental hazards noted by the manager and other hazards which had been brought to the managers' attention by staff and visiting professionals.

Staff were unable to locate the first aid box. It was eventually located by the manager from the back of a drawer in a communal area of the service. The contents of the first aid box were out of date and there were missing items. The manager confirmed that there was no system in place for checking on the contents of the first aid box or ensuring it was accessible to staff. This posed a risk to people in the event of them requiring first aid.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected against the risks associated with unsafe or unsuitable premises and equipment.

People's medication was not safely managed. The provider had a policy and procedure for the management of medication, however staff told us they had not seen it and that they were unsure where it was kept. The policy and procedure was eventually located by the manager. The medication cupboard was untidy and dirty and there were excessive quantities of medication dating back several months which could lead to confusion or expired stock. There was also excessive stock of medication which was no longer in use and should have been returned to the pharmacist. The member of staff who was administering medication said they knew about the excessive stock but did not have the authority to do anything about it. When administering medication the member of staff did not follow the correct procedure. They administered people's medicines with their bare hands. This practice did not protect people from cross infection nor did it promote their dignity. Some people's medication administration records (MARs) had gaps where they had not been signed or coded. This meant there was no guarantee that people had received their prescribed medication. Staff had administered PRN (as required medication) to one person; however there were no instructions or guidance on the person's MARs or in their care records about when the medication should be administered. The provider had a system in place whereby the home manager was required to carry out monthly medication audits. The last medication audit was carried out by the manager in January 2015. The annual audit carried out in May 2015 did not include any checks on medication.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from the proper and safe management of medicines.

Inadequate

Is the service effective?

Our findings

People told us they often felt cold, their comments included; "We are all shivering when we get up. It's been like this for ages". "The heat in here is like Iceland when you come down in the morning". A family member commented "It's cold, I believe they have had problems with the central heating".

The temperature in parts of the service felt cold and some people told us they often felt cold in bed and whilst sitting in the lounge. We saw that people were sat with blankets wrapped around them and staff told us that this was because people complained about being cold. We brought this to the attention of the manager and she told us there had been problems with the heating system and that it had been repaired but further problems had occurred, which meant the heating was unpredictable at times. There were a number of portable heaters situated around the service including people's bedrooms and we were told that they had been used to help warm the areas which were particularly cold. We were assured that the heating was working prior to us leaving the service.

Some people's bedrooms smelt of urine and equipment, items of furniture and carpets were damaged and in poor condition. For example, a wardrobe had a door missing and a number of rooms did not have lampshades fitted. The toilet cistern in one person's en-suite bathroom was hanging off the wall and the lid to the cistern was on the toilet seat. Staff told us the person had not been able to use the toilet in their room for several weeks due to the broken cistern and that they had had to use the toilet in a communal bathroom across the corridor.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

People's rights were not protected in relation to decision-making and staff lacked training in relation to obtaining people's consent and ensuring people's legal rights. The manager and staff demonstrated limited understanding of the MCA and DoLS. They told us they had not been provided with any training in the subject. Staff training records and the services annual training plan for 2015 did not include any MCA or DoLS training. The provider had a policy and procedure in relation to MCA and DoLS, however the staff were not familiar with this, despite it being available in a policy and procedure manual which was accessible to them. The manager said a DoLS authorisation was in place for a number of people who used the service, however she was unable to provide the details of those people and the reasons for the authorisations. The manager was also unable to provide the relevant documentation in relation to the applications and authorisations. Staff had no idea of those people who were subject to a DoLS authorisation and they did not understand what a DoLS meant for the person and what their responsibilities were for implementing it.

Decisions were made on behalf of people without their consent or the consent of a relevant person. For example; the manager had made a decision to move two people out of their bedrooms into other rooms without consulting the person or other relevant people. The manager told us that the people concerned did not have the capacity to understand what was happening, however the manager did not consider the principles of the MCA for example; what was in the persons best interests.

People's care records did not include any evidence to show that the principles of the Mental Capacity Act 2005 had been used to assess people's ability to make a particular decision. The manager told us there were no records in place for people around consent or about how to support people who lacked capacity, to make decisions which were in their best interest.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from inappropriate deprivation of their liberty.

Some staff had not received training and support relevant to the work they carried out and the needs of the people who used the service. Staff commented that training they had received was ineffective. Training records showed that staff had completed training in topics including first aid, moving and handling, fire safety and food hygiene. However; a number of staff had yet to complete any training. Four staff told us they had not received safeguarding training, fire training and moving and handling training. Staff also told us that they had not received training in dementia care; this was despite there being a number of people who used the service living with dementia. Staff told us that all the training had been in the

Inadequate

Is the service effective?

form of a DVD which they were instructed to watch at the service. The staff said they filled in questionnaires after watching the DVDs but had not received any feedback from them. Staff comments included; "We don't get any feedback after training, we just discuss it amongst ourselves". "I've filled in questionnaires after watching training DVDs but have never been told if I have passed". And "I don't think the training is very good and we don't get any support with it, we are just left to watch DVDs".

Training records did not evidence induction training for new staff. Six new staff had been employed since the appointment of the manager. We requested from the manager induction records for the newly recruited staff, however she failed to provide us with them. New staff told us that their induction consisted of being shown around the service on their first day and they said they had not received any training since starting work at the service.

The provider had a procedure in place for the supervision of staff but it had not been followed. The policy stated that all care staff should receive a minimum of three formal supervisions each year and that the manager should ensure that responsibility for supervision is delegated to an appropriately qualified and trained member of staff. Staff reported to us that they had not had supervision with the manager or any other more senior member of the care team. One staff member said I have been here for more than six months and not had supervision and another member of staff said, "No I don't think I have". Staff told us that they had not met as a team for some time and it was something they felt they would benefit from. The manager told us that they had held a number of staff meetings, however staff could only recall ever attending one staff meeting in January 2015, when the manager took up post. The manager provided us with the minutes of the meeting which took place in January 2015 but was unable to provide the records of any other staff meetings since that date.

The provider had a whistleblowing policy and procedure, however staff told us they were not confident about using it. One member of staff told us that in the past someone had raised a concern with the manager and everybody got to know about it. Staff commented; "I wouldn't tell her anything, I don't trust her".

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not supported by staff who had always received appropriate training and support for their role.

Inadequate

Is the service caring?

Our findings

Before our inspection we received some concerns related to caring for people who used the service. We looked at these concerns as part of the caring domain.

People told us that the staff were kind and caring. People's comments included; "The girls are lovely, they do whatever they can for you". "They treat me well, I've no complaints about that". One person's family member told us they thought the staff were kind and caring and did their best.

People were not respected because their privacy, dignity and independence were not promoted. Bed sheets, quilts and pillows on people's beds were thin, tatty, torn and faded, and pillows were lumpy and uneven. We checked the clean linen cupboard and found that the majority of bedding was also of poor quality. Staff told us they agreed the bedding was of poor quality and that they had on a number of occasions reported their concerns about it to the manager. Comments staff made included; "We have told the manager about the poor bedding. They said they were going to get some new bedding". "Most of the bedding is really bad. The manager just keeps saying it's on the list". The manager told us they were not aware of the poor bedding. One person who used the service told us their pillows were really uncomfortable.

There were packs of incontinent pads piled up on people's bedroom floors and stacked on top of wardrobes and chest of drawers, this undermined people's dignity because they were on full view on entering their bedrooms.

The dining room at the service was situated in a conservatory at the back of the service which overlooked the back garden. The conservatory was overlooked by a row of houses. However, there were no blinds or any other privacy screening fitted to the windows of the conservatory, therefore people's privacy was not respected. This was despite the provider acknowledging the need for blinds in the conservatory, back in February 2015 as part of a maintenance action plan. The manager was unable to evidence that she had progressed with this action.

The garden was littered with weeds, discarded cigarette butts and litter making it uninviting and unpleasant. One person told us they liked to spend time in the garden potting plants, however they said, "I'd spend more time out here if it was nicer. I'd have a go at doing it myself but it's too much for me".

The system for managing personal information failed to take account of people's confidentiality, privacy and dignity. A staff communication handover book which was in use contained confidential information about people who used the service. For example, outcomes of visits people reviewed from other professionals and daily progress notes. The book was stored on top of a cabinet in a communal area which was often unsupervised by staff. This was not person centred and undermined people's privacy and confidentiality. One person's medical records were left on top of the medication trolley which was stored in a communal area. In the same area there was an open top storage box containing opened and unopened mail addressed to people who used the service. There was an unopened birthday card which a person had not received. A member of staff told us that the basket was left there so that family members could check it for any mail belonging to their relatives. We brought this to the attention of the manager and they confirmed that there were no agreements in place to show that people had consented to their family members opening their mail. Receipts for a hairdressing service people had received were stuck to the side of the medication cupboard which was mounted on a wall in a communal area. The manager did not consider that the system for managing people's mail and the displaying of personal receipts in a public area was inappropriate. People's mail and receipts were removed and taken into the office.

The manager demonstrated little understanding of person centred care and we saw no evidence that people had been involved in planning and reviewing their care. Needs assessments included information about people's spiritual and diverse needs, for example one person's care plan stated they liked to attend prayers every Sunday and receive local newspapers, however staff told us that the person had not attended prayers and had not received newspapers. Staff told us they had not received any training in topics such as equality and diversity or person centred care and training plans did not include any future training in the topics.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not treated with dignity and respect.

Staff gave appropriate responses when asked how they respected people, and they knew the importance of

Inadequate

Is the service caring?

ensuring people's independence, choice, privacy and dignity was promoted. Comments made by staff included; "It is important for people to do as much as they can for themselves". "I knock on doors before going into bedrooms" and "I always ask people what they want". We observed staff supporting people in a caring and respectful way. For example, people received personal care in the privacy of bathrooms and their own bedrooms with doors shut and staff spoke with people patiently and in a caring way.

Inadequate

Is the service responsive?

Our findings

People's needs were assessed and planned for on admission to the service. However people's needs were not always met and changes to people's needs were not always recognised and acted upon. For example, one person living with diabetes was given biscuits with a cup of tea and had to remind staff that they could not eat biscuits. We asked the manager if she had considered purchasing alternative snacks which were more suitable for people living with diabetes and she responded by telling us that the supermarket they shop at do not sell such products, we then asked if alternative supermarkets had been considered and she said no.

Daily records for one person recorded details of contact they recently had with a visiting healthcare professional. The records showed that the person had expressed specific wishes in relation to their future care and treatment in the event of them becoming seriously ill. However, this information was not acted upon, therefore the person was at risk of receiving inappropriate care and treatment. We were assured following the inspection that the person's wishes were being addressed.

A staff communication book had been used daily by staff to report on people's progress and the care and support individuals had received. Some entries included reports about people's changing behaviour, moods, health and incidents which occurred at the service. They also included details of visits and outcomes from other health and social care professionals. However, the information had not been reflected in the individual's personal progress notes, despite this being a requirement by the registered provider.

People's needs were not fully reflected in their care plans. Reports had been written in the staff communication book on several consecutive days about deterioration in a person's health. However, the information had not been entered into the person's individual notes and there was no evidence to show that medical advice was sought for the person. Another report recorded that a person had fell and banged their head and again this information had not been transferred into the person's individual progress notes and there was no evidence of any action taken in response to the fall. There was no incident report completed and no medical advice was obtained. When we spoke with the manager about some of the reports she had no knowledge about them. The manager confirmed that she did not review the communication records, however she told us that she was responsible for reviewing and updating care plans. This meant people were at risk of not having their needs identified and met.

Care plans and review records did not evidence the involvement of people who used the service or significant others such as family members and health and social care professionals when planning care and support. People told us they knew nothing about their care plans and they told us they had not been invited to take part in developing or reviewing them. This meant people were not aware of the contents of their care plans or were given the opportunity to agree to them.

Staff told us they knew about care plans and had access to them, however they said they took no part at all in writing or reviewing care plans. One member of staff told us they sometimes read care plans but didn't understand them all. The manager told us that she was responsible for developing and reviewing care plans and it was something she had been working on continuously since her appointment as manager in January 2015. Review records were very brief and did not record how the review took place and who was involved. One person's care plan was last reviewed in February 2015. The review recorded 'no changes, review again in 4 weeks or sooner if needed'. However, since the review there had been a significant change in the person's needs and wishes there was no evidence that the care plan had been reviewed and updated. People who used the service were at risk of not receiving the care and support they need because their care was not planned effectively.

There were limited opportunities for people to take part in activities at the service. There was no activities coordinator at the service and the manager told us there hadn't been one since her appointment in January 2015. The minutes taken from a staff meeting which took place in January 2015 recorded that additional hours for activities had been removed because activities were not being done and those hours could not be justified. A family member told us; "There are no activities at all, people must get very bored, no stimulation for people". Staff comments included "We had a singer at Christmas, that's about it. We did nothing for VE day, I know loads of places that had tea parties and celebrations, not here".

Although we saw staff sitting and chatting with people there was very little going on in terms of any other activity

Inadequate

Is the service responsive?

and stimulation. Throughout the two days of our inspection most people who used the service were sat in the lounge either asleep or watching TV. A second lounge remained unoccupied with the exception of one person who sat in it for approximately 30 minutes on the first day of our inspection. There were books, board and soft ball games in the unoccupied lounge, however none of the facilities were used throughout our inspection. A member of staff told us that the manager had instructed that the lounge was not to be used. There were no newspapers or magazines available for people, this was despite one person's preference to receive local newspapers daily.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the needs of people who use the service were not planned for.

The provider had a comments, suggestions and complaints procedure which included timescales for responding to complaints. The procedure was displayed in the passenger lift and near to the entrance of the service. We asked the manager if any complaints about the service had been received and she said there they had received a number of written and verbal complaints. We asked to view the complaints records however the manager said she never kept any records of verbal complaints and the records of others were held at head office. The manager assured us that she would obtain the records for us to view. We did not receive the complaints records despite us requesting them on the first and second day of our inspection.

Staff told us they were not confident about raising complaints about the service. They said they didn't think the management team would deal with them appropriately. Staff said they had raised concerns in the past but nothing had been done.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was no system in place for people's complaints to be managed.

Inadequate

Is the service well-led?

Our findings

Before our inspection we received some concerns related to the management of the service. We looked at these concerns as part of the well-led domain.

Some people who used the service told us they knew who managed the service but others told us they were not sure who was in charge.

The service was being managed by an interim manager who took up post in January 2015 following the resignation of the registered manager. A new permanent manager had been appointed and they took up post on the second day of our inspection.

Although the manager was responsible for the day to day operations of the service she was accountable to an operations manager and the provider. This structure made up the management team for the service.

The management arrangements failed to establish good working relationships with other professionals and family members. We received a number of concerns from visiting professionals about the management arrangements, including their attitude and unwillingness to engage with them about matters concerning the care of people who used the service. Healthcare professionals had visited the home regularly and provided specialist healthcare support to people who used the service. They had also provided staff with advice and guidance in relation to people's ongoing care. All the healthcare professionals told us that they had not met with the manager because the manager had not approached them at any time to introduce herself or discuss the care they were providing people with. We discussed this with the manager who said she had left the staff to deal with visiting professionals because they knew the people better. Family members informed us that they had raised a number of complaints with the current management about their relatives care, however the manager was unable to provide us with any evidence of how they had responded to these concerns.

The service did not promote a positive culture that was open, inclusive and empowering. Staff told us that they found the management team unsupportive and unapproachable. They told us they did not feel that there was an open culture operated at the service and that they were afraid to approach the management team with any concerns they had. Staff said they would not whistle blow for fear of their concerns not being treated confidentially and for fear of reprisals. Staff said they had raised concerns in the past but they were not listened to or acted upon. Staff provided us with many examples of requests and concerns which they had raised about the service which they said were ignored. For example, concerns about poor quality bedding, the heating, the cleanliness of the service and the general condition of the environment.

Staff told us that a total of six staff had left the service in the last five months and this was confirmed by the manager. Staff said staff morale was very low and that they didn't feel valued, their comments , "We are never asked for our opinion, just told what to do", Staff have left because of the management" and "They don't talk to us much, just tell us what to do".

Staff told us that they thought the current management arrangements were ineffective and did little to improve the quality of the service for people, or to support the staff. Most staff had not received formal supervision in the last six months. Those that had were not given feedback about their performance and during supervisions they were not provided with an opportunity to discuss how the service was run, their training and development needs. Training provided to staff was not appropriately monitored and staff did not receive feedback based on competency tests which they completed following training.

The systems in place for assessing and monitoring the quality of the service and making improvements were ineffective. The provider had failed to make improvements following visits from other professionals including; infection control nurses and the local authority who commission people's care. Also concerns raised by staff and family members about people's care and the environment were not listened to and acted upon. We have cited a number of these under the other domains.

There was a lack of audits (checks) carried out across the service and those that had been carried out failed to identify shortfalls and others did not reflect the true findings. A maintenance audit was carried out by the management team in February 2015 and an action plan was developed based on the findings. The plan included a significant amount of improvements which were required across the service to improve the environment, for example repairs, cleaning schedules and replacement of fixtures and fittings. We were provided with a copy of the plan which included a record of progress made up to date. The records

Is the service well-led?

showed that the majority of the work had been completed or was ongoing. However, during a tour of the premises we found that most of the work identified in the action plan as being completed remained outstanding. The management team confirmed they had completed the action plan with incorrect information. This meant that the safety of people who used the service, staff and others was put at risk.

The monitoring of the service was overseen by a governance administrator who the provider appointed to carry out annual audits across the service. The manager was unable to provide any records of any other checks they carried out in addition to the annual audits. For example, on things such as infection control, medication, health and safety and the environment and equipment. We saw a recent audit carried out in May 2015 by a governance administrator. The audit reported on areas of practice such as: care planning, infection control, nutrition and activities. However, the audits failed to identify shortfalls in the service which we found. For example, under the heading infection control the audit stated that cleaning rotas were up to date, however we saw that cleaning schedules for the last three months were incomplete and had not been checked by a manager as required. The audit identified a lack of activities and activity records for people who used the service, however the manager was unable to provide any evidence to show how this was being addressed. The audit did not identify many other concerns we found. For example, the environment, health and safety practices, staff supervision and training, safeguarding records, accident records and medication. There was no evidence to show that people who used the service were consulted as part of the audit. For example, people's views had not been obtained about the choice of food and the care they received.

The manager was required to check and sign off weekly cleaning schedules displayed in people's bedrooms. We looked at a sample of records taken from four people's bedrooms dating back over the last three months and found a large number of gaps in signatures. None of the records had been signed by the manager or on behalf of them, as required. The manager confirmed to us that they had not carried out the checks as required or appointed anyone else to carry out the checks on their behalf. Staff told us that the gaps in the records had not been signed because the tasks had not been carried out.

There were no systems in place to assess risk, manage or check on infection control practices. We asked the manager for records of checks on infection control carried out across the service. The manager told us that they there was no system in place for regularly checking on infection control across the service including staff practice. The manager told us that an infection control audit had been carried out by the community infection control nurse in April 2015 and that they thought the audit was the only check on infection control which needed to be carried out at the service.

The manager told us that the provider had visited the service regularly and conducted checks on the service people received. However, no records of the provider visits were kept.

Incident records had not been fully completed and there was no system in place for monitoring incidents which had occurred at the service. Incidents were recorded onto an incident reporting form. There were eight recorded incidents completed since January 2015. The forms required the manager of the service to complete a section entitled outcome of investigation and follow up action, however this section had not been completed on any of the records. Care records showed a number of accidents and incidents had occurred at the service, however there were no reports for these and the manager confirmed they had not been completed. The failure to complete incident records and the lack of auditing of incidents meant there was no system in place to identify any trends and ways of learning to prevent any future reoccurrences.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People using the service were not protected against the risks associated with unsafe or unsuitable premises and equipment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Care was not provided to people using the service in a safe way. People were not protected against the risk of the spread of infections.**

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 **People were at risk of abuse because systems and processes were not in place to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People using the service were not protected from the proper and safe management of medicines.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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 **People using the service were not protected from inappropriate deprivation of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People using the service were not supported by staff who had always received appropriate training and support for their role.**

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The needs of people who use the service were not planned for.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **There was no system in place for people's complaints to be managed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.