Rizwan Iqbal and Mrs Parvin Khan & Mr Asif R Khan

The Maples Residential Care Home

Inspection report

66 Bence Lane
Darton
Barnsley
S75 5EP
Tel: 01226 382688
Website:

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Ratings

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

Overall summary

This inspection took place over two days on 12 January 2015 and 14 January 2015. The inspection was a short notice inspection. We provided notice because the service had recently appointed a new manager and we wanted a representative from the partnership to be present to answer any questions we had. A partnership is a legal relationship formed by the agreement between two or more individuals to carry on a business as co-owners.

Since 28 October 2013 Care Quality Commission inspectors have carried out five inspections and have found multiple breaches with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At the inspection on 28 October 2013 a breach was identified in records. At the inspection on 10 February 2014 sufficient improvements had not been made and the registered provider remained in breach of the regulation associated with records. At the inspection on 19 and 26 August 2014

Summary of findings

breaches of regulations were also identified in care and welfare and the management of medicines. Warning notices were issued for breaches of regulations associated with assessing and monitoring the quality of service provision and records. At an inspection on 24 November 2014 we found warning notices had not been met.

At this inspection we found sufficient improvements had not been made in the areas where previous breaches had been identified and we identified further breaches of regulations in safety and suitability of premises, recruitment of workers and supporting workers.

The Maples Residential Care Home is a care home registered to provide personal care and accommodation for up to fifteen older people, including some people living with dementia. At the time of our inspection ten people were living at the home.

The service had been without a registered manager since June 2014. Since that time there had been four managers. The current manager had commenced employment on 29 December 2014 and was in the process of applying to be the 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'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The home did not have effective systems in place to manage medicines, which meant people were not always protected from the risks associated with medicines.

Safe systems were not in place to manage risks to individuals and the service, for example, fire safety and hot water.

Robust recruitment procedures were not in place and staff were working without appropriate information and documents being obtained about them. This meant people were cared for by staff who had not been appropriately assessed as safe to work with people.

Staff had not received an appropriate induction and not all staff had received appropriate training relevant to their role and responsibilities. Staff had not received regular supervisions which meant their performance was not formally monitored and areas for improvement may not have been identified. This meant the service did not ensure staff received appropriate training, professional development, supervision and appraisal.

Assessments, care plans and risk assessments did not always contain up to date or accurate information about people. This meant that some people did not always receive the care and support they needed to meet their identified needs.

Effective quality assurance systems were not in place to monitor and improve the quality of service provided.

When we spoke with people who used the service they all told us they felt safe. Relatives spoken with did not raise any concerns about mistreatment or inappropriate care provision of their relative. Staff had received safeguarding training and were confident the manager would act on any concerns. However, we found that staff had failed to recognise that an incident that had occurred at the home should have been reported to the appropriate authorities.

People responded to questions about the numbers and availability of staff with positive comments and staff did not express any concerns about staffing levels at the home. However, we found people did not have access to call alarms in the lounge when staff were not present and needed to call for assistance. This meant people were unable to summon staff when they needed support in a dignified way.

The requirements of the Mental Capacity Act 2005 were not understood by staff, which meant there was a risk that people may be deprived of their liberty without due process being followed.

People were broadly positive about the food that they were served at mealtimes, but the meal time experience could be improved, for example, asking people their choice of menu on the day, a more varied choice of food and people not kept waiting at the dining table before lunch was served.

Summary of findings

We saw information in people's care files that health professionals were contacted in relation to people's health care needs, which included involvement from doctors and the community mental health team. This was confirmed by the people who used the service and staff.

This service was a small service and this impacted on people's experiences at the home, although they themselves did not say this. For example, there was one seat for each person in the lounge, which if everyone was sat in was cramped.

We observed very little interaction between people and staff, with most conversations being prompted by and based around tasks. At those times staff interactions were patient and caring in tone and language. About staff people said, "they are helpful in a way. The girls are very nice here – she's lovely, that lady (indicating a carer worker). Always a smile." and "they don't sit and talk".

People did not raise concerns about staff not respecting their privacy and dignity, but we saw occasions when this was not respected by staff, for example, we overheard staff saying "we need to start toileting".

We asked people how they passed their time and whether there were was a stimulating programme of activities. No-one we spoke with was able to tell us of about any activity that they had taken part in, or how they were encouraged or supported to maintain hobbies and interests. One person said, "we just sit and wait." Our observations during the inspection showed that the activities and stimulation for people to participate in could be improved.

We found the complaints procedure was not robust, staff were unable to locate a complaints log and the registered provider was not aware of one complaint.

The registered provider had not always informed the Commission about notifiable incidents in line with the Health and Social Care Act 2008, for example, serious injury notifications and outcomes of DoLS applications.

The registered provider was not aware of the requirement to register with the Information Commissioner's Office, the office responsible for enforcing the Data Protection Act 1998 and where providers who hold personal data about people need to register. This meant their legal responsibilities had not been met and there was a risk people's personal information was not held securely in accordance with the Data Protection Act 1998.

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.

We found people were at risk of potential harm, because the registered provider had not managed risks to people in terms of the environment, the recruitment of staff and medicines management.

People told us they felt 'safe', but incidents of safeguarding concerns had not always been reported to the appropriate authorities.

People responded to questions about the numbers and availability of staff with positive comments and staff did not express any concerns about staffing levels at the home, but we found instances where people were left alone in communal areas and did not have access to a call system to summon staff for support.

Is the service effective?

Inadequate

The service was not effective.

There was no system in place for staff to receive an induction, training and appropriate supervision relevant to their role.

The requirements of the Mental Capacity Act 2005 were not understood by staff, which meant there was a risk that people may be deprived of their liberty without due process being followed.

People were broadly positive about the food that they were served at mealtimes, but the meal time experience could be improved, for example, a more varied choice of food and people not kept waiting at the dining table before lunch was served.

We saw information in people's care files that health professionals were contacted in relation to people's health care needs such as doctors and the community health team. This was confirmed by the people who used the service and staff.

Is the service caring?

Requires improvement

The service was not always caring.

People and relatives made positive comments about the staff and people told us staff treated them with dignity and respect, but we observed practice that did not uphold people's dignity and respect.

We observed very little interaction between people and staff, with most conversations being prompted by and based around tasks. At those times staff interactions were patient and caring in tone and language. However, there were occasions when staff did not respect people, their privacy and dignity.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

People's assessments, care plans and risk assessments did not always contain up to date or accurate information about people. We found that people did not always have their care needs met in accordance with their plan of care or needs.

There was a lack of stimulating activities available for people to participate in or opportunities to maintain hobbies and interests.

The complaints procedure was not robust, staff were unable to locate a complaints log and the registered provider was not aware of one complaint.

Is the service well-led?

Inadequate 

The service was not well led.

The registered provider had not met their responsibilities in maintaining compliance with the regulations and there had been inconsistency in the management of the home.

Although the registered provider visited the home, they did not carry out any recorded checks themselves or have a system in place that kept them informed of events at the service.

The registered provider had not paid regard to previous reports of breaches with the regulations, in order that improvements were made with the quality of service provision and identifying, assessing and managing risk.

The Maples 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 12 and 14 January 2015 and was announced. We told the provider three days before our visit that we would be coming so that a representative from the partnership would be present to answer any questions we had.

The inspection was carried out by two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people's care services.

Before our inspection, we reviewed information we held about the service. This included correspondence we had received about the service and notifications required to be submitted by the service. We also gathered information from the local authority. We also sent a provider information return to the registered provider prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was not returned. At the time of our inspection the registered provider told us they didn't recall seeing it. This information was used to assist with the planning of our inspection and inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing the daily life in the home including the care and support being delivered. We spoke with five people who used the service, one of the registered providers, the manager, deputy manager and six staff. We also attended a relative's meeting where three relatives attended. They did not wish to speak with us privately. We looked round different areas of the home such as the communal areas and with their permission, some people's rooms. We reviewed a range of records including three people's care records, ten people's medication administration records, three people's personal financial transaction records, three staff files and other records relevant to the management of the regulated activity.

Inadequate

Is the service safe?

Our findings

This inspection included checking that improvements had been made with the management of medicines after a compliance action was issued after our inspection on 19 and 26 August 2014.

The provider sent in an action plan detailing how they were going to make improvements. The timescale for the completion of those improvements was 28 November 2014.

We checked to see those improvements had been made and that the systems in place for managing medicines was safe. We found people's medicines were not managed in a safe way.

We looked at ten people's medication administration records (MAR) and checked a sample of these against the prescribed medicines for those people, observed staff administering medication and spoke with staff about medicines management.

Staff were patient and caring when administering medication. For example, one person refused their medication. The member of staff encouraged them, saying, "You know how important it is to take this one. It has all the goodness and vitamins that your body needs." As the person refused another tablet the staff member explained to them that the medication being offered was to help control their stomach acid.

We saw a staff member had signed to say people had taken their medicines, before they had been given them. Eye drops were being administered without leaving sufficient time between them to stop the first drop from being diluted or washed away. The staff member didn't know what the eye drops were for. Information about the prescribed dose was not clear and the eye drops were being administered twice a day, conflicting with information in the care plan that stated 'one drop daily'. There was no instruction available for staff when a medication prescribed as 'when required' was to be given to one person. We found one medication where the quantity received had not been recorded, but the date had. In addition, controlled drugs (CD) had been received by the service and not entered into the CD register as required. A stock check of one medicine identified a discrepancy in the medicines remaining. The staff member stated they had not administered the medication that morning, but the MAR had been signed saying they had. One person had been administered paracetamol for headache. The person was not prescribed paracetamol and there was no homely remedy authorisation filed with the MAR.

We observed the member of staff issuing medication was wearing a tabard identifying them as working with medication and reminding others not to disturb her, was interrupted on several occasions by staff asking questions. This meant the staff member was being distracted from her task, presenting a risk of medication being administered incorrectly and lengthening the time when people received their medication.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked the systems in place for how the service managed risks to individuals and the service to ensure people and others were safe. We found systems were not in place to manage risk to individuals and the service. For example, the service's fire risk assessment dated 22 August 2014 identified 23 actions that needed to be taken to maintain fire safety. We checked a sample of these and found all the action to be taken had not been addressed. We checked the service's fire procedures policy. We found the policy was not being followed to maintain fire safety. We also found not all staff had been trained in fire safety. When we spoke with staff, some staff told us they had not been part of a drill whilst at the home and could not describe the evacuation procedure if there was a fire. Information was not available for the emergency services in the event of a fire. For example, the personal emergency evacuation plan for each person who resided at the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider told us maintenance and testing of the electrical power supply had been completed in August 2014. They were unable to provide a copy of a certificate to verify this. The registered provider also that said the service's weighing scales to weigh people had been serviced, but were not able to provide any documentary evidence to support this statement.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

We checked the recruitment of staff was safe. To do this we checked four staff's recruitment records. We found that all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 had not been obtained for each staff member. Schedule 3 is a list of information required about a person seeking to work in care to help employers make safer recruitment decisions. For example, there were gaps in the person's employment history, without a written satisfactory explanation of the reason for those gaps. Satisfactory evidence of previous employment concerned with the provision of health or social care and vulnerable adults or children had not been obtained. Documentary evidence of the staff member's previous qualifications and training had not been obtained. There was also a lack of documentary evidence of a Disclosure and Barring Service check (DBS). A DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. In three of the four files checked there was no evidence that a current DBS had been applied for. We spoke with the manager about those checks. She was aware the information should be available. She stated for herself and another staff member she had appointed she stated the information to apply for a DBS was given to the registered provider, but could not confirm the DBS's had been applied for or a reason why the information was not on staff files. She could not speak for two of the staff files as she had not been in post. We requested that information from the registered provider. This was received on 26 February 2015, subsequent to the inspection. It identified the current situation with staff DBS checks, but no explanation of why those records were not available.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked the systems in place for how the service protected people from harm and abuse.

When we spoke with people who used the service they all told us they felt 'safe'. No visiting relatives raised any concerns about mistreatment or inappropriate care provision of their relative.

The manager told us staff received safeguarding vulnerable adults training so that they had knowledge of what constituted abuse and how they must report any allegations. When we spoke with staff they confirmed they had received training and were clear of the action they would take. Staff were confident that the manager would listen and act on information of concerns and would report any allegations of abuse. However, the registered provider had been made aware by the local authority of an alert they would be raising in regard to an injury sustained by a person using the service as a result of a fall. This had not been recognised previously by staff as potential abuse and appropriate authorities notified. The registered provider had not submitted a notification of the allegation when they had been notified by the local authority, saying, "They said they would do that".

We were aware of four safeguarding incidents under investigation at the time of the inspection, in relation to finances and neglect of people who used the service.

We checked that sufficient numbers of suitable staff to keep people safe and meet their needs were on duty.

The registered provider did not have a system in place to identify the number of staff they needed to provider care to people and keep them safe.

We looked at staff rotas and found three care staff were on duty on the morning shift (8:00 – 14:00) and two care staff during other hours. Ancillary staff were provided for cleaning and the provision of meals. A manager and deputy manager worked Monday to Friday between 9:00 – 17:00.

People responded to questions about the numbers and availability of staff with positive comments. One person said, "They are very well staffed" and explained how they would get help in their room if they needed it. They said, "You have a bell – you press it and they're there quickly."

We observed people in the lounge did not have access to call bells or any means of attracting staff attention other than verbally. On more than one occasion we observed one person calling, "Hello" and staff did not respond. We also observed that staff were not always present in the lounge meaning that a resident would only get a response if someone could hear the person asking for assistance. Also, some people needed two members of staff to assist them, which meant at those times people were left in communal areas unsupervised presenting a risk to their care and welfare.

Staff spoken with did not express any concerns about the staffing levels at the home, but commented the increase of

Inadequate

Is the service safe?

an additional member of care staff on a morning, since the appointment of the new manager had been a benefit in being able to meet people's care needs in a more timely way.

Inadequate

Is the service effective?

Our findings

We found that staff had not received appropriate training and supervision relevant to their role and responsibilities. When we spoke with staff there was conflicting information provided as to whether they had received an induction to the service. Two care staff told us they had not received an induction. An induction is where an employer provides new staff with information and training about their new job role, giving them time to get to know people, their surroundings, the job and the business. One domestic told us until recently they had received no training and just did what they thought was 'common sense'. A newly employed domestic had received training in a previous role and had been shown how to use equipment at the service. A cook that had been employed had also received their training in a previous role.

The manager had completed a review of the training staff had undertaken, with certificates of training in their staff file and transferred this to a training record so that they had an overview, to identify future training needs. We viewed the staff training record and identified there were gaps in the training to provide staff with the relevant knowledge and skills relevant to their role. For example staff had not been trained in first aid, fire safety, moving and handling, control of substances hazardous to health (COSHH), health and safety, infection control and record keeping and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager had arranged for training in end of life care, dementia awareness and infection control. This meant there was a risk people were receiving care and treatment from staff who were not appropriately trained in their role or who required their knowledge to be updated.

When we spoke with staff they told us they had not received formal supervision. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager for the purpose of reflecting and learning from practice, personal support and professional development in accordance with the organisation's responsibilities and accountable professional standards. We viewed staff files and this confirmed what staff had told us. The manager was unaware of any previous staff supervision that had taken place. The registered provider told us the previous manager had carried out one supervision, but there was no record to confirm this.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty in order to keep them safe they are not subject to excessive restrictions.

The registered provider had not received any training in MCA or DoLS. The manager had received training in the subject and was aware one person was subject of a DoLS authorisation and we saw confirmation of this. Staff spoken with were unsure of the implications for them working with the people they cared for who had a DoLS in place. This meant there was a risk that the deprivation may not be applied to keep the person safe, or subject the person to more restrictive practice than that agreed with the DoLS authorisation.

Staff said they had received MCA and DoLS training, but this was not verified by certificates or the training record.

People did not raise any concerns about any incidents where behaviours of other people who used the service that were challenging affected their wellbeing.

Observations of staff practice meant there were occasions when they did not ensure they gained consent from people before taking action. For example, staff explained to one person why they could not accommodate their choice of their preferred seating arrangement in the lounge. The person remained unhappy. The person then began to use critical language about other people in the room. Staff were discussing the course of action to take in the lounge without the inclusion of the person. The person objected, but the staff carried out the course of action they had decided.

We saw in people's care plans global decisions were being made about people's mental capacity and the decisions being made were not decision specific as required by the MCA.

Inadequate

Is the service effective?

We looked at care records for people who used the service and found evidence of involvement from other professionals such as doctors, optician, tissue viability nurses and speech and language practitioners. This meant staff involved professionals, so that people received intervention for their healthcare needs.

People were broadly positive about the food that they were served at mealtimes. One person said, “The meals are reasonable.” Another person’s expression became animated as we asked them about the food at the home. One person was able to tell us about how they decided what they would eat. They said, “They ask you the day before what you want to eat.” Some people who used the service had short term memory loss and would not be able to retain and recall information, so may not remember what they had ordered the previous day. The cook told us conflicting information and that people decided that morning what they would like for lunch. Again, this meant people with short term memory may not be able to retain and recall that information.

We observed the lunch time meal. Tables were set with tablecloths, cutlery, glasses and a table decoration. One person asked whether there would be any salt and pepper and another had to ask for a serviette. People were taken to the dining room 25 minutes before lunch was served. One person waited at the table alone in excess of 30 minutes and expressed this happened regularly. It is important people receive their meal in a reasonable amount of time so that they do not lose interest in their meal, which is particularly important where people have short term memory loss and do not remember why they are sat at the table or are tired.

On our visit on 12 January 2015 there was a menu on a chalkboard offering a choice between “beef stew and dumplings” and “steak pie”. This did not offer any choice to anyone who did not want beef. Everyone had chosen the same option; we did not see any variation in the meals other than for the vegetarian meal, as one person preferred a vegetarian diet.

We observed that meals were plated in the kitchen, meaning that people could not exercise choice as to how much they had.

The lunchtime meal was unrushed. We observed staff providing good assistance where people needed help to eat their meal. Before the staff member helped them they asked if this was what they wanted. Whilst assisting the person to eat the staff member remained focused on the person and explained what food they were being offered and if that was alright. When they had eaten one mouthful they asked if they were ready for the next. During the meal the staff member also chatted to the person about their day and their family.

We saw that staff placed meals within reach of people and where people needed equipment for meals to promote their independence this was provided.

We did not see drinks available for people to help themselves during the day, but tea was brought round and people felt that this would be available at any time. One person said, “I could have a cup of tea now, you just shout and they come.” We observed biscuits were served with the tea and coffee, but did not see any fruit on offer. We found fruit was available, but did not see any other snacks offered.

Requires improvement

Is the service caring?

Our findings

We asked people for their views about living at the home. They did not tell us anything other than it was kept clean. We found the lounge was small and offered little personal space for people seated in there. There was space for one seat per person, meaning that if everyone was in the lounge together it would have been very cramped. The medicines trolley was in the lounge for over an hour on the day of the inspection meaning several people were unable to see the television, which was the only source of entertainment for all but ten minutes of the day while we were there.

We asked people about the relationships they had with staff. One person said, "They are helpful in a way. The girls are very nice here – she's lovely, that lady (indicating a member of staff). Always a smile."

We also spoke with people about whether the staff took time to develop wider relationships with them. One person said, "They don't sit and talk." This was confirmed with our observations. We observed very little interaction between people and staff, with most conversations being prompted by and based around tasks. One person received a great deal of the staff's attention as they were regularly talking and asking for reassurance. This impacted on other people who used the service, as those people were not provided with the same level of attention.

We observed staff giving care and assistance to people throughout the inspection. Those interactions were patient and caring in tone and language. For example, one person who was very disorientated on the day of the inspection was insistent that they wished to go to visit a relative. A member of staff spoke gently to them, asking them to think about their age and how old that this would make her relatives. She then distracted the person with other conversation.

People who were able to speak with us about how staff respected their privacy said, "The carers knock on the door before they come in. It's a simple thing, but they should do it." We observed several instances where people were assisted to transfer using either a hoist or a stand-aid. We did not see any practice which compromised a person's dignity or privacy. However, one person's skirt when they were sat down rose above their knee compromising their dignity. We did not see staff respond to this. We also saw the person moved into the living room in a wheelchair and at that time the staff had also not adjusted their clothing or covered their legs to protect their dignity.

During the inspection we also heard staff say loudly that they needed to 'start toileting.' Statements like this, in the presence of people who might need that assistance, did not show respect for them.

We looked at people's care files. This contained people's life histories where important information about people's lives were recorded. This assisted staff in establishing relationships with people and ensuring important information about their diverse needs were incorporated into the care provided.

In addition, there was information in people's care files about their preferences, which assisted staff in caring for people in the way they preferred.

Inadequate

Is the service responsive?

Our findings

This inspection included checking that improvements had been made in relation to the care and welfare of people after a compliance action was issued after our inspection on 19 and 26 August 2014.

The provider sent in an action plan detailing how they were going to make improvements. The timescale for the completion of those improvements was 13 December 2014.

In addition, the inspection included checking that improvements had been made to record keeping following a warning notice issued after our inspection on 19 and 26 August 2014.

We checked to see if those improvements had been made and that systems were in place for people to receive the care they needed and records in regard to their care and treatment were in place. We found sufficient improvements had not been made, which placed people at risk of not receiving the care they needed.

We were told the new deputy manager had been responsible for reviewing people's assessments, care plans and risk assessments and all care staff were responsible for recording the care delivered to people on a daily basis.

We reviewed three people's care plans to check improvements had been made.

When the manager had started working at the service they identified that people living at the service had not been weighed for seven weeks. The manager instructed staff to weigh people and told us four people were identified as having sustained a significant weight loss. Two of those people had been referred to a dietician by the service. The manager had requested that people be weighed on a weekly basis by staff. We found staff were not always following these instructions and some people had been weighed 11 days later. Whilst reviewing the care records we also identified an additional person who had lost weight. We spoke with the deputy manager regarding the person's weight and asked whether the scales had been calibrated to check they were accurate. The deputy manager informed us that they had checked the scales by standing on them and checking her weight measurement. This meant staff had not been responsive to people's needs and the planning and delivery of care had not protected them from risks of receiving care to ensure their welfare and safety.

On our arrival some people were sat having breakfast in the dining room. Two people were sat in the lounge. There was discussion amongst staff as to why the two people had not had breakfast, though no staff seemed to know why. Later we observed one of those people eating their breakfast in the dining room.

At the resident's meeting one visitor raised a concern about their friend having difficulty chewing. We had observed that the person had left their meat at the lunchtime meal. This showed it was possible that the preparation of the meal was not suitable for their needs. We reviewed the person's plan of care where swallowing had been identified as a concern and a discussion with a specialist healthcare professional had taken place over the telephone, with the service explaining the actions they were taking to meet the change in need. Due to the actions identified the healthcare professional felt an assessment was not needed at that point. However, the information of that discussion, such as providing foods that are easier to swallow or blended food if swallowing became a problem was not included in the person's plan of care. The visitors comments and our observations identified that the care being provided was not in accordance with that advice. We also noted that a further referral to the specialist healthcare professional had not been made. We asked the manager to do that on the day of inspection.

These were breaches of Regulation 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not able to explain how they had chosen the home or how they made decisions about the care provided. People were unable to explain their involvement in their care plan or how staff knew about the care they needed and their likes and dislikes, although one person said, "They know me and that's that." During a resident's meeting the manager discussed care plans with the visiting relatives and made it clear that it was their intention to involve both people who used the service and relatives.

Inadequate

Is the service responsive?

When we spoke with people we felt that they had a choice regarding what times they got up and retired to bed. One person said, “You can please yourself about getting up and going to bed.”

We asked people how they passed their time and whether there were was a stimulating programme of activities. No-one we spoke with was able to tell us of any activity that they had taken part in, or how they were encouraged or supported to maintain hobbies and interests. One person said, “We just sit and wait.”

During the inspection a resident’s’ meeting was held. Relatives raised the lack of activity and one person said, “When we come at 10am they are all asleep, there’s a real lack of stimulus.” One relative raised a concern that they had brought in photographs from their relative’s life and that these had not been used in the three years they had been resident. The manager confirmed that it was an aspiration to encourage staff to use resources like that.

We saw a member of care staff arrange a game of skittles and try to engage people. We saw two people laughing as they took part in the game. However, ten minutes after the game began, another member of staff brought the hoist into the room and the game had to be moved to accommodate the hoist. In addition, we saw the medicines trolley in the lounge for over an hour on the day of inspection, which meant people were unable to see the television if they wanted to. Other than the game, the television was the only source of stimulus for people. We asked people how they chose what they wanted to watch. One person said, “it’s just put on.” The television was left on one channel and the remote control placed in front of it, out of the reach of people who could not transfer and move without assistance.

The registered provider told us a complaints record was in place. We found the complaints procedure was not robust, with a complaints record that could not be found by either the registered provider or the manager. We found in the minutes of a staff meeting information about a person who used the service raising a concern. The registered provider and manager were not aware of the concern or how it had been investigated and responded to.

Inadequate

Is the service well-led?

Our findings

This inspection included checking that improvements had been made with assessing and monitoring the quality of service provision following a warning notice issued after our inspection on 19 and 26 August 2014.

We found sufficient improvements had not been made, which placed people and others at risk from the carrying on of the regulated activity.

In the last six months there had been five managers at the service, two of whom had no management experience and lacked knowledge of their roles and responsibilities as a manager of the regulated activity. The current manager of the service was not registered with the CQC which is a requirement of the home's registration. They had commenced duty officially on 29 December 2014. They had begun the process to register with CQC as a registered manager. The manager told us they had been provided with some information from the registered provider about action that was needed, but acknowledged they hadn't realised the scale of improvements that were needed. This demonstrated a lack of awareness by the registered provider about the scale of the improvements needed.

We spoke with one of the registered providers about the breaches of regulations. They told us they were confident some areas would be met, because they had spoken with people who used the service and staff about those areas, for example, care and welfare, medicines and quality assurance. There was no record to confirm this. They told us they had not carried out any checks themselves. This meant they could not be assured the improvements they had identified and implemented to identify, assess and manage risks to people and others were being carried out by staff and that they knew about any of those risks.

One of the registered providers told us there was no formal system to keep them informed of events that were happening at the service. This meant the provider did not have an overview of the quality of the service.

There was not an effective system in place to analyse accidents and incidents that had taken place at the service. This meant trends were not identified to reduce ongoing risks to people who used the service.

The registered provider provided a quality assurance policy/procedure. This was not dated or signed. It did not describe actions that might be taken to meet the requirements of the regulations. The manager could not describe what the quality assurance process was.

The manager was aware of systems and processes they would implement to monitor the quality of the service and identify, assess and manage risks. They explained it was too early for these to have been implemented, but was confident in time these would be an effective tool. The systems and processes included meetings with residents and relatives and staff to obtain their views of the quality of service provided and implementing audits and checking systems to identify, assess and manage risks.

When we spoke with people who used the service they were not aware of who the manager was or whether they had had an opportunity to talk to them.

There was a relatives' meeting on the day of the inspection which we attended. Relatives at the meeting referred to seeing the manager walking about and talking to people who used the service and expressed their appreciation of this.

During the relatives' meeting the manager asked about the usefulness and frequency of them. One relative said, "We don't want to waste your time when there's nothing to say, we should get together when there are strong feelings about something." This gained consensus. The relatives were confident in changes that had been observed since the new manager had been in post, and offered to contact the registered provider on the manager's behalf if there was a problem 'getting things done.'

At the residents' meeting visiting relatives discussed investment in the home and asked the registered provider whether this could be properly funded and sustained. One relative said, "It needed to happen."

There was agreement in the meeting that the latest change in staff had been for the better.

We observed the manager speaking with people who used the service during the inspection and she knew people's names.

All staff spoken with made positive comments about the staff team working at the home and were willing to embrace changes that needed to be made.

Inadequate

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The manager told us that there had been staff meetings to review the performance of the home and this was confirmed by staff when we spoke with them.

We looked at the minutes for one staff meeting. We saw that a range of topics had been discussed regarding the performance of the service. The minutes recorded that lots of audits were needed. We also noted a concern had been raised by someone who used the service. We asked for the complaint record to identify what the concern was and that it had been appropriately investigated and responded to. The complaint record could not be found and the registered person and new manager could not identify what the concern was about or what action had been taken to address the complaint. This meant there was not an effective system in place to identify and manage complaints to the service, so improvements can be made where necessary.

We found refrigerator temperatures were undertaken to check that items stored in the refrigerators such as food and medicines were stored at the correct temperature. We found the checks for refrigeration of medicines identified potential risks to people. The manager confirmed staff had not reported those risks, meaning the risks had not been addressed. For food, a staff member told us the refrigerator and freezers in the outside stores were not monitored. The registered provider told us they had been implemented. A record could not be found. This meant the risks of food not being stored at the appropriate temperature were not being identified and managed.

We found a fire risk assessment in place that identified actions to be taken to keep people who used the service and others safe. These had not been addressed. Fire maintenance systems, for example, checks of fire extinguishers were also not being maintained as required placing people and others at risk of harm. Although staff had received training, regular drills had not been carried out with them, so that they were competent in the procedure to follow should there be a fire. This meant risks associated with fire safety had been identified, but were not being managed.

The manager told us they had implemented a training matrix to identify and monitor the training needs of staff.

The monitoring of staff supervision had not commenced as staff had not received supervision. Previous to their appointment they told us there was no monitoring of the training staff had undertaken. The information they used to complete the training matrix was taken from certificates to evidence the training from staff files. The registered provider contradicted this information, saying staff had undertaken some other training. They were unable to provide certification to confirm this. This meant the systems in place to identify, monitor and manage staff training and supervision was ineffective in practice.

We found that people had lost weight, care was not always delivered in accordance with people's care plans and records that were not always up to date and accurate. The manager told us no system had been in place to identify risks to the manager and audits of care records and care delivery were not in place.

The service had not maintained consistency in meeting regulations. We have now inspected the service on four previous occasions where the provider had been in breach of one or more regulations.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there was not a safe system for the storage of records. This was because we found confidential safeguarding meeting minutes at the back of a policy/ procedure for safeguarding vulnerable adults that was available for staff.

Also, when we asked for a record of notifications submitted to the Commission, we found they were being stored on different personal computers.

We asked the registered provider if they were registered with the Information Commissioner's Office, the office responsible for enforcing the Data Protection Act 1998 and where providers who hold personal data about people need to register. The registered provider was not aware of the existence of the office.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.