Care Quality Commission

Ravenswood Care Home Limited

Ravenswood Care Home

Inspection report

15 The Avenue
Kidsgrove
Stoke On Trent
Staffordshire
ST7 1AQ

Tel: 01782783124

Date of inspection visit:
31 July 2017
01 August 2017
04 August 2017

Date of publication:
26 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 31July 2017 and the 1 August 2017 and was unannounced. This was a comprehensive ratings inspection. Ravenswood Care Home is a residential home for up to 55 older people. There were 46 people living at the service at the time of the inspection. People who used the service were older people and may have had physical and/or mental health needs.

At the last inspection on 22 February 2017, we asked the provider to take action to make improvements to meet regulations 10, 12, 13, 17 and18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of Care Quality Commission (Registration) Regulations 2009. At this inspection we found the provider had not made the required improvements and there had been further deterioration in the quality of the care people received.

There was no registered manager in post. There was a manager in post; however they had not undertaken the registration application at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we identified nine breaches of the Health and Social Care Act 2008. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

People did not always have their needs met, because there was not enough staff to meet people's needs. Where people were at risk, staff did not understand how to manage the risks to keep people safe. People did not always receive their medicines safely. Medicines were not always available to people. People were not protected from the risk of abuse. Staff did not always identify potential abuse, which meant incidents were not investigated and reported to the local safeguarding authority.

People received support from staff that did not have the knowledge to support people safely. We found not all staff understood how to provide some aspects of people's care. People were not always supported in a way that protected them from unlawful restrictions. People did not always have their food and fluid intake managed safely. Staff did not always make sure people had enough to eat and drink. Staff did not always seek support for people from health professionals when they needed it.

People did not have their privacy and dignity respected. People were not involved in making decisions about their care and support. People did not have meaningful relationships with staff. Although some staff were seen engaging with people positively, most staff were too rushed to speak with people and sometimes missed the opportunities for interaction.

People's needs and preferences were not understood by staff. People did not receive the care and support they needed. Staff did not always understand people's needs and preferences. People had access to group activities, but there was little evidence of people being able to follow their individual interests. People's complaints were not always responded to in a timely manner and action was not always taken to resolve people's concerns.

The provider did not have systems in place to ensure people received the care and support they needed. The provider had failed to monitor the quality of the service and ensure people were protected from harm. The provider did not always take action to make required changes when incidents occurred.

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.

People were not always protected from harm because potential abuse was not always identified and investigated.

Medicines were not always administered as prescribed.

People did not always have risks to their safety managed by staff.

People did not always have support from sufficient suitably employed staff.

Is the service effective?

Inadequate

The service was not effective.

People did not receive support from suitably skilled staff to meet their care and support needs.

People did not always have their rights upheld in line with the Mental Capacity Act 2005.

People were not always supported to ensure they were eating and drinking enough.

People's health was not always monitored effectively.

Is the service caring?

Inadequate

The service was not caring.

People did not always have their privacy and dignity respected.

People were not involved in decisions about their care and support.

People did not always have a positive experience with their interactions with staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs and preferences were not always understood and met by staff

People had limited opportunities to follow individual interests.

People and their relatives did not always receive a timely response to their complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to ensure people's care and support needs were met

Arrangements for the quality monitoring of the service were ineffective.

People and staff did not always have an opportunity to share their views about the service.

Care Quality Commission

Ravenswood 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 was 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 unannounced inspection took place on 31July 2017 and the 1 August 2017. The inspection team consisted of three inspectors and a specialist nurse advisor. A specialist advisor provides additional specialist knowledge during an inspection.

The inspection was prompted in part by notification of concerns raised by the local Authority about people's safety which indicated there was potential concerns about the management of risk to people . As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We reviewed feedback from the commissioners of people's care to find out their views on the quality of the service. We reviewed information shared by the Local Authority Safeguarding Team. We used this information to help us plan our inspection.

During the inspection, we spoke with seven people who lived at the service and five visitors. We spoke with the provider, the manager, the general manager who was providing management support to the home. We also spoke with five members of staff, including two senior care staff.

We carried out observations throughout the service to help us understand the experiences of people living at the home and to review the quality of care people received. We looked at the care records for 17 people. We also looked at other records relating to the management of the service including staff files, training records, complaint logs, accident reports, audit records, and medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection on 22 February 2017 we judged the service as inadequate as we found that the provider had a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a further breach of Regulation 12 and 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving safe care from sufficient staff. At this inspection we found that the provider had failed to make the required improvements and remained in breach of the regulations and we found the provider was also in breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were issues with safe recruitment.

People we spoke with told us there were not enough staff to support them effectively. One person said, "I sometimes think where have they [the staff] all gone". The person added that it can take a long time for staff to answer the call bell. We saw people had to wait for care and support. For example; we saw one person waited 20 minutes to go to the toilet and we saw the person ask four different staff to help them during this time, each time they were told to wait. In another example; we observed one person shouting out, "I am dying to get out of this bed, I don't want to wee the bed". We saw the manager enter the person's room and cancel the call bell. We asked the manager if the person had received assistance, they told us they were fetching a staff member, we saw the call bell rang again and a staff member came to assist the person that had waited for ten minutes at this point. This showed there were insufficient staff to meet people's needs at the time they needed them. The provider had failed to ensure there were sufficient staff to meet people's needs when they needed support. Staff told us they thought there were insufficient staff. One staff member said, "Every day is a struggle, people need more hours of support than we have to give". Staff told us people had to wait as a result. Staff told us they were concerned that things would be missed and important events would not be documented as they were very busy. The manager confirmed they had not yet put in place a system to determine how many staff were needed to meet people's needs safely, so they were unable to evidence there were currently sufficient staff to provide safe care.

Our observations confirmed what we had been told and we saw there were insufficient numbers of staff available to support people safely. People did not receive the support they needed from staff to keep them safe. One person was at high risk of falls and required support from staff to move and we saw this person moving without staff support. We saw staff were not present to provide the support or monitor this person. This meant the person was at risk of falling as there were insufficient staff to provide support to this person. In a further example, we found people did not receive continuous support from staff to prevent them from harming themselves or others. For example, one person was observed on several occasions alone in the lounge with other people, although the person's care plan confirmed they should have constant staff supervision and staff were of this requirement. This meant the person was at risk of harming themselves or others. In a further example we saw an altercation between two people who used the service when staff were not present and were not aware this had taken place. This meant people were at risk of harm because there were not enough staff to manage and mitigate risks to themselves and others.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Staffing

People and their relatives told us they felt staff understood how to support people. However, staff told us they felt they were unable to provide care in the way people needed it. One staff member said, "It makes you feel bad that you don't have time to monitor people properly, sometimes people's needs are higher than reflected in their plans". We observed staff were unable to provide appropriate and safe care. For example, we saw a number of occasions where people were assisted to move using inappropriate techniques and where professional advice had not been followed. One person was observed being pulled by their arms when staff were supporting them to stand. This was unsafe as it could cause an injury to the person's shoulders. This person's records stated that the person should have been assisted to move by the use of a hoist if they were unable to stand. In another example, we saw staff were supporting one person to use a standing hoist to move. This person was hanging from the hoist by their arms as they were unable to weight bear. This meant the person was at risk of injury to their arms. The person's care records showed that professional advice had stated the person should have a full hoist for all transfers. The manager was unaware the professional had been given for this person. In a further example, we saw one person had to be lowered to the floor by staff as they were unable to stand when attempting to move. We asked staff how this person should be supported to move and they told us they needed to do an assessment each day to determine how to move the person safely. Staff could not describe what this assessment looked like. The general manager confirmed this was the instruction of a professional. However, we checked this person's records and found a physiotherapist had visited this person and given instructions that staff needed to support this person to move with the hoist at all times as this person was unable to weight bear. This showed the general manager and staff were unaware of how to mitigate the risks for this person and were not following professional advice. This meant the person had an unsafe transfer, which resulted in them being placed on the floor. The provider had failed to ensure staff had the skills to transfer people safely which left people at risk of injury and harm.

Risks to people's health, safety and wellbeing were not always effectively assessed and plans were not always put in place to mitigate the risks to peoples' safety. For example, one person had sustained an injury. There was a risk assessment in place which identified the risk to this person, however the plans did not give staff clear instructions on how to prevent the person from sustaining injuries and keeping them safe. There had been no update to this person's risk assessment or care plan since the injury occurred. This meant this person continued to be placed at risk of continued harm. We spoke to the manager about this and they said they would ensure the person's risk assessment and care plan was updated straight away. This showed peoples risk assessment and care plans were not reviewed and updated to keep them safe.

Peoples risk assessments and support plans were not always followed. For example, we saw one person mobilising unaided on a number of occasions as staff were not present. We looked at this person's records and found they were at high risk of falls and required assistance from staff at all times to mitigate their risk of falls. This meant staff were not following the plans in place to keep this person safe, which meant the person was at risk of injury from falling. We found people were not supported to manage risks to their skin integrity. Another person had not received their prescribed medicines as required to prevent pressure sores and had developed a moisture lesion. This meant people did not have their needs met and were at risk of further skin damage. This meant the provider had failed to ensure people were safe from harm.

People told us they received support with their medicines and mostly had them on time. On the day of the inspection we found medicines were being administered by one senior carer as there had been an unexpected staff absence, we were told there were usually two staff administering medicines. The staff member told us they made sure people that had lunchtime medicines had their medicines first to allow for enough time between doses. We saw medicine administration records were not always completed to show

if people had received their medicines. For example, we found a number of records which showed people that required topical cream applied were not having their records completed and it was not possible to confirm if the people had received their topical medicines as prescribed, and one person had suffered skin damage. We found one person had not received medicine which was prescribed for a period of one month. This was because the advice from the doctor about this medicine had not been followed. Staff were unaware the person should have had this medicine, or the impact on their health condition if this was not received as prescribed. The general manager confirmed the person had not received their prescribed medicines. We asked the manager to speak with the doctor immediately to seek advice, the doctor arranged for the person to have some tests. This showed people did not always receive medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

We found people were not always protected from abuse. Staff did not always protect people from potential abuse and records showed not all staff had received training in how to protect people. We found incidents where staff had not identified potential abuse and therefore the incidents had not been investigated. For example, we found one person had several incidents where they had displayed aggression; we could not confirm these incidents had been reported to the appropriate body in order to keep people safe. In another example, one person had been having serious symptoms which suggested their mental health required assessment; staff had not recognised this and had taken no action to seek support for this person. In a further example, we saw one person had a skin tear, we spoke to staff and they were unable to tell us how this had occurred. We saw the skin tear was documented but there was no indication of what the cause of the injury was. There had been no review of this person's risk assessment or care plan which meant the person was at risk of further injury. This meant the provider had failed to take investigate incidents and take action to protect people from the risk of harm.

We found a number of concerns about people being at risk of neglect during the inspection. For example, we found one person had not received the correct level of care to prevent them from developing pressure sores. We saw this person had a plan in place to prevent their skin from being placed under pressure. However, staff had failed to follow this plan and the person had not received the medicines required and they were not repositioned in accordance with their plan. The person's care records showed they had developed a grade three pressure sore. A pressure sore can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. There are four grades of damage, with one being the least amount of damage (other than having no sore), with grade four being the worst. The provider had failed to ensure this person was protected from harm. We referred these people to the local safeguarding authority and they are now undertaking an investigation. We made the manager aware of our concerns and they confirmed the incidents had not been investigated. This showed people were not always protected from the risk of abuse or harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

People were not supported by staff that had been recruited safely. We found staff had been appointed without the required references in place. We looked at five staff files and found the provider had not consistently followed their policy and therefore could not be assured the staff appointed were of good character. For example, where references had not been provided or showed staff may not be suitable to work in a care environment there had been no assessment of those staff members' suitability to work with people who used the service. We found the provider had not taken any mitigating action to ensure people were safely supported by suitably skilled staff. However, we found the provider completed Disclosure and

Barring Service (DBS) checks. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We found checks were completed prior to staff members starting work with people. This showed the provider could not be assured staff were suitable to provide support to people who used the service.

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed
People told us they felt safe. One person told us, "I feel safe because there are people around and there is company here". Staff could describe different types of abuse and were able to tell us how they would report any concerns. One staff member said, "Report concerns to the manager, the local authority of CQC if no action is taken".
Staff responsible for medicine administration had received training and felt this was sufficient to support them in their role. We saw medicines were stored safely. For example, medicines requiring refrigeration were stored at the correct temperature and controlled medicines were stored safely.

Inadequate

Is the service effective?

Our findings

At our last comprehensive inspection on 22 February 2017 we judged the service was inadequate as we found that the provider had a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were supported by staff without the appropriate skills and having unlawful restrictions placed on them. At this inspection we found that the provider had failed to make the required improvements and remained in breach of the regulations and the service had deteriorated which resulted in further breaches in Regulation 11 and 14 of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014 regarding consenting to care and treatment and meeting nutritional needs.

People and their relatives told us some staff appeared to have the skills to carry out their role. One relative said, "Some staff help more than others, I don't think all the staff understand [my relatives] needs". Staff told us they did have access to training. For example; one staff member said, "We have had safeguarding training, mental capacity act and manual handling training, some is on line and some is face to face". Staff told us there was support from agency staff and they felt there was not sufficient guidance for agency staff to follow. They said this meant the burden was on permanent staff to ensure agency staff provided the correct level of care. However, we found staff did not always have the skills and knowledge to support people effectively. For example, we found staff did not always escalate concerns about people that were at risk of neglect. This showed they did not have an understanding of how to take action to keep people safe. In another example, people's dietary requirements were not understood by staff. We found staff had not followed the guidance for people to prevent choking. Staff had not received training in supporting people with special diets. This meant people were left at risk because staff did not have the sufficient skills and knowledge required.

We observed a number of examples where staff did not display an understanding of how to use safe manual handling techniques. We viewed staff training records and found some staff had not received training in the areas where we had seen inconsistent practice. We spoke to the manager about this and they confirmed staff training was required and told us they had arranged for staff to complete online training, but could not provide dates for when this would be complete. The also confirmed that competency checks were undertaken as part of induction of newly appointed staff, but competency was not checked after this point. We found staff were not always completing their inductions. We saw records with incomplete inductions for some staff. This meant the provider could not be assured staff had the competency to carry out their role. The records we saw of staff meetings showed these were not regularly held and did not look at staff practice. This showed us people were not always receiving care and support from staff that had the knowledge and skills to provide safe and effective care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

People told us staff sought their consent before providing care and support. Staff told us they understood

they had to seek consent from people before giving them care and support. However staff could not always describe how decisions had to be taken in people's best interests.

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

We found decisions had been taken for people with no MCA assessment completed and no documented discussion about what was in people's best interest. For example, one person had a consent form for bed rails signed by a third party and there was no evidence to confirm this person had the legal right to give consent. This meant the principles of the MCA had not been followed. In another example, applications had been made for people for a Deprivation of Liberty Safeguard (DoLS). We found there had been no assessment of people's capacity to verify a DoLS was appropriate and no consideration of whether the restrictions being placed on people were in their best interests. We found these people were subject to a number of restrictions which included the use of bed rails, coded doors and sensors. However, their capacity had not been assessed and documented best interest discussions had not been held, which meant the legal safeguards were not in place to prevent these people from having their liberty unlawfully restricted. This showed the provider had failed to ensure the principles of the Mental Capacity Act 2005 were followed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People were subject to an authorised DoLS did not have their conditions met. One person was receiving their medicine covertly. A DoLS had been granted for this with a condition to review the medicines plan monthly to ensure it remained the least restrictive option. We found there were not monthly reviews documented and the manager confirmed these had not taken place. This meant the provider had not followed the principles of the Mental Capacity Act 2005.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People told us they thought the food was good. One person said, "The breakfast is good, I have a choice". Another person told us, "The macaroni was nice yesterday". Staff told us they understood people's needs and preferences regarding food and fluid. They were able to describe how people at risk should be monitored and what instructions were in place to keep people safe. However, we found staff were not always following the care plans for those with nutrition and hydration needs. For example, we saw people did not have their nutritional needs met as instructed by health professionals. For example; we found staff were not following the advice sought from the Speech and Language Therapist (SALT) team to ensure people that required a special diet were supported effectively. For example; one person had been assessed as needing a specialist diet which was in place to prevent them choking. The care plan gave guidance to staff about what foods the person should not eat. Staff could describe this to us, however, we saw records that showed this person had been given food items that may have resulted in them choking. This meant this person was at risk of harm. The provider had failed to ensure people had the required support to meet their nutrition and hydration needs safely.

People did not have their nutritional needs assessed and monitored. Where potential signs of dehydration had been identified, there was still no evidence of accurate monitoring. For example, people had not had

targets for fluids set and there were no totals to see how much fluid a person had received. In other examples we found people had not had sufficient fluids and this had not been escalated as requested by the person's doctor. In another example; one person had experienced significant weight loss and we found that no action had been taken by staff to escalate this to a medical professional, despite the care plan stating this should happen. This showed us staff did not support people to manage nutritional risks.

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

People and their visitors told us they had access to health professionals. We saw records which showed people had access to district nurses, doctors and physiotherapists. We spoke with a visiting health professional and they told us staff did not always follow the instructions that were given to support people with managing their health. We saw records which showed staff had not followed the advice of a physiotherapist for one person. In another example we saw the advice from a doctor had not been followed accurately. This meant a person had not received their prescribed medicine for over a month. We prompted the general manager to take action and contact the doctor about this person during the inspection. This showed that whilst people had access to health professional's staff were not always following the advice given to maintain people's health.

Inadequate

Is the service caring?

Our findings

At our last inspection 22 February 2017 we judged the service as requires improvement. This was because the service was not always caring and people were not treated with dignity and respect. At this inspection we found the provider had failed to make the required improvements and the service was less caring. This had resulted in a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding dignity and respect.

People did not always have their privacy and dignity maintained. One person told us, "I could do with a key to my door, the staff are in and out at night and they wake me up". One person told us their clothing kept going missing. They told us they had purchased new items and placed labels on things but it had not stopped this from happening. The person was upset by this they liked to be able to wear these items daily and it was concerning them that they couldn't. This showed staff did not ensure people's belongings were kept safe, which meant the person became distressed when they could not access their clothing. Staff told us they understood how to maintain people's privacy and dignity. However, our observations showed staff did not always maintain people's privacy and dignity. For example, we saw one person was assisted to put clothing on in a communal area, the staff member did not ask the person if they would like to go to a private area. In another example we observed one person was supported using a hoist in a communal area. The person's underwear was showing whilst they were in the hoist. Staff did not recognise this or attempt to cover the person to protect their dignity whilst carrying out the transfer. This meant people staff did not consider how their actions would impact on people's privacy and dignity.

We saw staff were asked for information by one person, the person waited for over two hours to get a response, which meant the person became distressed and worried. We saw staff used inappropriate language to describe people and events. For example one staff member referred to a person that was experiencing hallucinations as "talking to their imaginary friend". We saw another staff member describing one person that was displaying behaviours that challenged as being "In a mood". We saw staff talk about people and their needs inappropriately. For example, one staff member shouted across the room about a person who needed support. In another example we heard staff talking about all the tasks they still had to do whilst supporting a person to stand. We saw staff used inappropriate language to record in people's daily records. For example, we saw an entry which described an incident that had taken place with a person, the entry focused on how the staff member was feeling, with the staff member writing, "This has caused great upset to me". There was no reference to how the person was supported or how they felt. This meant staff used language to communicate service users' needs, which was not respectful.

People told us they had good relationships with staff. We observed staff were familiar with people but spent little time talking to them during the day. We spoke to staff about this and they confirmed they were busy and did not always have time to talk to people. We saw staff were too busy to have conversations with people and often missed the opportunity to engage with people when they could. For example, we saw staff supporting a person with their meal; they did not speak to the person or check they were ok throughout the experience. The person was rushed with their meal and did not have an opportunity to speak to the staff member who looked away the whole time and did not engage. Staff were not aware the impact this may

have on the person. We saw examples of staff telling people that were asking for care and support they would "be back in a minute", however people continued to have to wait. This showed staff had little understanding of the impact of their approach on the wellbeing and needs of people using the service.

Staff did not always offer people choices about their care and support. For example; we saw staff did not offer one person a choice about where they wanted to eat their meal. This person was having difficulty in standing to enable them to move to the dining area. We saw that staff did not offer the person a choice of staying in the lounge or moving to the dining area and the staff decided this person would be left in the lounge to eat their meal. This meant this person was not provided with the opportunity to express their wishes. In another example, we saw a person have their chair moved to a reclining position. The staff member did not ask the person if this was ok, or explain what they were going to do and why, the person did not react when this happened. This showed staff did not involve people in making decisions about their care and support.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 22 February 2017 we judged the service as requires improvement. This was because people's needs were not always reviewed, care was not personalised and people did not have support with activities and their complaints were not acted upon. At this inspection we found the provider had failed to make the required changes and the service had deteriorated further which had resulted in a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

People told us they did not always get their needs met as required or in some cases in the way they preferred. One person told us they liked to change their clothing twice daily, but sometimes this wasn't possible as staff did not return their clothing to their room. Staff did not consistently understand people's needs and preferences. We spoke to staff about people's needs and not all staff could describe these to us. For example one staff member was unable to tell us why a person was being cared for in bed. Another staff member was unable to tell us how frequently a person required repositioning, we found from the records this person was not always being repositioned as set out in their care plan. This meant some staff were not responsive to people's needs.
People did not always have their needs as they required. We found staff did not follow peoples care plans. For example, one person had a plan in place due to behaviour that challenged which said the person had to be supervised by staff at all times. We found multiple occasions where staff left this person unsupervised in communal areas. This showed staff had not followed the guidance in place to manage the person's behaviours which meant people were left at the risk of harm.
People's preferences were not always followed. We found people had assessments which took account of their preferences; however these were not always followed by staff. For example, one person had said they preferred to drink tea. We found this person was at risk of dehydration and although the preferences for this person were known, staff continued to offer other fluids and the person was not drinking sufficient fluids. This showed staff had not followed the person's preferences for fluids which meant the person did not have sufficient fluids, leaving them at continued risk of dehydration. In another example, we found one person required end of life care. There had been no discussions with the person about their preferences for the provision of end of life care and there was no care plan in place for staff to follow. This showed staff did not have the information available to them to support this person on their end of life journey. This meant the provider had failed to ensure the people's preferences were understood.

People did not always have reviews to their assessments and care plans. We found care plans were not always effectively reviewed and updated when people's needs changed. For example, one person had sustained an injury following an incident. We found this person's risk assessment had not been updated and no additional guidance had been provided in their care plan for staff to prevent further incidents. In another example, one person's needs had changed following an assessment of a health professional for transfers. This person needed staff to support them with the use of specific equipment. We found the staff were unaware of this change and the person's care records had not been updated. This meant the person was being moved using the wrong techniques because the provider had not ensured their care plans had been reviewed when their needs had changed. This meant the provider had not responded to a change in

people's needs to ensure appropriate care was provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People told us they had support to be involved in activities. One person told us, "Staff support me to go out to the shops". Another person told us they attended the bingo. Staff told us they tried to undertake activities with people but that sometimes there were insufficient staff to do this. We saw there were activity plans on display in the home and we observed some people attending a bingo session during the inspection. We saw one person was knitting, the staff told us this person loved to spend their time knitting. However; we saw that most people spent their day in the communal lounge watching television, with minimal interactions from staff. People's care plans did not show what their interests were and whether they had participated in the activities which had been on offer. This showed further improvements were required to the support people had to engage in meaningful activity.

People and their relatives told us they did not feel complaints were responded to effectively. One person told us they had made complaints about clothing going missing, and other people's clothing being placed in their room. They told us the manager had arranged for a clothing tagging system, however this had still not solved the issue and clothing was still going missing. We found formal complaints had not been responded to in line with the provider's policy. For example; the policy stated a response would be received within 28 days however one complaint had taken 41 days to receive a response. We found where a complaint had been given verbally this was not responded to, which meant the person had to make a formal written complaint. In a further example one relative about a person's preferences not being followed, the records stated that action was taken to remind staff about people's preferences. However it was further documented from the complainant that this was still not being followed. This meant the provider did not always listen to people's feedback, concerns and complaints to make improvement to their care.
This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had not submitted notifications to the CQC about certain incidents within the home. At this inspection we found the provider had made the required improvements. However the provider was still in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they had not made the required improvements and had continued breaches in the regulations and we found the quality and safety of care in the home had deteriorated further.

People's health and well-being was not sufficiently protected as the provider had failed to implement systems that ensured people received the care and support they needed. We found there was a system in place to monitor the care and support people received, however it was not effective. Care plan audits were operated on a sample basis. This meant the audits were done on a sample of care plans each week. However we found these were not effective in identifying areas of concern that we found during the inspection. For example, we found people's food and fluid intake was not being recorded and monitored and steps were not being taken to protect people's health. This was despite some people refusing food and drink and staff identifying that some people had lost weight. The management systems had failed to provide adequate monitoring and auditing. This meant people were continuing to receive poor care and there was an increased risk of harm to people. In another example we found people were at risk of developing pressure sores and required regular repositioning to reduce the risks, we found this had not taken place. We found there was no checks in place to ensure this had been done by staff. The manager told us they checked a sample of records weekly and confirmed this would not have picked up the concerns we raised. This meant the provider could not be assured people received the care and support they needed.

We found the provider did not have systems in place to ensure peoples risk assessments were up to date and clear care plans were in place to manage people's health needs. We found concerns about people were not being escalated and advice of health professionals was not been followed. Checks were not completed to ensure health professional advice was being followed and the monitoring of peoples care had not identified the concerns which were not escalated. This meant people continued to be at risk of receiving unsafe and inconsistent care. The provider had failed to ensure information was accurate and up to date and reviewed by appropriate staff, which meant concerns about people had not been escalated appropriately. We also found people's preferences were not always known by staff and followed when care and support was given. The manger told us care plans were being reviewed to include clearer information for staff about people's needs and preferences, however they had only updated one care plan at the time of the inspection. As the provider was not able to provide assurances that some people's health needs had been met we reported our concerns to the local safeguarding authority for further investigation and requested the provider addressed specific concerns immediately.

The provider had a system in place to check if people had received their medicines as prescribed. The system was not effective as the issues we identified with people's medicines were not always identified through the audit process. For example, one person had not had their prescribed medicine for over one

month. In another example, the audit had identified staff were not signing the MAR charts for topical medicines. However there had been no investigation to determine if people had received their medicines. Reminders had been issued to staff about missed signatures; however there were still unexplained gaps on MAR charts during the inspection. For example, one person's MAR chart showed they had not had their barrier cream applied as part of their skin integrity plan. Care records showed this person had developed a grade 3 pressure sore. The manager was unaware of this until we raised the matter and they said they would investigate. This meant despite the audits undertaken people continued to be at risk of receiving unsafe and inconsistent care.

The provider did not have effective systems in place to ensure staff were deployed appropriately and could demonstrate an understanding of their role. The manger told us they had not yet implemented a system to check the number of staff needed to meet people's needs. They also confirmed that observations were completed as part of staff induction only. This meant there was insufficient staff to meet people's needs safely and the provider could not be assured staff were suitably skilled. This meant some staff did not have the skills required to provide safe care. For example; staff were unclear about applying the principles of the MCA, safe manual handling techniques and how to report incidents. The manger told us they had booked staff to attend training updates and provided a list of staff, however there were no dates by when this would be completed. This meant people were at risk of receiving unsafe care.

We found the provider did not have effective systems in place, to assess and monitor the quality and safety of services. For example; the manager undertook daily room audits, however, we found these were not effective in identifying areas of concern. One room which had been audited had a socket with exposed wiring; this placed the person that used this room at risk of harm. We found that there were ineffective systems in place to investigate incidents to ensure action was taken to prevent further incidents from occurring. For example; when people had received a skin tear there had been no investigation to determine how this happened and no guidance for staff on how to prevent a further incident. This meant people were left at continued risk of harm because action had not been taken by the provider to mitigate risks to people.

The provider did not ensure polices were followed. For example the recruitment policy was not followed and this had resulted in staff being employed that may not be suitable to support people who used the service. The complaints procedure had not been followed consistently and this meant some people did not have their concerns addressed in a timely manner.
People told us the manager was nice and had told them to come to them with any concerns. However they told us that when they had raised issues with the manager nothing much had changed. Staff told us the manager was approachable and they had raised concerns about staffing levels. However staff felt the manager was unable to make any changes. We found the manager did not have regular opportunities for people and staff to give their feedback. There was some evidence of meetings being held, however the records from meetings showed these were not consistent.

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

There was not a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The provider had appointed a manager however they had not yet registered with the commission. We found the manager was notifying us of certain events such as incidents and deaths. We found statutory notifications which we had

received notified us of relevant events and incidents in a timely manner. The current rating was on display.

The manager told us they had been working on improving the service since our last inspection. The provider told us they had increased staffing and had made some changes. We saw an action plan which outlined improvements which were required some of which was showing as completed. However we found the actions had in some cases not been taken or had not been effective in bringing about the changes required to make improvements to the service.