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Angel Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 29 and 30 October 2018 and was unannounced. At the last inspection completed in April 2018 the service had been rated as 'requires improvement'. The provider was not meeting the legal requirements regarding safe care, staffing levels, dignity and good governance. The service was in special measures. It first entered special measures following an inspection that ended on 11 September 2017. The service remained in special measures following the last inspection. At this inspection we found the provider had endeavoured to make some improvements, although these had failed to improve the quality of care provided. We saw overall the standards of quality had deteriorated. The provider remained in breach of some legal requirements and we identified further breaches of regulations.

Angel Court Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 30 older people. At the time of the inspection there were 19 people living at the service, most of whom were living with dementia.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had not ensured that all incidents that may be considered as safeguarding concerns were identified, reported to the local safeguarding authority and investigated appropriately. People were not always protected from the risk of ongoing harm. Risks to people including those due to behaviours that can challenge, mobility and swallowing issues were not fully understood and managed safely.

People were supported by sufficient numbers of care staff although these staff were not always deployed effectively in order to ensure people's needs were met. While some improvements had been made to medicines management systems, further improvements were still required. In particular around the management of creams and medicines that had been prescribed to treat those people with challenging behaviours.

People were not always supported by care staff who had been equipped with the skills and knowledge they required to support people safely and effectively. People's consent to their care was not always obtained and steps were not taken in people's best interests in line with the law where they lacked mental capacity. People's basic nutritional needs were mostly met although improvements were still needed.

While care staff had good intentions, the care people received was not always caring. People's dignity was not always upheld and people were not always treated with respect and empathy. People's independence was not always fully promoted and they were not given maximum control over their choices and lives.

People did not always receive fully personalised care. They were not always involved in planning the care they received and care staff did not fully understand people's needs. People did not have sufficient access to the leisure opportunities and they were not encouraged to pursue personal interests.

People were not encouraged to complain and share their views about the service in order to ensure improvements could be made.

People were not cared for by a staff team who were fully supported by the provider. People did not feel the culture within the service was open and that it was safe to speak out about concerns they had. People were not living in a service where a culture of continuous improvement was present. Further improvements were still needed to quality assurance and governance systems which remained ineffective.

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

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

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

The provider was in breach of the regulations surrounding safe care, person-centred care, the need for consent, dignity and good governance. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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 the risk of potential abuse. People were not protected from further risks such as those including accident or injury due to poor risk management processes.

People were supported by sufficient numbers of care staff although these staff were not always available when they needed them. Further improvements were required around medicines management systems.

Is the service effective?

Requires Improvement

The service was not effective.

People were not always supported by care staff who had the skills and knowledge required.

People's consent to their care was not always obtained and steps were not taken in people's best interests in line with the law where they lacked mental capacity.

People's basic nutritional needs were mostly met although improvements were still needed.

Is the service caring?

Requires Improvement

The service was not caring.

The support people received was not always caring. People's dignity was not always upheld and people were not always treated with respect and empathy.

People's independence was not always fully promoted and they were not given maximum control over their choices and lives.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive fully personalised care. People were not involved in planning the care they received and they did not have sufficient access to the leisure opportunities.

People were not encouraged to complain and share their views about the service in order to ensure improvements could be made.

Is the service well-led?

Inadequate

The service was not well-led.

People were not cared for by a staff team who were fully supported by the provider.

People did not feel the culture within the service was open and that it was safe to speak out about concerns they had.

Quality assurance and governance systems remained ineffective.

Angel Court Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 October 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector, a Specialist Advisor 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 Specialist Advisor was a qualified nurse with experience of working with older people and people who may exhibit behaviours that can challenge others.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 11 people who used the service and four relatives. We spoke with the provider (who is also the registered manager) and 10 members of staff including, deputy managers, the cook and care staff. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, nine people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our last inspection completed in April 2018 we identified breaches of regulations relating to safe care and staffing levels. At the previous inspection, completed in November 2017 there had been a breach of regulation around safeguarding people from abuse which had been met when we returned in April 2018. We rated this key question as 'inadequate'. At this inspection we found insufficient improvement overall had not been made although the provider was meeting the basic requirements of the law around the numbers of staff required. We found further concerns around safeguarding people and they continued to fail to meet the legal requirements around providing safe care.

Care staff we spoke with were able to describe signs of potential abuse and how they would report any concerns they had. We were told safeguarding concerns would be documented, reported to a member of the management team and they would then refer this to the local safeguarding authority. We found that in practice this was not happening. One person had a large bruise to their hand which care staff told us had been caused by another person grabbing them. We saw a body chart document had been completed but no referral had been made to the local safeguarding authority. The registered manager was aware of the incident but had not ensured appropriate investigations were completed. They had not taken steps to put measures in place to minimise the risk of any reoccurance and therefore further harm to the person involved.

We found from behavioural records that another person had been 'grabbed' by a person living at the service and had a hot drink thrown at them. We also identified one person had demonstrated aggressive behaviour towards other people on more than one occasion. We found the management team were not aware of these incidents and they had not been reported to the local safeguarding authority. The provider had failed to ensure effective systems were in place that resulted in staff identifying potential abuse and reporting these incidents to the management team to enable a referral to be made to the local safeguarding authority. As a result, investigations had not been completed and steps had not been taken to minimise the risk of any reoccurrence. Therefore people were exposed to the risk of ongoing harm.

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

We found people were put at risk of either physical or emotional harm due to poor risk management around behaviours that can challenge others. People we spoke with did not feel completely safe living in the service due to these behaviours of others. One person told us they were sometimes frightened in their bedroom at night as they felt someone may have walked in. Another person told us about one person who threw things around and other who tried to take people's food. The management team and care staff we spoke to told us people no longer wandered into the rooms of others and nobody exhibited any behaviours that impacted on other people living at the service. This was not consistent with what we were told and what we read in records. We identified from behaviour records that there had been several incidents where people's behaviour had caused emotional harm to others and there had been threats of physical violence by people using the service towards other people living at the home. The management team told us they were

unaware of these incidents. We looked at the care plans and risk assessments for these people and saw there were no clear guidelines in place for care staff around how they should manage these behaviours in order to minimise risks to others. They had also not identified potential triggers for these behaviours in order to minimise the likelihood of behaviours escalating. The management and staff team recognised that some people demonstrated behaviours that were aimed towards care staff or would cause damage to the environment. Risks associated with these behaviours were also not being effectively managed. There was no acknowledgement that these behaviours could impact on the emotional wellbeing of others and there were no robust plans in place that outlined triggers and outlined steps to mitigate the risk of harm to other people, staff and property.

We found risks associated with people's mobility were not managed effectively which exposed people to the risk of harm such as physical injury. One person was experiencing multiple falls and staff had sought advice from the fall referral team in September 2018. They were advised to continue with this person's physiotherapy exercises. We looked at this person's care plan and risk assessment and there was no instruction to care staff to complete the exercises. The management team had been unaware of this instruction, their exercise instructions were archived and no support had been given to the person to do this. The most recent fall this person had experienced had resulted in them being admitted to hospital, yet the provider had not taken all reasonable steps to minimise the risks to them.

We saw another person had experienced several falls, some of which causing significant injury. We saw in the person's care records they had a history of glaucoma and required an optical prescription. Their care plan around communication outlined they should have their glasses with them at all times. Care staff we spoke with were not aware of the requirement for this person to wear glasses and the person did not wear glasses for the duration of the inspection. We saw the person's sight issues had not been considered in their risk assessment for mobility of falls, therefore no action had been taken to minimise the potential risks to this person. We also saw this person was required to mobilise down several sets of steps with their frame when moving between their bedroom and the lift to the lower floor where the lounges were situated. The provider had not considered the risks present to the person while using these steps and they were not included in the risk assessments for this person.

We saw another person in the service mobilising up and down steps while carrying their walking frame. The person's care records assessed them as being at risk from falls due to their legs giving way underneath them. The risk assessment did not consider how to keep this person safe while they mobilised up and down stairs. Care staff told us the person had capacity and they would try to help if they were present. We asked the person if care staff had discussed the potential risks to them while using the stairs and how these could be minimised. The person told us they had not. We saw another person struggling to get up from their chair with no care staff present and their walking frame not present. We saw care staff transfer this person in a wheelchair yet the risks had not been assessed and considered around the use of this equipment. We saw another person walking around the service either carrying their walking frame or not using it. Care staff told us they were aware the person needed prompting to use the frame and this was reflected in the person's care plan. The person told us, "I am supposed to use that walking frame because I have had falls but I don't and they don't make me". Care staff told us the person had mental capacity although there was no evidence the person had been involved in any discussions about how the risk could be managed proactively.

We saw risks associated with people potentially choking on food had not been thoroughly assessed and understood. We saw sections of two people's care plans outlined they were at risk of choking while eating. These people were not able to discuss these risks with us during the inspection. One person also had instructions in the kitchen stating their food should be cut up due to this risk and a staff member told us the person had porridge for breakfast to ensure they didn't choke. All other care staff we spoke with were not

aware of the potential risk to either of these people. The management team were also not clear on the potential risk and told us one person had choked on bread once and the other person had an issue swallowing a large capsule which they felt had represented a choke risk. The care plans and risk assessments for these individuals were not clear on whether there was a potential risk and appropriate healthcare professionals had not been consulted to ensure there was no risk present. The two individuals were eating a standard diet for most meals which would pose a risk to them if they were at risk. We referred these concerns to the local safeguarding authority to ensure any potential risk was identified and the individuals could be protected from harm.

We found monitoring systems were not robust where people were at risk of weight loss. Care staff were aware of who they should be monitoring the food intake for, although these monitoring records were not always in place. Where people's care plan stated they should receive snacks to ensure their weight is maintained this was not always reflected in food monitoring records. While care staff told us they should give people snacks we did not see this being proactively done during the inspection. One of these people was continuing to lose weight although care staff were not aware of this and believed all individuals were now maintaining their weight.

We looked at how the provider was managing medicines within the service. We saw some good practices around the administration of medicines and that medicines given in tablet or patch form were recorded appropriately when given. We saw the provider had no safe systems for recording and monitoring the administration of topical creams. One person had seen the district nurse two weeks prior to the inspection. An instruction had been given to administer cream. There was no record that cream had been applied and the management team were not aware this instruction had been given, despite it being recorded in the person's daily care notes. We saw further issues with the recording and administration of creams. Care staff were not clear around where they should be recording the administration of creams. One member of staff told us it should be recorded in personal care records, another told us it should be recorded on a person's medicines administration record (MAR). This confusion was reflected in the inconsistent recording we saw. One person's MAR had not been completed but there was reference to cream being applied in their personal care records. The management team advised this was due to the person preferring a cream they were sent from home rather than the one prescribed by the GP. Steps had not been taken to consult with the person's GP or other appropriate healthcare professional to ensure the alternative cream would be effective and safe for use.

We saw medicines were being administered in the food of one person. No steps had been taken to consult with a pharmacist to ensure this did not impact on the effectiveness of the medicine. Another person was being given a benzodiazepine medicine on an 'as required' basis to assist with managing their distressed behaviours. These medicines have a sedative quality and should be administered under careful guidelines. While care staff told us this was only given as a last resort, they did not give us a consistent explanation around how they would support the person and when they would administer the medicine. While the registered manager provided a copy of guidelines for the administration of this medicine following the inspection, care staff we spoke with were not aware of these guidelines. We saw the medicine was being administered without staff making clear records around why this had been done. There were no records in daily care records or incident reports to state this person had been exhibiting distressed behaviours at the time the medicine was administered.

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

We found some improvements had been made around the management of infection prevention and control

as cleaning practices had improved within the service. One relative told us, "I've never seen my Mom's room look so clean". However, significant further improvements were still required. The infection control lead was not aware of the national guidelines for the management of infection prevention and control which are required to be followed by law. We saw concerns such as open bins, toilets covered in faeces and high level areas that required cleaning.

We saw the provider was now ensuring safety checks and services on equipment and within the building were completed on a regular basis. We saw fire evacuation plans were in place although the individual evacuation plans for people stated they would need assistance from at least one member of staff. The overall evacuation plan did not outline how they would ensure sufficient numbers of staff members would be available simultaneously in order to provide this support safely.

We looked at how the provider determined how many care staff they needed to support people safely. We saw the provider was using a formal tool to calculate the required staffing levels and this was reflected in the staffing rota and the number of care staff we saw during the inspection. While people living at the service did not share their views on staffing levels, care staff told us they felt there were now sufficient numbers of them on duty to care for people safely. We saw while the numbers of staff on duty had improved, the deployment of these staff was not always effective. There remained long periods of time where people were sitting in communal areas with no interaction or support available from care staff. During these times we saw people needed assistance. For example we saw one person with poor mobility trying to stand unsuccessfully and care staff were not available to provide support.

We looked at how the provider ensured staff members were recruited safely and were appropriate to work within the service. We saw that basic employment checks were being completed; for example identity checks, references and Disclosure and Barring Service (DBS) checks. DBS checks are completed to enable an employer to view a potential employees criminal history to ensure they are suitable for employment. We saw some improvements were still required to recruitment processes; including checking the identity of referees and ensuring gaps in employment histories are appropriately checked.

Requires Improvement

Is the service effective?

Our findings

At our last inspection completed in April 2018 we rated this key question as 'requires improvement'. At this inspection we found the provider had failed to make sufficient improvement and was not meeting the requirements of the law around the Mental Capacity Act 2005 (MCA).

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We found decisions were being made on behalf of people living in the service without their consultation and consent where they had mental capacity to make decisions. Where people lacked capacity we found these decisions were being made without the correct procedures under the MCA having been followed. For example we found that hourly checks during the night were being completed as a standard practice within the service and without considering people's individual needs. We asked one person who care staff told us had capacity if they had been consulted about staff entering their room each hour at night and they told us, "I don't know anything about that". Where care staff told us people lacked capacity to make these decisions we found decisions had not been made in their best interests in line with the Act. The staff team were not taking decisions that resulted in the least restrictive practices possible as required by the law. We saw one person was being given sedating medicine on an 'as required' basis without the required steps under the MCA having been followed. We saw the service was planning for people's annual flu jabs and were obtaining consent from people's relatives who did not have the legal authority to provide this consent. We also saw a high number of refusals from people around personal care and staff had not considered how they needed to make decisions in these people's best interests in line with the MCA.

The management team and care staff did not have a sufficient knowledge of the requirements of the MCA, despite having received training less than two months prior to the inspection. Care staff did not fully understand how people's capacity and ability to make decisions and provide consent could fluctuate and vary depending on factors such as the type of decision, their health or the time of day. One person was deemed to have full capacity, however, this did not match our observations and discussions with the person during the inspection. A staff member also told us, "Some days [person's name] will be fine and other days [they'll] be asking for [their sibling] who staff have to say is in heaven". They did not identify this could mean their mental capacity was fluctuating. The staff team had not considered how they should support this person as their capacity fluctuated and how they were required to take steps under the MCA.

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

We saw where the management team had assumed people lacked capacity they had made legal applications to deprive people of their liberty. Care staff had a basic understanding of why these legal applications were required. They were not always clear in understanding who these applications had been made for. One staff member told us, "There's five of them [that don't have a DoLS]". Another said, "I think six don't have DoLS". Another named seven people who they thought didn't have DoLS. Care staff told us they would only have allowed one person to leave the service without staff presence and therefore were restricting people's liberty without the required authorisation. We saw one person had an appropriate representative meeting regularly with them to ensure their interests were safeguarded. This wasn't however consistent across the service.

People did not always enjoy the food they ate. One person told us, "The food is okay but I have to be careful what I eat as my teeth are not good. I left the pork as it was very tough". We saw food was cooked freshly on site and a choice of two options were available to people each day for their main meal. Care staff told us and records confirmed that one person required picture cards to help them choose their food each day. We saw this person was offered food and the cards were not used. While we saw some choices were available to people, they were not always proactively involved in designing menus and consistently choosing what food should be available to them. One person following a healthier eating plan had chosen to have brown bread and this was made available to them.

We saw most people's basic dietary needs were met. However, we found care staff were not certain which people were diabetic and if any special dietary adaptations were required. Where people's care plans stated they required regular snacks, their food intake records did not outline this requirement had been met and we did not see regular snacks being offered. Care staff were not certain who should be eating a texture modified diet and care plans did not always contain clear guidelines due to people's needs not being fully understood. Where people's needs were not clearly established we referred these concerns to the local authority to ensure people's needs could be understood and met.

People told us they were not always happy with the environment in the service as it was very cold. One person told us, "It's cold when you first get up". They also told us, "I try to keep going and moving but it gets very cold that's why I move about. Couldn't sit and relax in my room it's too cold". Another person told us, "It's very cold in here. It's too cold to sit and relax". This person told us, "The quilt is too thin and I do get cold at night which isn't very nice and it's hard work getting another blanket I can tell you. It isn't right in a place that's supposed to be caring for you that you have to make a song and dance to get another blanket – that's basic stuff". We saw some people sat in coats in communal areas and one person was in their bedroom with a hat on and sat under a blanket as they felt cold. We found some areas in the service felt cold and one person told us the provider had commented on the cost of heating bills when they had arrived and turned radiators down. The provider, when asked, denied having made these comments. We found there was no system in place to monitor the temperature of rooms, other than for the storage of medicines. The provider had no system to ensure the service was kept at a temperature recommended for older people.

We saw some improvement had been made to signage within the service; however, the decoration of the premises remained not in line with best practice guidelines around dementia friendly environments. There was also a lack of consideration around how people with mobility issues could mobilise safely around the service due to the large number of steps within the service. We saw one person fall up these steps during the inspection. The provider had not ensured the environment maximised the independence of those living in the service.

People who had the capacity to share their views and their relatives told us they were happy with the care staff in the service. Care staff told us they felt the staff team had the skills required to support people effectively and that more training had been made available to staff. One staff member told us, "We're up to date with the training…we've done loads". Some staff told us they felt there had been too much training delivered in one go. Staff told us that the training had been delivered in an intensive two day session, however, some staff had been required to go 'in and out' of training. One staff member said, "It wasn't the most effective". We saw the deputy managers were now completing one to one meetings with care staff and some competency checks had been completed. However, competency checks had been completed on an 'ad hoc' basis and had not been completed for all care staff. There was no system in place that determined which competencies should be checked and when. We saw the skills of care staff had improved, however, further improvement was still required as care staff were not always able to recognise when care delivery did not meet the required standards.

While people were unable to share their views about how their health was maintained on a day to day basis, relatives we spoke with were happy with the involvement people had with healthcare professionals. One relative told us care staff were also good at ensuring they were kept informed about any concerns or accidents. We saw people had regular contact with professionals such as doctors, nurses and the dentist.

Requires Improvement

Is the service caring?

Our findings

At our last inspection completed in April 2018 we rated this key question as 'requires improvement'. We found the provider was not meeting the requirements of the law around the promotion of dignity and respect. At this inspection we found the provider had failed to make sufficient improvement.

While some people told us they were happy in the service, others told us they were not. One person told us, "I'd be better if I wasn't in here". Another person told us, "They just don't care about you here and they are so miserable I just get on the best I can". We found care staff were well intentioned towards people although ineffective training meant staff did not always have the skills to recognise when people were not treated with dignity and respect. The provider had also developed a culture within the service that was not caring or dignified and respectful. For example; we saw everyone within the service was required to eat using plastic plates and to use plastic beakers. There was no safety requirement for these outlined in care plans that had been considered on a case by case basis. The provider had taken the decision for all people to use plastic items. We saw one person walking in a communal area with their skirt tucked into their underwear. Another person living at the service pointed this out to care staff to request it was removed.

We saw people were sitting in communal areas with dirty clothes and poor standards of personal care. We looked at the personal care record for a male we saw with long fingernails and their personal care record outlined these had not been cut for over two weeks. We saw personal care records showed people had infrequent baths and showers. People's bedrooms were also cold, bare and often untidy. We saw one person's bedroom had a cleaning sign resting against a wall and a plastic glove strewn over a radio. The room appeared uncared for and the discarded items demonstrated a lack of respect by staff for the person's environment. The person lacked capacity to take full control of their own environment. A deputy manager told us they were implementing a new key worker system which would assist in ensuring rooms were tidy, baths were done at least weekly and that toiletries were obtained from families when needed. We saw this system had not yet been fully implemented so the impact had not been felt by people living in the service. The management team told us they were committing to the '10 Dignity Dos' in order to improve standards of care within the service. We saw this included having a zero tolerance of all forms of abuse, respecting people's privacy and maintaining the maximum possible level of independence, choice and control. We saw these standards were not yet being met within the service.

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

People confirmed they felt care staff were well intentioned. One person told us they were concerned about possibly having to move to a new home. They told us while they knew improvements were needed at the service, they were comforted by the fact care staff weren't intentionally unkind to people. One relative told us, "I trust the staff here". We saw some positive examples of interactions between care staff and people on a one to one basis. Care staff we spoke with were also very passionate and committed to making improvements within the service. However, they were not provided with the skills, resources and management support needed to operate a caring and effective service.

People told us they did not always have regular interaction with care staff. One person told us, "I just get on with it here, they [staff] don't really bother with me". This mirrored our observations during the inspection, where people often went for extended periods of time with no interaction from or presence of care staff. The culture within the service appeared not to place importance on warm, one to one interactions with people. People also told us they were sometimes impacted by the behaviours of others. One person told us how a person threw things around and other tried to take their food. The provider, management team and care staff had failed to recognise how the behaviours of others could have a significant emotional impact on other people living in the service.

We found people were given basic choices such as giving them a list of options to choose from for breakfast. The provider felt providing people with these basic choices meant the service was offering a fully personalised service to the people living there. They failed to recognise that they were not giving people maximum choice and control over their lives and how they wished to live them.

We did see that people were able to maintain relationships with those who mattered to them. People's relatives were welcomed into the service and were able to visit without any unnecessary restrictions.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection completed in April 2018 we rated this key question as 'requires improvement'. At this inspection we found the provider had failed to make sufficient improvement and was not meeting the requirements of the law around providing person-centred care.

People who care staff told us had full capacity to be involved in their care were not aware of their care plans and told us they had not been fully involved in the development of them. One person told us, "No, I don't know about that [my care plan]". We saw care plans were in place that did contain more personalised information than at our previous inspection. However, they did not demonstrate that people were fully involved in the development of their care plans. We saw recent relatives meetings where staff had asked family members to read and sign care plans as, "This shows evidence of family involvement in care plans". The provider had failed to recognise the need for family members to be fully involved in the development of the care plan itself. We saw a one page personal preference summary was at the front of each person's care plan which demonstrated a lack of understanding around person-centred care. These sheets indicated if people preferred a skirt or trousers, their window to be opened or closed and if they preferred tea or coffee. They did not reflect that people's preferences may change on a day to day basis or depending on varying circumstances. We saw this reflected the care we saw being delivered during the inspection. For example; one person told us they did not like the coffee they were drinking and would prefer a lemonade. We requested this from care staff for the person and care staff responded with, "But they always have black coffee". This demonstrated care staff had not been given the skills to understand how people's preferences may fluctuate and change.

We saw that people's needs were not fully assessed and understood. For example; care staff told us two people in the service liked to hold dolls. Doll therapy is a specific type of support that can be provided to people living with dementia in order to calm them and alleviate forms of distress. We asked care staff how they used the dolls with one of the people effectively. They told us, "She just likes it". They were unsure if a care plan had been developed around the use of the doll and we confirmed from care records it had not. Care staff did not understand how they could support this person with the use of the doll. We found multiple people demonstrated behaviours that could challenge others. Robust care plans were not in place that identified the potential triggers for this behaviour and outlined how care staff should safely manage these behaviours in order to alleviate distress and protect others. We saw multiple people were declining personal care and care staff had not established the reasons for these declinations and developed care plans that would assist in minimising refusals and providing care in a way that would meet these people's needs and preferences. We found low levels of baths and showers were being completed in the service. One person told us they were aware there was a 'timetable' for baths and showers but they weren't sure when they were scheduled to have one or when they had last received one. We also found effective care plans were not in place to identify where people may be experiencing pain but may not be able to verbally express this to care staff. One person was seen to be clutching their stomach during the inspection and appeared distressed. We were required to alert care staff to the fact this person may be experiencing pain. We found work was being done to develop information held about people's past histories although relatives and other significant people had not yet been fully involved in these and this work had not yet been fully completed. Nobody

living in the service yet had a care plan around their end of life wishes. This meant that people's wishes may not be met in the event they passed away while living at the service.

Where care plans identified certain health conditions or life histories, people's needs were not fully understood and care staff were unaware of these needs. For example; one person's legs were seen to be swollen during the inspection and their care plan stated they had a diagnosed health condition. The care plan did not outline how care staff should support them with this condition. Care staff we spoke with were also unaware of what support they should be providing. For example; if the person should have their legs elevated or not. We also asked care staff about the personal history of one person as their care plan outlined they had been exposed to a traumatic childhood. Despite, one member of staff acknowledging this person had been known to 'flinch', care staff nor the management team were aware of the details outlined in their records about their history. Care plans had not been put into place around how this person could be effectively supported in order to minimise any potential distress.

We saw people were not effectively supported to pursue leisure opportunities or personal interests. One person told us, "I'm cheesed off with the place to be honest…You never go anywhere". Another person said, "I get so fed up here. There is nothing to do and nothing going on. I am [very] bored all the…time. We never do anything here or get taken out. I am just fed up that this is where I have ended up!". A third person said, "You don't get anything here. I want to get my free bus pass because I still go out and it costs a fortune in taxis. That bus pass would make a real difference to me and I am entitled…but [the provider] won't help me get one". We saw a lack of interaction and activities taking place during the inspection. We saw there were long periods of time where there were no care staff in communal areas. We saw in one person's care records a health and social care professional had recommended that one person was taken out more. We asked a member of care staff if this had happened and they told us, "No, I'm not aware". We looked at the records of the activities this person had completed and they confirmed they had not left the service for any leisure activities. We saw there was an activity plan developed for September, however, activities records showed this had not been followed or completed. We saw activities recorded for people were mostly simply interacting with other people or watching TV. There had been no attempt to understand people's individual preferences and to develop personalised opportunities for people to pursue their own interests. The activities audit completed in September acknowledges a new activities coordinator was in place and that the lack of one to one activities would be addressed. That activities coordinator was not in post at the time of the inspection and the issue around the lack of personal interests and activities had not been addressed. The provider has stated on previous occasions that a new activities coordinator would be commencing, however, to date a coordinator has not yet remained in post.

We found people's needs around their ethnicity, culture, religion and sexuality had not always been recognised and addressed. We saw some positive examples; for example, one person's first language was Punjabi and we saw there was always a staff member present who could speak this language. We also saw examples of where people's needs had not been considered appropriately. We asked one member of staff if they were aware of anyone who may be lesbian, gay, bisexual or transgender (LGBT). The member of staff said, "I don't even know how to find that" and confirmed these needs and had been considered. This meant that people's diverse needs had not been identified and they may not be receiving the support they required. We saw multiple people's care plans stated a religion they were baptised in but stated they no longer practiced due to their dementia. They had not fully considered with the involvement of the person and their representatives in line with the Mental Capacity Act 2005 (MCA), how there past religious beliefs could continue to be respected.

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

Most people at the service were unable to share their views around how effectively the provider managed complaints. The provider told us there were no complaints received about the service from either people living there or their relatives. We saw a complaints process and policy was made available in the entrance hall within the service and we saw this had also been made available in an easy read format for people. We did however speak with people during the inspection who shared complaints about the service that had not been identified by the provider. For example the temperature within certain parts of the service, the lack of bacon at breakfast and the lack of activities. One person told us they did not always feel comfortable raising concerns with the provider as they were not approachable and would not listen. We saw the provider had not ensured they were encouraging people to share negative views about the service in order to identify areas for improvement and to enhance the service provided.

Inadequate

Is the service well-led?

Our findings

At our last inspection completed in April 2018 we rated this key question as 'requires improvement'. The provider was not meeting the requirements of the law around the effective governance of the service. This regulation was also not being met at inspection visits we completed in November 2017, August and September 2017. At this inspection we found the provider had failed to make sufficient improvements and continued to fail to meet the requirements of the law. The provider had failed across multiple inspection visits to make sufficient improvements and to achieve or sustain a rating of good across all domains.

At the time of the inspection the provider remained the registered manager for this service. Since the provider was first entered into special measures they had stated they would be recruiting a new manager who would become registered with CQC as the registered manager. The provider had recruited three managers who had commenced and had not remained in post. This had resulted in a high turnover of managers and had caused instability for the staff team. There remained two deputy managers in post in addition to an acting deputy who was providing management support at both of the provider's registered services.

People did not always feel they could approach the current registerd manager and provider. One person told us, "[The provider] is a very strong and powerful woman and we don't want to cross her as she would make life even more difficult – especially if money is involved". We a respondent to a feedback questionnaire returned to the provider had asked who the manager was and said, "Is it the owner?". This demonstrated the lack of clear leadership and management within the service. A relative however said, "[The provider] is good!". Care staff gave us mixed views on the management support they received from the current registered manager and provider. One staff member told us, "When [the provider]'s here, it's chaotic". They told us when the provider 'backed off' they could see improvements. Another member of staff said, "We work hard but we don't have support". Other care staff told us they felt they had support from the deputy managers within the service. We found the deputy managers were given minimal time where they could focus on management duties and driving improvements. For the majority of the time they worked as care staff and were included in staffing numbers. We asked the provider to confirm how many days the deputy managers had spent focusing purely on management duties during the last calendar month and they were unable to provide this information. We were told by a staff member when any management time was planned for deputy managers, care staff may call in sick and they would lose this time again. The provider acknowledged they needed to give deputy managers more time to complete required management tasks. These issues showed us there were unclear and ineffective leadership and management structures which resulted in a lack of direction for care staff and poor outcomes for people in terms of the quality of the care provided to them.

We found the acting deputy manager and deputy managers had been working to develop and implement improved audit and governance systems. We saw these had identified some areas for improvement for example; that improvements were needed to leisure opportunities, end of life care plans were not present and some health and safety issues were identified. While we found some areas had been addressed due to the audits, we found the audits continued to fail to identify certain areas for improvement required and

some of the areas had not yet been addressed due to the lack of resources available for the staff team. Some audits that were outlined as being required monthly had not been completed since August; for example the accident audit. The last premises audit completed in September stated a rolling programme for redecoration was required and was marked as completed. A template for this programme had been developed but a plan was not yet in place. We saw some items that posed a risk had not been identified and were not recorded in the maintenance book. For example; a broken bath panel in the downstairs bathroom had not been identified and addressed. We found records of when people's beds had been fully changed showed some people's beds had not been changed in August in September. The provider's audits had not identified this issue and therefore this had not been questioned to identify if this concern needed to be addressed.

The provider is required to send information regarding quality assurance checks completed to CQC on a monthly basis. The information sent up to the date of the inspection stated that all required action around the Mental Capacity Act 2005 (MCA) had been completed, that accidents had been audited monthly and that issues around audits not previously being robust had been addressed. During the inspection we found this not to be the case and we found improvements were still required across the board. This demonstrated the provider had a failure to assess the areas of improvement required within the service which was a barrier to them understanding how they needed to improve the service provided to people.

We found improvements were still required around records kept within the service. We saw handover sheets did not include incidents that we observed during the inspection; for example, a person falling up a flight of steps by a communal lounge area. We saw the dates on some records within daily care records, behaviour charts and accident records did not match. We found one person had a body chart record indicating they had injured their arm, however there was no record available to outline how this injury had been sustained or when. The management team were also not able to confirm this information. We saw another person's daily records outlined they were mobilising well with their frame during the inspection when we had seen them carrying their frame in a manner that exposed them to risk of accident and injury. The provider's audits had not identified these improvements were needed. We found numerous records could not be located during the inspection and many records were found, after searching by the management team, within archived records which were not available to either care staff, healthcare professionals, people or their relatives. The meant that care staff and professionals were not able to access important information about the risks present to people or information about their health and care needs. As a result they were not always getting the support they required.

We saw the provider had not always developed effective systems within the service. For example; we saw systems to ensure food was not kept past a safe date were not in place. We saw one fridge contained food that had expired past it's used by date and had food with no 'opened on date' marked. We also saw freezers contained frozen fresh food and we asked both the provider and cook how they ensured they knew when this food should be eaten by. They told us the food was purchased weekly and would be eaten within the week, despite some of this food being dated in August 2018. We saw systems were had been developed for care staff to sign to say they had read and understood care plans, however, this was not being effectively completed. For example, one care plan had only signatures from deputy managers and the provider which demonstrated care staff were not reading the care plans. Care staff did not have a good knowledge of the content of some care plans. This was also reflected in ineffective systems around ensuring care staff understood people's needs. For example; care staff were unaware if one person wore hearing aids and were not aware another person should wear glasses. Systems to ensure care staff were aware of incidents and safeguarding concerns were also not effective. For example; two care staff we spoke with were not aware of the bruise one person had that was caused by other person living at the service. We saw new systems implemented such as a system to review a care plan each day were not being completed. The last care plan

review documented within this system was nearly a month prior to the inspection. We found further systems that were ineffective; including ensuring the administration of cream was completed and was consistent. These failings within the systems meant that the provider was not aware of when people's needs had not been identified and were not met. They had not identified potential risks to people or inadequacies in their care delivery and the appropriate improvements were not being made.

We found the provider had not developed systems to ensure they were obtaining feedback from people, relatives and staff members in order to identify areas for development and to drive improvements. We saw feedback questionnaires had been obtained from some relatives that mostly outlined positive feedback. However, we saw an email from the provider to families stating they required positive feedback for an upcoming CQC inspection. This demonstrated the provider was not encouraging complaints or constructive feedback in order to identify where they may need to improve and to ensure they were developing the service positively for people. We saw residents and relatives meetings had recently been held which were mostly focussed on the findings of CQC and the possible future for the service. We did however, identify some examples of where requests had been made by people that were granted. For example; one person had requested a new mattress and they told us this had been done.

We found care staff had been involved in meetings although they did not demonstrate care staff were listened to and used as a positive resource for ideas around how the service could be improved. We asked one member of staff what the current focus for improvement was within the service and they told us, "I don't think there's anything…They might be updating paperwork". We were told the provider had a care quality consultant engaged to support the improvements within the service. However, they were being engaged on an infrequent basis and care staff told us they did not have any contact with them and were unable to ask them questions and to obtain feedback on their care practice.

We found overall the improvements that had been assured to us by the provider had not been consistently made and further improvements were still needed across the service.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in the planning of their care. People's needs were not fully assessed, understood and met.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not upheld and they were not consistently treated with respect and empathy. People's independence was not fully promoted and they were not given maximum choice and control around they way they lived their lives.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always supported to consent to the care they received. Where people lacked mental capacity, decisions were not made in their best interests in line with the requirements of the law.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from harm due to poor risk management processes.

	Improvements were required to medicines management and infection control processes.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure there was a robust system in place that ensured safeguarding concerns were identified, reported and investigated. As a result appropriate plans were not in place to protect people from any further harm.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An accurate and contemporaneous record of people's care was not always kept as required by law. People were not protected by robust quality assurance and governance processes. Improvements required were not always identified and steps were not being taken to rectify areas of risk and poor care delivery within the service.

The enforcement action we took:

We have taken action to remove this location from the provider's registration.