Mr & Mrs J B Wescott

Neilston Residential Care Home

Inspection report

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Date of inspection visit:
01 February 2017
02 February 2017

Date of publication:
19 July 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 1 and 2 February 2017 and was unannounced. We brought the inspection forward due to concerns raised in relation to people's care and welfare. In April 2015, the service was rated "inadequate" and the local authority quality monitoring team worked with the provider and staff to support them to bring about improvements. In January 2016 the home was rated as "requires improvement" after improvements were made. Evidence gathered during this inspection showed the service had not been able to maintain these improvements as nine breaches of regulations were found.

We have shared our concerns with commissioners and the safeguarding team. Following this, with the agreement of the provider, health professionals visited the home to assess people's safety and wellbeing. Some people's care needs are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are working with the provider and staff to support them to bring about improvements.

Neilston Residential Care Home is registered to provide personal care and support to 22 people who may be living with dementia. The registered manager was also the provider of the service but they did not have day to day responsibility for the running of the service. They are referred to in this report as the registered provider. The registered manager who did have day to day responsibility for the service left in January 2017. Another manager had been appointed and had been working at the home for four weeks 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.

People were not safe and were placed at risk of harm. Risks to people's physical health were not identified and managed. The management of falls, choking, skin and pressure area care, medicines, and moving and handling was unsafe. Poor monitoring and management of people's eating and drinking put some people at risk. Care plans were not clear and up-to-date, which meant staff did not have current information on how to meet people's needs. This meant people were at risk of receiving inconsistent care and not receiving the care and support they needed. Staff did not always make referrals to other healthcare professionals to ensure people's care and treatment remained safe.

The provider did not operate safe and robust recruitment procedures. Checks required by law had not been carried out before staff started work at the home. This exposed people to unnecessary risk.

People did not benefit from enough staff to give them the care they needed. At various times throughout the inspection, we observed people sitting in the lounge with no staff present. Some of these people were unable to mobilise independently and had no way of calling for assistance if they needed it. The care and

support we saw staff giving in the lounge was largely task based. For example, supporting people with moving and handling transfers and offering drinks or food. There was little meaningful communication between staff and people in the lounge area throughout the inspection. This meant people's social needs were not being met and there was a lack of consideration for their wellbeing.

People did not receive support from staff who had appropriate training and supervision to ensure they had the skills and knowledge to meet their needs. Although some dementia training had been completed, we observed not all staff understood how to meet the needs of people living with dementia. Most interactions between staff and people were poor. We observed staff did not always listen to people or support them to express their views. For example, one person asked to go to the toilet and was ignored, despite there being a strong smell of urine. People were not treated with respect at all times. For example, we observed staff telling one person they were a 'good girl' and another person was told they were 'being naughty'.

People did not benefit from meaningful activities. People had not been supported to follow their individual interests. We saw people who sat in the main lounge spent most of the time dozing or looking round the room. The television was on but not many people were watching it. The manager told us organised activities took place for two hours on a Tuesday and Friday. There was little attempt to engage any of the people with any form of activity or conversation.

There were restrictions to people's movements around the home and these had not been assessed as being the least restrictive option to keep people safe. For example, people's bedroom doors were alarmed and stairgates were in place. The environment was not suitably adapted to meet the needs of people living with dementia. We had made a recommendation at our inspection in April 2015 in relation to the environment but there had been little progress since then in meeting people's needs.

Risks to people within the environment were not assessed or managed. In people's bedrooms and communal areas we observed items that people living with dementia may misuse or swallow. People were not protected by the prevention and control of infection. The environment was dirty and dusty. The premises were not free from offensive odours. Odours of urine were noted at different places and different points of the inspection. Infection control practices were poor. We identified concerns in relation to the safety of the electrical installation and hot water temperatures. We asked the provider for more evidence so that we could judge whether people were safe but we did not receive this.

Weak leadership and a lack of oversight of the service had allowed poor practice and inconsistent care to be delivered. When the registered manager who had day to day responsibility for the service left in January 2017, another manager was appointed. Following our inspection, we were informed this manager had resigned from their post. The previous manager then returned to cover three hours a day each afternoon, from Monday to Friday. The provider told us they were unaware of events relating to the care of people living in the home. The provider had not developed the staff team to ensure they displayed the right values and behaviours towards people. At times, this resulted in poor outcomes for people who lived in the home.

Management systems were not effective as they had not identified and addressed the risks and issues we found during our inspection. There had not been any recent audits at the time of our inspection. Where the registered manager had identified issues previously, these had not been actioned within the timescale given. The local authority quality monitoring team had completed a report with recommendations, following a visit to the home in October 2016. We identified the same issues during this inspection. Records relating to the care and treatment for each person were not accurate, up-to-date or easily accessible. This showed the provider had not taken action to ensure improvements were made.

During the inspection, we identified a number of concerns about the care, safety and welfare of people who lived at Neilston Residential Care Home. We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's physical health were not identified and managed which placed them at risk of harm.

People did not benefit from enough staff to give them the care they needed.

People were at risk of receiving care from unsuitable staff as recruitment processes were not robust.

People were not protected from the risk of harm because the premises and equipment were not well maintained.

Is the service effective?

Inadequate

The service was not effective.

People were placed at risk because of poor monitoring and management of eating and drinking.

People did not receive support from staff who had appropriate training and supervision to ensure they had the skills and knowledge to meet their needs.

Care was not always provided in people's best interests as staff did not understand what they must do to comply with the mental capacity act.

The environment was not suitably adapted for people living with dementia.

Staff did not always seek professional advice or act upon this with regards to people's health and well-being.

Is the service caring?

Inadequate

The service was not caring.

People did not benefit from staff who showed kindness, respect, and compassion.

Staff routines took priority over the wellbeing and needs of the people who lived in the home.

People did not benefit from staff who listened or supported them to express their views.

Is the service responsive?

Inadequate

The service was not responsive.

People were at risk of inappropriate care as care plans were out of date. Staff did not have clear information on how to meet people's needs.

People were not always at the centre of the care they received because staff focused on the task, rather than the individuals.

People didn't have meaningful activities or engagement and were not supported to live fulfilled lives.

Is the service well-led?

Inadequate

The service was not well-led.

Outcomes for people living in the home were poor at times, as the provider had not developed the staff team to ensure they displayed the right values and behaviours towards people.

Weak leadership and a lack of oversight of the service had allowed poor practice and inconsistent care to be delivered.

The provider did not understand the principles of good quality assurance which meant improvements had not been made.

Records relating to the care and treatment for each person were not accurate, up to date or easily accessible.

Neilston Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 inspection was brought forward because we had received concerns.

This inspection took place on 1 and 2 February 2017. The first day was unannounced. The second day was announced. The inspection team included two inspectors over the two days and a specialist advisor, on the first day, who was a nurse with experience of working with older people and people living with dementia.

Before the inspection we had received concerns relating to the health and welfare of people using the service. We reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We met all of the people who lived in the service; most of them were living with dementia and were unable to communicate their experience of living at the home in detail. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with one relative.

We went into all rooms and areas in the home. We spoke with the registered provider, the manager, the deputy manager, six staff, and one visiting health care professional.

We observed the interactions between staff and people living at the home and reviewed a number of

records. The records we looked at included eight people's care plans, the provider's quality assurance system, policies and procedures, three staff files, training files, accident and incident reports, records relating to medicine administration and staffing rota.

Inadequate

Is the service safe?

Our findings

People were not safe and were placed at risk of harm. There were not always sufficient numbers of competent staff on duty to meet people's needs; risks to people's health and wellbeing were not assessed or managed; safeguarding concerns were not always managed appropriately; systems for preventing the spread of infection were not robust; medicines were not well managed; and staff recruitment was not robust. Prior to this inspection, we received concerns from a social worker and a relative that there were not enough staff on duty. We raised our concerns with the local safeguarding team and commissioners.

At the previous inspection in August 2016, we identified concerns in relation to staffing levels at the home. At that inspection, the registered manager told us they planned to increase staffing levels. However, at this inspection we found there were still not enough staff on duty to meet people's needs. There was one senior member of care staff and two care staff on duty, during the day. In addition to their caring role, staff managed the laundry and prepared tea in the kitchen. A member of domestic staff worked three or four hours a day totalling around 25 hours per week. The cook worked Monday to Friday and were responsible for preparing breakfast and cooking lunch, the provider was currently covering the weekends whilst another cook was being recruited. There were two staff on night duty; one waking and one sleeping.

At various times throughout the inspection, we observed people sitting in the lounge with no staff present. Some of these people were unable to mobilise independently and they had no way of calling for assistance if they needed it. One person was walking around the home and told the inspector they were looking for the toilet on several occasions. We asked a staff member to assist them. At mealtimes, some people had to wait for assistance to eat their meal and their food was cold by the time a staff member was available. We observed staff offer one person a cup of coffee. Before giving the person the coffee, the staff member left the lounge. The person waited 34 minutes until staff offered them a cup of coffee again and they received a drink. One person told us they often had to wait for assistance when people were getting up or going to bed. A relative told us they had observed people having to wait for assistance when they needed the toilet. A staff member said "we could do with more staff".

The provider told us they felt there were enough staff on duty to meet people's needs. However, they did not have a system for determining how many care staff were needed in relation to the number of people who lived in the home and their dependency needs.

This was a continued breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks were not managed to ensure people were kept safe. There was no system in place to review accidents or incidents to prevent a re-occurrence. One person was identified as being at a high risk of falls. Records showed they had fallen 17 times since August 2016. However, their care plan had not been reviewed and updated since May 2016. The falls risk assessment stated one member of care staff should support this person with their mobility. We saw this person mobilising independently without staff supervision on a number of occasions. We observed them trying to climb over a stairgate at the bottom of the stairs in the

hall. This gate was in place to prevent people from going up the stairs. A member of care staff intervened and persuaded them to return to another area. However when the staff member was distracted, the person again tried to climb over the stairgate. This placed them at risk of falling. On the first day of the inspection, we observed this person's slippers were too big. We raised this with the manager. On the second day of the inspection, the person was still wearing the same slippers. The manager had contacted the GP to see whether anything else could be done to prevent this person from falling or to protect them if they did fall. However, in the meantime this person was at risk of further falls and potential injury.

Another person had been assessed as needing two staff to transfer them with a stand aid hoist. We observed staff carry out this transfer and saw the person did not have a stable footing on the base plate. This meant the person was at risk of falling during the transfer. We raised this with the senior staff member on duty. They confirmed that the staff member who was leading the transfer needed to complete further moving and handling training. The senior agreed the staff member should not take the lead on transfers until they were appropriately trained.

Risks to people who were on a pureed diet were not well managed. For example, one person's risk assessment in relation to choking stated they required a member of care staff to support them with eating. Staff were not supporting this person at lunchtime, on the first day of our inspection, and the person began to choke on their meal. The two care staff on duty were supporting two other people to eat in the same room. They did not realise the person was choking. The inspector intervened, checked the person and gave them a drink. We observed their food had not been pureed to the required consistency. We discussed this with the cook, care staff, and the provider, and asked them to take immediate action to ensure this person received a diet which did not put them at risk of choking.

Some people were at risk of pressure sores. We saw that pressure relieving equipment was in place. However, four pressure mattresses were not set correctly for the person's weight. There was no guidance in the care plan so staff knew which setting to use. This meant people may be at increased risk of developing pressure sores. One person's care plan stated they should be repositioned every three hours in bed or every two hours when sitting in a chair. There were no records of when the person was repositioned. When we spoke with staff they told us they only repositioned the person when they needed assistance to change their incontinence pad. This placed people at risk of skin breakdown.

We observed one person became distressed and frustrated by another person's behaviour. They told the person to stop. The person responded by swearing at them. The person's care plan did not contain any information for staff to follow to know how to manage the person's behaviour. Staff were aware of the person's behaviour and had completed behaviour monitoring charts in October 2016. The GP visited the person to carry out a review during our inspection. However, the service had failed to carry out risk assessments or put in place management plans to ensure the person and other people were not placed at risk of harm.

Risks to people within the environment were not assessed or managed. In people's bedrooms, we observed vinyl gloves, razors, and denture cleansing tablets. In communal areas, we observed nail polish remover, fish tank water treatment, and sanitizer spray. This placed people living with dementia at risk of misusing or swallowing these products. We took these items to the manager's office. The sanitizer had been dispensed from its original container and placed in a plain container with the word 'sanitizer' written on it. This meant if a person had drunk the product, there was no related Control of Substances Hazardous to Health (COSHH) datasheet so that staff knew what action to take.

The provider had failed to take sufficient action to ensure care and treatment was provided in a safe way,

and that identified risks were being mitigated or managed.

This was a breach of Regulation 12 (2)(a)(b)(d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were not managed safely. The medicines trolley was not secured to the wall when not in use. This meant medicines were not stored safely and the trolley could be removed. We observed staff give one person their medicines and the person began to choke. The staff responded by giving the person more juice but they had not checked the person's airway was clear. One person had a prescribed cream that was to be applied twice daily. The record sheet in their room was not filled in. If the cream was not being applied this person would be placed at risk of skin breakdown. Some people had been prescribed creams and several of these had not been dated upon opening. This meant staff were not aware of the date when the cream would no longer be safe to use. We found a prescribed cream for a person who no longer lived at the home and had not been returned to the pharmacy. We saw a medicine pot on top of a hand rail in a communal area which contained Paracetamol. We handed this to staff for disposal. The Medicine Administration Record Sheet (MAR) showed that one person was prescribed medicine to enable staff to carry out a measurement as requested by the GP. However, we found staff were also using the medicine to provide personal care. The provider told us the CPN had agreed this but we did not see any evidence of this. This was being followed up by the local authority.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff's awareness of how to keep people safe from abuse was variable. One staff member was able to tell us about types of abuse, and how they would respond if they saw or suspected abuse. However another staff member had no real understanding of safeguarding despite completing online training in September 2016. They did not know who they could contact outside of the home. We had been made aware of a recent safeguarding concern for a person who lived at the home. Staff from the local authority had visited the home to discuss this person's care. We asked the manager about the safeguarding but they were not aware of it, as the incident had happened before they started working at the home. The provider told us they were aware of the concerns but did not know the outcome of the safeguarding. The manager was unable to find evidence relating to any internal investigation.

This was a breach of Regulation 13 (2)(3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The information given to us by the provider in the "provider information return" stated "we carry out a robust recruitment when employing staff". However, we found the provider did not operate safe and robust recruitment procedures. We looked at three staff files. One file did not contain any dates in relation to the staff's employment history. Another file had gaps in the staff member's employment history. Two of the files didn't contain any references. These staff had worked in health and social care before, so this information was required by law. One staff file showed a member of care staff had started working nine days before a completed Disclosure and Barring Service (DBS) check had been received. DBS or police checks are used to help ensure staff are suitable to work in the care sector. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk.

This was a breach of Regulation 19 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not protected by the prevention and control of infection. The service did not have a designated infection prevention and control lead. This meant no one had oversight and responsibility for ensuring risks were managed. We saw ripped covers on commodes, stains on chairs and rips to the fabric, and gaps in bathroom flooring.

The service did not maintain and follow policies in line with current national guidance in relation to the laundry and linen. The washing machine was domestic in type and stored at the end of the dry food store. There was soil on the floor around the front of the machine which had spilt out from a bag of potatoes. The washing machine was dirty and dusty. The tumble dryer was stored in an outhouse in the garden. Clean linen was stored in a bin and bowls in the dining room. Clean bedding was left on a chair in a bathroom. This meant there was no system of workflow to prevent the risk of infection. Following the previous inspection, the registered manager said all machines would be moved to a designated laundry room. The provider told us this had not happened due to issues with pipework.

This was a breach of Regulation 12(2)(h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Although there were cleaning schedules in place, the environment was dirty and dusty. The premises were not free from offensive odours. Odours of urine were noted at different places and at different times during the inspection, in some bedrooms and communal areas.

The local authority food safety unit had carried out an inspection in December 2016. They had given the service a rating of three out of five and 'generally satisfactory'. We saw they had left an action plan for the staff to follow. We looked at the kitchen and found not all areas of the action plan had been completed. A cleaning schedule was in place but on checking the area we found this was not being followed. For example, the schedule for the day before our inspection was to clean shelving. We found the shelving was dirty with debris on it.

This was a breach of Regulation 15(1)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider did not maintain the premises to ensure people were safe. An electrical installation condition report carried out in January 2016 had assessed the installation as 'unsatisfactory'. The report stated that 12 issues were potentially dangerous and urgent action was required. We were unable to find a report to confirm the action had been taken. We asked the provider to send us a copy of the report but we did not receive it. We observed a socket had come off the wall in one person's bedroom. The provider called the electrician to come and repair this.

When we looked around bathrooms and bedrooms, we found the water felt very hot. We asked the provider to confirm whether thermostatic mixing valves were fitted. We also asked for the most recent test records relating to hot water temperatures. We did not receive this information. This meant we could not be assured that people were protected from the risk of scalding themselves.

This was a breach of 15(1)(e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Equipment including hoists and lifts had been regularly serviced. An up-to-date gas safety check had been carried out. Fire alarms and fire equipment had been serviced.

Inadequate

Is the service effective?

Our findings

Care given to people was not effective. People's needs relating to eating and drinking were not well managed or understood; staff did not have the skills, knowledge or training to meet people's needs; staff did not seek advice from health services in a timely way; people were not afforded their legal rights; and the environment was not suitable for people living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The majority of people at the home were living with dementia. We saw that bedroom doors were alarmed to monitor people's movements and stairgates were in place in communal areas to prevent people accessing staircases. Restrictions to people's movements around the home had not been assessed as the least restrictive option to keep people safe. There was no evidence that best interest decisions had been made with the involvement of people's relatives, representatives, or healthcare professionals. Although the provider had made applications to lawfully deprive people of their liberty, they had not considered alternative actions to restricting and continually monitoring people's movements.

One person was being cared for in bed following a fracture. Staff told us the person was kept in bed as they were at risk of falls and may injure themselves. No assessment or best interest decision had been made in relation to this. This meant the decision had not been made in accordance with the Mental Capacity Act. The service could not demonstrate the decision to keep them in bed was made in the person's best interests.

DoLS applications had been made for all those living in the home. However, we found an envelope which contained one person's DoLS authorisation. This was dated October 2016 and was unopened. The DoLS authorisation, contained recommended that the person should have a named advocate but this had not been actioned. This meant the person's rights had not been upheld.

This was a breach of Regulation 13(4)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with did not have a good understanding of the Mental Capacity Act and records showed they had not completed training. Care plans had consent to care forms. However, we saw that these had not been completed. The consent to care forms were worded that if a person was unable to give consent, then the person's relative could consent on their behalf. This showed a lack of understanding of consent.

This was a breach of Regulation 11(1) and Regulation 18 (2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's nutritional needs were not well managed. We observed the lunchtime experience for people. One person living with dementia was brought to the table and waited 30 minutes before they received anything to eat. Another person was not helped to eat until an hour after the food was served, so their meal was cold. There was no menu choice and people were confused about what they were eating. For example, the menu board showed the meal for lunch. However, the provider told us the board was seven days out of date. Therefore, people received a different meal to the one shown on the board. We saw people who enjoyed their food were looking for more. However, staff came and took away the plates without offering any more food.

There was a board in the kitchen which gave information about people's dietary needs. However, there seemed to be confusion over who was on a special diet. For example, we saw a dish of vegetarian meatballs which had been pureed for a vegetarian. However, this person was not on a pureed diet. Where people did require a pureed diet, we observed this was not always prepared to the required consistency to ensure it was safe. Care plans did not reflect what was happening. For example, according to the kitchen meal list, one person was on a pureed diet. However, their care plan dated May 2016 stated they were on a soft diet. This person's name was not on the dietary needs board for either a soft diet or a pureed diet.

People's hydration needs were not fully assessed, reviewed or met. Where people's fluid intake was being recorded, there was no information on how staff should support people to ensure they had appropriate and sufficient quantities of drink. For example, one person's care plan stated they were at risk of dehydration. A dietician had assessed the person's fluid intake requirement to be 1150mls per day. This information had not been transferred to the care plan. When we checked people's bedrooms, we saw several jugs containing water. The jug covers were covered in dust and it was not clear how long they had been there. We checked the fluid charts for the day and found they were blank. When we looked at them again, they had been completed. We spoke with staff and they told us they had falsified the records. This meant it was impossible to monitor people's correct fluid intake and ensure they received adequate hydration.

This was a breach of 12(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff did not always seek advice from healthcare professionals in a timely way to ensure people's care and treatment remained safe. For example, we found evidence of delays in making referrals in relation to weight loss and falls. One healthcare professional had found one person was sleeping in a chair which was not suitable for them. However, no referral had been made to the occupational therapist service to arrange an assessment.

This was a breach of Regulation 12 (2)(i) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff did not have the skills and knowledge to meet people's needs effectively. Although some dementia training had been completed, we observed not all staff understood how to meet the needs of people living with dementia. The training matrix was not up to date as some staff were no longer working at the home and new staff had not been added to the record. The provider information return stated "before working independently they (staff) must complete and pass all mandatory training". We checked the individual staff file for a staff member who had started working at the home in September 2016. Although they had worked in care previously, there were no training certificates from that employment. Since they started at the home

they had completed two courses, in safeguarding and moving and handling. These were both online courses. There was no evidence the manager had checked the staff member's competency following the training. We spoke with the staff member and they did not have a good awareness of safeguarding. We asked about practical training in how to use moving and handling equipment and they told us other staff had shown them how to use it. During the inspection, we observed staff using moving and handling equipment inappropriately. For example, we saw staff lifting people with handling belts, handling belts are not designed to lift people and using them to lift people is unsafe practice.

Staff did not receive regular supervision. During supervision staff should have the opportunity to sit down in a one to one sessions with their direct line manager to talk about their job role and discuss any issues they may have. We spoke with one staff member who had not had supervision since September 2016. Another staff member had their last supervision in February 2016. This identified a training need in relation to care plans. However, there was no evidence this had been actioned. The manager had recently re-introduced supervisions. One staff member told us the manager had carried out an observation and identified training needs. We saw the manager had booked this staff member on seven online training courses. Our observations of poor practice showed staff had not been provided with suitable supervision or monitoring to ensure they met people's needs effectively.

This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were living in a home which was not effectively maintained or beneficial to their wellbeing. The environment was not suitably adapted to meet the needs of people living with dementia. We made a recommendation at our inspection in April 2015 in relation to the environment but there had been a lack of progress in relation to this. We saw one 'dementia friendly' sign for a toilet had been placed on a window sill. One person asked us where the toilet was on several occasions. Some items including an electric typewriter and music records had been placed in the hallway but we did not see staff using these to engage with people with dementia. Although photographs and pictures of the royal family and old advertising posters had been placed on the wall, some bedroom doors did not have anything on them to support people to identify their own rooms. Other doors had recent photographs of the person who used that bedroom. People with dementia may not recognise themselves as they are now. We saw three clocks that had stopped and one calendar showing the previous month. This could be confusing for people and would not help them to orientate to time and date. Several en-suite toilets had red toilet seats but at least one was not in use as there were boxes and a commode stacked in front of it. The door to the garden was locked and there was another gate and step to get down to the garden. There had been no improvements to make the garden accessible and 'dementia friendly'.

Some of the areas of the building were in need of redecoration and maintenance. We saw marked walls, broken and chipped furniture, broken taps, a broken lamp, and two patio doors in empty bedrooms on the ground floor could not be locked.

This was a breach of Regulation 15 (1)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People did not benefit from staff who showed them kindness, respect, and compassion. Staff routines took priority and staff had little understanding of the impact this approach had on people's wellbeing and needs.

The care and support we saw staff giving in the lounge was largely task based. For example, supporting people with moving and handling transfers and offering drinks or food. There was little meaningful communication between staff and people in the lounge area throughout the inspection. This meant people's social needs were not being met and there was a lack of consideration for their wellbeing.

Most interactions between staff and people were poor. We observed staff did not always listen to people or support them to express their views. For example, one person asked to go to the toilet and was ignored, despite there being a strong smell of urine. Staff took them for their meal instead. We saw staff offer one person a cuddly toy and they responded with thanks and attempted to engage in conversation but the staff moved on to another duty. After a person started to choke, the person became distressed but staff didn't give them any reassurance or comfort.

People decisions were not respected and they were not involved in planning their care. We observed staff offering choices in relation to drinks and taking part in an activity. However, staff did not always respect people's decisions. For example, one person said they wanted a cup of coffee and staff gave them tea. Another person chose not to take part in a ball game but staff threw the ball at them for them to catch anyway. We saw a bath rota which showed each person had an allocated day to have a bath each week. If a person refused their bath on their allocated day, staff were instructed to catch up on a Sunday.

People were not treated with respect at all times. We observed staff telling one person they were a 'good girl' and another person was told they were 'being naughty'. When we spoke with a staff member, they described one person as sounding like a baby. We observed a staff member lift two people's arms off of the arms on their chairs so they could sit down in the middle. This was carried out without any conversation. One staff member stood over a person whilst assisting them to eat. We observed another person jump up in their chair when staff touched them on their back and started to assist them with their food as they couldn't see the staff.

People's care needs in relation to their personal hygiene were not always met. For example, we observed that several people's teeth had not been brushed and one person's glasses were dirty throughout the day.

There were incontinence aids on show in some people's rooms. These had not been stored discreetly to promote people's dignity. We looked at one bed and found the stuffing was coming out of the pillow and the sheets and pillowcases were stained. We asked staff to attend to this. After staff confirmed they had done this, we checked again and found the pillow had been removed but the other pillowcase and the sheet had not been changed. We told the senior care staff this had not been done but they didn't acknowledge this.

This was a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We also saw some good practice in place. Staff respected people's privacy. They were observed knocking on people's doors before entering. People's bedroom doors were seen to be closed when care was being delivered.

We saw an example of a staff member offering help to a person. The staff member offered to put a phone number on speed dial so it would be easier for the person to contact their family. The person was pleased by this.

A relative who had a family member living at the home was complimentary about the service they had received. They sent us their feedback and said they could not thank the home enough for the care their family member had received and the support given to them as a family.

Inadequate

Is the service responsive?

Our findings

The service was not responsive because people were not always at the centre of the care received. Staff focused on the task, rather than the individuals receiving the care and their wishes. Staff did not have the information or knowledge they needed to support people appropriately; people did not have access to person centred activities and were not encouraged to maintain their hobbies and interests.

People were at risk of receiving care that did not meet their needs. Care plans were confusing and information was not easily accessible. Each care plan had a section which showed monthly reviews had been carried out. In the care plans we looked at the monthly reviews had stopped in November 2016. The information in the monthly reviews had not been used to update the main section in the care plan. This meant people's care plans did not accurately reflect their care needs. For example, one person's mobility had deteriorated. Their mobility care plan dated May 2016 stated two staff were needed for transfers using a Zimmer frame and handling belt. The monthly review summary in November 2016 showed there had been no change in mobility. However, the detailed comments on the back of the document stated this person had been assessed by the occupational therapist (OT) who advised not to use the handling belt. This person had recently been assessed by the OT as needing a stand hoist for transfers. The care plan had not been updated to reflect this.

We found one person had shingles in December 2016. Staff told us this person had stayed in their room to control the risk to others. There was no short term care plan or risk assessment on how staff should manage the illness and respond to this person's needs. There was no evidence staff had sought professional advice.

Staff did not always respond to requests from healthcare professionals. For example, a GP had requested that a person's abdomen was measured regularly. Records were not completed in relation to this. . This meant any issues would not be identified promptly. Another person had a prescription for glasses dated March 2016. The optician had noted the person had poor eyesight with glaucoma. Staff told us the person did not need glasses and did not know about the prescription.

Care plans did not give information about how each person's dementia impacted on their day to day life or how to care for people with more complex needs in an individualised way. Care plans contained information in relation to communication which was generic and not person specific. Every plan we looked at stated staff should speak clearly and be at eye level with the person when communicating. This showed staff had not considered each person's individual needs.

There was no detailed information so that staff knew how to deliver consistent and appropriate person centred care based on the person's needs and preferences. One care plan contained a document "About me" which could be used to record people's preferences but this had not been filled in. There was no evidence that people or their representatives had been involved in writing and reviewing the care plan. This meant staff did not have important information which could help them to understand and respond to each person's dementia care needs in a caring and compassionate way.

People did not benefit from activities or engagement that had been designed to address issues such as preventing isolation, helping to maintain the person's identity, and helping the person feel valued, helpful and involved. There was no evidence people had been supported to follow their individual interests. We saw people who sat in the main lounge spent most of the time dozing or looking round the room. The television was on but not many people were watching it. The manager told us organised activities took place for two hours on a Tuesday and Friday. There was little attempt to engage any of the people with any form of activity or conversation. Some people went to see the visiting hairdresser. Staff carried out a ball game activity which some people took part in. Staff interacted with people when they were carrying out specific tasks but not at other times.

This was a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people had developed friendships with the people they lived with. For example, we saw two people chatting and holding hands in the lounge. Another two people walked around together enjoying each other's company.

The service had a complaints procedure in place. We asked to see the complaints file but the manager was unable to locate it. They told us complaints were logged in a book in the entrance hall. We checked this book and found the last recorded complaint was 2009. We received a complaint which was passed to the provider and investigated in August 2016. The provider information return told us the service had not received any complaints since our previous inspection in August 2016.

Inadequate

Is the service well-led?

Our findings

Neilston Residential Care Home has not been able to meet the CQC regulations over a prolonged period. Over four inspections, carried out between 2015 and 2017, the service has only met all of the regulations on one occasion. In April 2015, the service was rated "inadequate" and the local authority quality monitoring team worked with the provider and staff to support them to bring about improvements. In January 2016 the home was rated as "requires improvement" after improvements were made. Evidence gathered during this inspection shows the service has not been able to maintain these improvements as nine breaches of regulations were found. During this inspection we have found people were not receiving a safe, effective, responsive, well-led or caring service.

We have shared our concerns with commissioners and the safeguarding team. Following this with the agreement of the provider, health professionals visited the home to assess people's safety and wellbeing. Some people's care needs are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are working with the provider and staff to support them to bring about improvements.

The registered manager was also the provider of the service but they did not have day to day responsibility for the service. The registered manager who did have day to day responsibility for the service left in January 2017. Another manager had been appointed and had been working at the home for four weeks at the time of our inspection. Following our inspection, we were informed this manager had resigned from their post. The previous manager then returned to cover three hours a day each afternoon, from Monday to Friday.

The service did not have a positive culture. Care was task orientated which meant people did not benefit from a personalised and empowering approach. There was a lack of oversight of the service which allowed poor practice and inconsistent care to be delivered. When we spoke with one staff member they were not aware the registered manager had left and told us they would go to them with any concerns. The provider told us they were unaware of events relating to the care of people living in the home. The provider or previous manager had not developed the staff team to ensure they displayed the right values and behaviours towards people. At times, this resulted in poor outcomes for people who lived in the home.

The service had sought feedback from people, their relatives and staff. Surveys had been returned but were not dated. The provider told us these surveys had been sent out recently. We saw that eight relative's surveys and five staff surveys had been completed. The results had not been collated or analysed and there was no evidence any action had been taken as a result of the survey. A residents and relatives meeting had been held on 27 January 2017. The manager had introduced themselves. Minutes from this meeting showed one family member had asked for their relative's bedroom door to be locked as other people had entered their room. The manager told us they had asked staff to lock the door. We checked the door and found it was unlocked. There was request that fruit was offered as a snack and we observed staff had actioned this. A staff meeting had been held on 19 January 2017. The manager spoke with staff about the standards they expected. They had identified the lounge as a high risk area and asked staff to start a system to record the supervision by staff in the lounge. We checked the daily records and found staff had not recorded the

supervision of the lounge.

Systems were not effective as they had not identified and addressed the risks and issues we found during our inspection. The provider information return told us there was a quality assurance system in place stating "we use a strong bases quality assurance tool to assess our service and identify improvements." It stated that audits were carried out in the following areas; health and safety; care plans; medication; infection control; and food hygiene. An infection control audit was carried out in June 2016. It identified there was no system in place for the deep cleaning of furniture and carpets. Our findings showed this had not been actioned. A medicines audit had been carried out in March 2016. It identified the medicines trolley needed to be attached to the wall. Throughout our inspection, the medicines trolley was unsecured. The registered manager had set up a monthly review which checked areas such as people's care, records, the environment, activities, and mealtimes. The last recorded review was carried out in September 2016. We also so an action plan with other improvements that needed to be made. Some action points had not been completed within the timescale given. For example, in relation to DoLS, records, gaps in staff recruitment, and training.

The local authority quality monitoring team had completed a report with recommendations, following a visit to the home in October 2016. They observed food was not correctly pureed for one person and this put them at significant risk of aspiration and choking. They found fluid charts were not completed fully and accurately. They observed a staff member standing next to a person whilst assisting them to eat. We also identified all of these issues during the inspection. This showed the provider had not taken action to ensure improvements were made.

Records relating to the care and treatment for each person were not accurate or up to date. Records were not easily accessible. We found accident records being stored in three different places. We looked at people's individual care plans but found other people's records within them. This made it difficult to monitor what had been happening for people. We asked for an archived record and found the person's records were not stored together but in a number of different boxes.

This was a breach of Regulation 17 (2)(a)(b)(c)(e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 Regulation 9(1)(a)(b)(c) People's care and treatment was not appropriate, did not meet their needs, or reflect their preferences.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

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

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) Care and treatment was not undertaken with the proper consent from the person.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Regulation 12 (2)(a)(b)(d)(g)(h)(i)

Risks to people were not assessed and action was not taken to mitigate risks.

The premises were not safe to use for their intended purpose.

Medicines management was not safe.

The risk of infection control was not assessed or prevented.

The provider did not work actively with others to make sure care and treatment remains safe for people.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the 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 Regulation 13 (2)(3)(4)(b) Systems were not operated effectively in relation to preventing abuse or investigating allegations of abuse. Care was provided in a way that controlled or restrained people.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 (1)(a)(b)(c)(e) The premises were not clean, secure, suitable for the purpose they were being used, or properly maintained.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2)(a)(b)(c)(e) Systems were not operated effectively to assess, monitor and improve the service. Systems did not assess, monitor and mitigate risks to people. Records were not kept securely. People did not have accurate, up-to-date records. The provider did not act on feedback to improve the service.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19(2) Recruitment procedures were not operated effectively to ensure staff were suitable.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1)(2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Sufficient staff were not deployed to meet people's needs. Staff were not suitably qualified, competent, skilled, and experienced. Staff did not receive appropriate training and

support to enable them to carry out their duties.

The enforcement action we took:

An application to deregister has been received. If this hadn't we would have served an NOP to cancel the registration