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Minster Rest Home

Inspection report

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09 May 2016

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Inadequate 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

We carried out an inspection of Minster Rest Home on 14 and 15 April and 9 May 2016. The inspection was unannounced.

Minster Rest Home provides personal care and accommodation for up to 19 older people. Some people had mental health conditions. There were 17 people living at the home when we carried out our inspection on 14 and 15 April and 18 people on 9 May 2016.

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

People we spoke with had mixed views about whether they felt safe at the home. We found risks associated with people's care, as well as health and safety risks related to the premises, were not always identified and assessed to make sure people were protected from the risk of harm. We spoke with the local authority about concerns we had identified. A visit by the local authority and other health professionals resulted in one person being relocated to alternative accommodation.

There were insufficient numbers of staff to meet people's needs safely and effectively. Care staff were required to complete additional duties such as cleaning and cooking which prevented them from focusing on meeting people's needs. People told us they felt some of their needs were met but said staff were always rushed and had little time to spend with them. People had limited opportunities to engage with staff and build relationships with them so they felt valued as a person.

Some pre recruitment checks were completed on new staff, but it was not always clear the provider had checked their suitability to work with people in the home. Staff training was not up-to-date and we observed staff did not always support people in a safe way.

People received their medicines but records were not sufficiently detailed to confirm these were always given as prescribed.

People were not routinely provided with a choice of meals and people told us they wanted more choices to be offered. Meals, snacks and drinks were provided at set times during the day as opposed to as and when people wanted them. Where required, people were supported to eat although this was not always a positive experience for them. People had access to healthcare support when needed.

The principles of the Mental Capacity Act were not understood or routinely followed by staff. There were people in the home who were subject to restrictions related to their care. It was not clear whether these

people had capacity to make their own decisions or whether decisions about restrictions applied to their care had been agreed with them or were made in their best interests.

The provider had not ensured the rooms people occupied were safe and comfortable. We found many of the rooms had broken items of furniture and some of the taps did not work effectively. Some people had portable heaters in their rooms either due to heating problems or because they felt cold. The heaters had not been risk assessed to ensure they were safe to use.

The home was not consistently responsive to people's needs. People's choices and preferences were not regularly sought and people felt they were not listened to. People had limited stimulation and opportunities for their social needs to be met. A lack of background information about people's interests and preferences meant there were people who did not experience person centred care.

There was a complaints procedure and a system to record complaints. Relatives told us they felt confident to raise any complaints with the registered manager if needed. However, we could not be confident that complaints received were always recorded to demonstrate the provider had taken them seriously and had addressed them.

The provider did not have sufficient systems and processes in place to assure themselves that people living at the home received a good quality service that met their needs. People were not given opportunities to provide their opinions of the service and to be regularly involved in decisions related to their care. There was a lack of audit processes to ensure improvements to the service were identified and acted upon in a timely manner, for the benefit of people who lived there.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service will therefore be placed 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?

The service was not safe.

Staff knowledge of safeguarding people from abuse was limited and there were not always enough staff to meet people's needs. Risks to people's health and safety were not always identified to protect people from the risk of avoidable harm. Medicine records were not sufficiently clear to show people received their medicines consistently as prescribed.

Inadequate ●

Is the service effective?

The service was not effective.

Staff training was not up to date and staff did not always have the skills and knowledge to meet people's needs effectively. People did not have a choice at mealtimes and they told us they did not enjoy eating the same meals.

The provider and staff knowledge of the Mental Capacity Act 2005 was limited, which placed people at risk of not being appropriately supported if they lacked capacity to make their own decisions. Support from health care professionals was sought when needed to ensure people's healthcare needs were met.

Inadequate ●

Is the service caring?

The service was not caring.

Staff had limited time to spend with people to develop caring relationships and make people feel valued. When people described their experiences of the home, it was evident they did not consistently feel well cared for. There were some occasions when people's privacy and dignity was not met.

We saw some caring interactions between people and staff, and relatives were mostly positive in their comments about the staff and the home.

Inadequate ●

Is the service responsive?

Inadequate ●

The service was not responsive.

Care was provided in a task orientated way. This was not based on people's preferences and wishes which meant there was a lack of person centred care. People had limited opportunities to exercise their independence and be involved in decisions about their care. There were some social activities provided but these were not based on people's interests, preferences and social care needs.

Is the service well-led?

The service was not well led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. This meant that a number of shortfalls in relation to the service had not been identified. This had led to poor outcomes for people who lived at the home.

Inadequate ●

Minster Rest 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 14, 15 April 2016 and 9 May and was unannounced.

We reviewed the information we held about the service. We looked at information received about the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with Coventry local authority commissioners who funded the care for some people at the home. They told us they had identified some areas for improvement and they were working with the home in relation to these. Following our inspection visits, we informed the local authority commissioners about concerns we had identified related to the safety and quality of care that people received.

The inspection was carried out by three inspectors over a three day period. We spoke with seven people who lived at the home, three visitors and five care staff. We also spoke with both owners of the home, one of whom was also the registered manager of the service. When referring to the provider in this report this includes the registered manager.

We observed the staff interactions with people and the support they delivered in the lounge and dining area. We also visited people in their rooms where staff also provided support.

We reviewed the care plans of three people and viewed some of the records in the files of others to see how their support was planned and delivered. We also looked at other records such as medication records, accident and incident records, recruitment files, complaints records and health and safety records.

Is the service safe?

Our findings

People described their care to us and it was evident there were times when they did not feel safe. One person told us, "I feel safe but I don't like the treatment from [manager] and some of the staff as well." Another said, "Yes I do (feel safe)." Another told us, "No, I want to be out of the place." People told us they were negative in their comments due to the lack of staff support and the tone of voice used by the manager at times.

During our visit there were not enough staff to effectively meet people's care and support needs. Staff were very task orientated with little time to interact with people. This impacted on people's experiences of care at the home with many reporting negatively to us about living there. People told us that staff were always busy and this made them feel their needs were not met. One person told us, "It was okay at first and now it has gone right down. They used to help you, the carers, but now it is nothing, do it yourself." Another commented when they used the call bell, "Sometimes they are a little bit late, sometimes a bit slow." This person told us they did not have a "bed bath" every day because the home was "short staffed" although this was needed in order to meet their personal hygiene needs.

At lunchtime we saw how insufficient staff numbers impacted on people's lunchtime experience and their nutritional needs being met. For example, one staff member was assisting a person to eat their meal in the dining room when a call bell was activated in another area of the home. The staff member left the person they were assisting to respond to the call bell. The person's meal was left on the table going cold and they did not receive further support to finish it.

Staff told us about another incident related to staffing which was of concern. They explained that two care staff had spent 30 to 40 minutes assisting a person with their personal care due to the person being unwell. During this time no other care staff member was available in the home to support the other people. They told us, "We had to clean [person], clean the bed, clean the furniture, clean the cupboards." When we asked who was looking after everybody else, they told us, "Nobody. We had to make sure everyone was safe and all the doors were secured." This further demonstrated that the staff numbers available were not always sufficient to maintain people's health and safety and support needs.

The provider told us about one person who frequently rang their call bell and how they always wanted assistance "there and then" which they said was accommodated. However, when we spoke with the person they told us how staff did not respond quickly enough when they rang the bell and they had called 999 themselves as a result of this. They told us this was because staff were not available when they needed them. The person told us, "I was frightened I didn't think they were going to do anything. They should just say 'we are busy and will be with you soon', not shout at you." The provider had been contacted by the police about this and explained, "They (staff) were busy with someone and could not leave right away."

Staff told us they needed more staff to support people, in particular in the mornings. One staff member told us, "Sometimes it is stressful when there is not enough staff." They went on to say they were also challenged to meet people's needs when new staff were rostered on duty with them. This was because their time was

further stretched to support the new staff member as well as support people's needs.

The provider told us they were aiming to employ more staff and informed us of their intention to do this as soon as possible. However, in addition to there not being enough staff to support people's needs, staffing arrangements were also not effective. A staff member told us when two experienced staff were on duty this was still not enough because they had to "do a lot of duties." These duties included domestic, laundry and catering duties in addition to their care duties.

One staff member told us, "There is quite a high turnover (of staff), yes especially in the last three months." Visitors to the home had noted some staff had left resulting in an inconsistent staff team. A visitor told us, "There has been a higher turnover of staff in the last year." We found this had impacted on people at the home because new staff had to get to know people's individual needs.

We had received concerns about how people were cared for due to lack of sufficient staff being available prior to our inspection visit. We had made a referral to the local authority safeguarding team to ensure risks to people's health and safety could be followed up. The concerns reported to us reflected some of our findings during this inspection. The provider had not identified that their working practices placed people at risk of their needs not being safely met.

This was a breach of Regulation 18 (1) (2) (a) HSCA 2008 (RA) Regulations 2014 (Part 3) Staffing

Staff spoken with were not confident in understanding the different types of abuse, what signs to look for and how to protect people from harm. When we asked one staff member about their understanding of abuse, they told us, "Hitting them, speaking to them in the wrong way, I don't know." Another staff member told us they knew nothing about abuse. One member of staff knew to report any concerns to the registered manager. Training records showed that five out of ten staff had not undertaken any training about safeguarding people. The provider had not ensured that staff had the skills and knowledge to protect people from harm or abuse. There had been no safeguarding referrals to the local authority about people living in the home. However, we had received concerns of a safeguarding nature prior to our inspection visit. We had made a referral to the local safeguarding authority to ensure risks to people's health and safety could be followed up. The concerns reported to us reflected some of our findings during this inspection. Shortly following day three of our inspection, the local authority notified us that a decision had been made to find urgent alternative accommodation for a person who they identified was at risk if they remained in the home.

We asked staff how they knew about the possible risks associated with people's care needs and the actions they needed to take to minimise potential risks. One staff member told us they did not know where people's risk assessments were stored. The staff member said if they needed to know anything then the registered manager would tell them. Another staff member said, "Risk assessments? I don't know about those." When we discussed risks associated with people's care staff knew about some of these. However we observed that staff did not always recognise risks when providing care. For example, we observed one person appeared in pain when walking. The person told us their feet were painful. We saw the person had long toe nails that required attention. The person said, "They [Manager] won't sort it. My feet hurt." We made the registered manager aware of our concerns because we identified the person had diabetes which increases the risk of them developing complications associated with foot care. The registered manager told us the person had been referred to a chiropodist but had missed their appointment and there were no current arrangements for this the person's feet to be attended to. We discussed this with a visiting GP who agreed to address this.

There were some people at risk of skin damage due to them sitting for long periods. Staff knew to check

people's skin when they delivered personal care. However, when a staff member assisted a person in their room to move back to their bed following personal care, the staff member did not ensure the sheets on the bed were straightened and comfortable for the person. We noticed the sheets for the bed were smaller than the size of the bed. This meant the person did not have a smooth surface to lie on to reduce the risk of developing sore areas on their skin. This person told us they were blind which meant they were unable to adjust the sheets on the bed themselves.

When we looked at one person's care plan file, we found staff were not following the instructions in the "sskin" care plan. We found risks associated with the person's skin were not being managed to maintain the person's health. The person's care plan informed staff to monitor and record information about the person's skin every day. There was a "pressure ulcer trigger" record for this information to be recorded. This had not been completed consistently to show the person's skin had been monitored. We asked staff if they monitored the person skin. One staff member told us, "We do most of the time." We asked the staff member to show us where they recorded these checks. The staff member was not able to show us any recent checks that had been completed. We asked the staff member how they knew what to look for when checking the person's skin. The staff member told us they had not received any training. They said, "I just know." We saw there had been a daily record completed for this person that showed they had bruises on their skin and a soiled dressing on their leg. There was no information in the person's "sskin" care plan that identified the person had any wounds to indicate how these were to be managed. The registered manager told us the district nurses would be visiting and they would attend to the person's dressing. There was no risk assessment showing the person's skin had been assessed or detailed actions for staff to help prevent the risk of further problems developing. The manager looked at the skin monitoring records and said, "Well, they [Staff] are supposed to do it but they haven't. I will talk to them."

We noted a staff member did not move a person safely in accordance with instructions in their care plan. The instructions stated the person was to be moved with two staff using a rotunda (equipment used to assist staff to move a person safely). We observed the staff member moved the person alone. We further noted that two people were moved using unsafe moving and handling techniques in the lounge and dining area. This placed both people and staff members at risk of harm. One person told us how they were not always assisted safely by staff. They told us, "Some of them (staff) are alright but some can bump you a bit. One bumped me off the bed one night." The provider told us they would need to organise moving and handling training for staff. They also told us that the person moved with one staff member no longer required two staff to support them. They advised when the person first moved to the home the person required two staff.

We asked staff if they had time to read peoples' care plans. One staff member told us, "I don't know what a care plan is." Another staff member said, "Umm, I don't know." We could not be confident that staff were using care plans to safely and effectively manage people's care.

We looked at the personal care records for one person to see how their needs were met. We saw there had only been seven days in the whole month when they had received personal care. The person had refused personal care on all other occasions placing them at risk of infection. There was no plan to show how staff should manage this risk. When we asked a staff member what they did when people refused care they told us there was nobody who refused support which was not accurate.

We identified some people had portable heaters in their rooms. No risk assessments had been completed in regards to the use of these. One person who was cared for in bed had a heater resting on a shelf at the end of their bed. There was a potential fire risk should this fall onto the bed.

There was no fire risk assessment for the home and people did not have personal emergency evacuation plans to indicate how they would need to be supported in the event of an emergency situation such as a fire. A contingency plan for people was not in place should the home not be safe to re-enter in the event of a fire. The provider had not ensured there was effective risk management within the home.

Accidents and incidents had been recorded but it was not evident they had been analysed to identify any patterns or trends to help prevent them from happening again. We noted there had been three occasions when accidents were linked to moving and handling people which suggested there may be a staff training issue.

Medicine Administration Records (MAR's) were not fully completed to show medicines carried forward from the previous medicine cycle. This meant the provider could not easily carry out a medicine count and we could not confirm people had been given their medicines as prescribed consistently. We also noted that some of the times when the medicines had been prescribed to be given had been changed from at night to 17.00hrs. The provider told us they had changed the times. These changes had not been agreed by the GP. In some cases the medicines that had been changed contained a warning they could make people drowsy. There was a suggestion by the provider that the times had been changed because of the times people retired to bed. However, by changing the times to 17.00hrs there was a risk that those people on medication that could make them drowsy could be placed at risk of falling. The provider agreed to review these times with the GP to make sure they were at times when people needed them. We noted on the third day of our visit the times had reverted to night time.

Medicines were stored securely on the days we visited in April but not in May when they had been left in the kitchen. There were two sealed bags of medicine on the worktop in the kitchen during the morning. We asked the provider why the medicine was in the kitchen. They told us, "It's probably just been delivered. It should be locked away, staff should follow the procedure. It's probably because they are busy." We heard the registered manager instruct a staff member to ensure the medicine was locked away.

The provider had not ensured risks were identified and appropriately managed. This was a breach of Regulation 12 (1) (2) HSCA (RA) Regulations 2014 (Part 3) Safe Care and Treatment.

We saw that staff administered medicines appropriately by observing people take their medicines and signing the MAR's. The provider told us there was always a trained staff member on duty who could administer medicines. There were checks carried out to ensure medicines were kept in accordance with manufacturer's instructions. This included temperature checks of the room where medicines were stored to make sure the medicines remained effective. Temperature records viewed showed medicines were stored within the recommended guidelines with the exception of on the day of our visit. We noted there was a fan in use in the medicine room but the temperature was still 27°C which was above the recommended guidelines to ensure medicines remained effective. The provider said they would address this by adjusting the heating in the home.

We saw specialist mattresses and pressure cushions in use at the home to minimise risks of skin damage. In one person's care plan we saw instructions to staff regarding skin care. This stated, "Carers must observe skin and pressure areas daily and during every change of clothes. Reposition every 2 hours and chart it." We saw there were charts completed to confirm these checks were undertaken.

New staff were subject to a number of recruitment checks to make sure they were suitable to work with people at the home. Recruitment records showed the provider had sought references and a Disclosure and Barring Service (DBS) check to help minimise the risks to people's safety and welfare. The DBS assists

employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services. However, we found recruitment records were not always sufficiently detailed to confirm checks had been fully completed to manage any potential risks of employing unsuitable staff. For example, in one staff file there were gaps in the person's employment history that had not been explored by the provider to rule out any employment concerns. There was no clear start date to confirm the DBS check had been obtained before the staff member had started. In another staff file there were numbers on a piece of paper with no explanation as to what they were. The provider said these were reference numbers from the DBS check but there was insufficient information recorded to confirm the DBS was satisfactory and whether the person was suitable to work with people in the home. The provider told us staff were not allowed to work until the DBS checks had been completed. The provider subsequently provided start dates to confirm DBS checks had been sought for staff before they started work at the home.

Is the service effective?

Our findings

We asked people about the staff support they received. Comments included, "They are alright" and "The staff are not bad, they have their days like everyone else."

Relatives told us they were overall satisfied with the staff and the support their relative received. One told us, "Generally speaking they are ok. I may witness some irritation when someone has played up a little bit.staff are as good as they can be."

Some staff told us they had followed an induction programme when they started work at the home to help them understand their role. Other new staff were still to complete training. A recently recruited staff member said they had not completed an induction programme and told us, "I was put on the rota and started." Another staff member told us during their induction they learned "How to feed them [people], how to toilet." However, we noted during our inspection that these duties were not carried out safely and appropriately by all staff. For example, at lunchtime one person was rushed to eat their food when a staff member was assisting them to eat using a spoon. The staff member did not assist the person at their own pace which meant it was an uncomfortable experience for the person. Another staff member told us, "I had an induction. [The provider] told me about people and what they wanted. But I didn't do any training." The staff member went on to explain they had recently been told by the provider they must do some training and were waiting for further details.

Some new staff told us they had worked alongside more experienced care staff so they could become familiar with people's care and support needs when they started. However, a comprehensive induction programme provided in accordance with the Care Certificate was not in place. The Care Certificate is expected to help new staff members develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

We observed staff did not always follow safe infection control procedures. One staff member delivered personal care to a person and then walked upstairs to assist another person. They then walked downstairs again to assist in providing people with lunch without removing their gloves and apron. This meant there was a risk they could spread infection. We observed a second incident where a staff member had noted there was urine on the floor in a toilet a person was going to use. There was a 'standaid' (equipment used to move people safely) that had been wheeled into this toilet ready to use so the staff member wheeled it through the urine on the floor, along the corridor, through the dining room and into the second toilet where they were going to support the person. We asked the staff member about this and if they had completed infection control training. The staff member said, in relation to what we had observed, "I shouldn't have done it." We noted that the urine was not cleaned up from the floor for the rest of the day and was left to dry. We saw from training records that most staff had not completed infection control training to support them in carrying out safe infection control practices.

Staff had not completed any recent training linked to people's needs such as diabetes and dementia awareness to help them develop their skills and knowledge to meet people's needs effectively. The lack of

specific training was linked to an observation we made in relation to one person in particular who we saw repeatedly asked to go home. There were no clear instructions for staff on how they should respond to this request to ensure a consistent approach, so the person did not become anxious. The person told us, "I am dying to get home."

Some staff we spoke with told us they had training planned or had completed it in their previous employment. One staff member who had completed some training said their training was "okay" and another said it was "good". We looked at the training schedule for the home which the provider had updated following our visit. This showed most staff needed to complete or update their training to help them meet people's needs safely and effectively. This included moving and handling people, Mental Capacity Act and infection control training.

We asked the registered manager how they assessed staff competence to ensure they had the skills and knowledge to care for people safely and effectively. They told us they observed the staff team when working. However, we could not see this regularly took place to ensure staff carried out their role in a competent manner. Records seen showed very few observations had taken place in 2015. Those undertaken had consisted of expectations being discussed with a staff member followed by an observation to confirm their learning. Observations had included hand washing and observing good practice was followed when supporting people with catheters. There were no learning points for staff identified from these observations.

Staff supervision was not routinely completed to ensure staff were given opportunities to talk with the registered manager about their role, raise any concerns they had or discuss their training and developmental needs. Recruitment files contained a "supervision contract" which stated staff were to be provided with supervision for one hour every two months. This was not being done. One staff member told us they had received a supervision meeting in the past but none had taken place during 2016. The provider confirmed these had not been undertaken in 2016 and staffing arrangements at the home had impacted on their ability to do this. The provider said this was something they "Need to look at."

The lack of staff training and supervision to ensure staff had the skills necessary to support people safely meant the provider was in breach of Regulation 18 (1) (2) (a) HSCA 2008 (RA) Regulations 2014 (Part 3) Staffing

Staff did not have a good working knowledge or understanding of the key requirements of the Mental Capacity Act 2005 so they could ensure people's human and legal rights were respected. 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider and staff were not always working within the principles of the MCA. Two staff members we spoke with did not know what the MCA and DoLS were. This meant there was a risk they may not identify when authorisations should be sought for restrictions placed on people's care. We noted from care records there had been an incident that had not been managed in accordance with the principles of the MCA. For

example, a person with a mental health condition had refused personal care. Staff had considered that it was in the person's best interests to deliver personal care. However, the person had become agitated and staff had recorded they had used "force" in order to make sure the person's personal care was attended to. This suggested some of the staff had not understood they had used restraint that had not been authorised.

We asked a staff member what they would do if a person refused personal care. They told us, "I don't know, probably leave them and go back and see if they would co-operate with us." We asked if they would use force to support them and it was clear they knew this was not acceptable. They told us, "No we are not allowed to do that, it would come under abuse."

There was one occasion when we saw staff obtain consent from the person when administering medicine. The staff member asked a person if they wanted their medicine demonstrating they knew to seek their consent before administering it. However, on six occasions when people were moved by staff in their wheelchairs between the dining room and lounge, their consent was not sought. We saw staff approached the wheelchairs from behind and began to move the wheelchairs. Staff did not announce themselves or ask if the person was ready to move to another part of the home.

It was not clear which people at the home lacked mental capacity. We identified from speaking with people that restrictions were placed on their care but could not see these restrictions had been agreed with them. For example, some people smoked but had been told they could only smoke at certain times of the day. There were some people who told us they wanted to go out of the home but staff had told them they could not. One person told us, "I can't go to the shop or anything."

The registered manager told us that everyone in the home had a representative that could act on their behalf if needed. Arrangements had been made for some people to access the services of an advocate. An advocate is an independent person, who is appointed to support a person to make and communicate their decisions. For example, to manage their money.

People were provided with a meal each day but choices were limited and not routinely given. One person told us, "The food is alright, the only thing I find fault with is the fish and chips. The chips are the little tiny ones and the fish is a little piece." A second person told us, "It's not that great; they never ask what you want. They just give you what they have got." A third person commented, "It's not too bad." We asked people if they could have something to eat and drink when they wanted. One person told us, "No, it's always a time when they have got it ready. No snacks, no apples or bananas, they don't have that type of thing."

We spent a period of time observing mealtimes to see if this was a positive experience for people. On the first day of our inspection visit there were 13 people in the dining room. Some people had chosen to eat their meals in their room. People were provided with sausages and mash with peas and carrots for lunch. We asked one person if they had enjoyed their meal. They told us, "I sent them back. I've had that many sausages here. I'm sick of them." There was no conversation amongst people and staff placed people's meals in front of them with little or no interaction. People did not appear to be given a choice, although portion sizes were sufficient for most people. We noted on the second day of our visit there was a choice of fish and chips or egg and chips. On the third day of our visit the provider had three choices of main meal for people although the same vegetables were available for each meal. These being mashed potatoes, carrots and cabbage.

When we observed tea time we found people were given limited portion sizes. One person commented they were always hungry. They told us, "At teatime you get one sandwich, one slice of bread, I am hungry all of

the time." We asked a person if they were enjoying their sandwiches and they showed us what they were eating. The meat content was minimal in that it was approximately 1cm round in one quarter of a sandwich and 2cm round in another. The person sitting next to them showed us their sandwich which had a similar content of meat. This mirrored what one person had told us about choices and food offered. This person had told us, "It's always the same item like little square bits of meat and spicy things." Those people who had been given sandwiches had three quarters of a sandwich each with a small cupcake. We asked a staff member if there were any additional sandwiches in case anyone wanted more but were told no more had been prepared. The registered manager said nobody complained about the food. They told us, "I see a clean plate and I ask if they enjoyed their dinner and they say yes."

Menus seen provided very limited choices and variety for people. Most days people had mash, peas and carrots with either meat or fish. Sandwiches were usually provided at teatime and the first two days we visited there was no choice offered. People ate what they had been provided with. Menus showed a limited range of sandwiches were provided. These included ham and tomato, spam and tomato, cheese and tomato.

When we looked in the kitchen there were barely any food supplies for staff to access for people aside from bread, a few eggs, biscuits, jam and cereals. We asked a staff member if they knew what people were having for their meals. They told us the provider supplied them with food to prepare the meals each day and they did not know what meals were planned. The provider showed us the food available that was kept in freezers in an office on the top floor. We saw there were minimal supplies of fresh food and some stocks of tinned food also stored in the top floor office. The office was kept locked and staff did not have access to the food should people wish to have snacks of their choice between meals. Following a discussion with the provider about this, action was taken by the third day of our visit to place additional food items in the kitchen. A new freezer was also purchased for the kitchen.

We observed that all but two people in the dining room were able to eat independently and assistance was provided to those who needed it. We asked a staff member how they knew what foods people liked and disliked. They told us, "They leave what they don't like." We asked the provider how they knew the meals they provided were nutritionally balanced. They told us, "We have meat every day except Friday when we have fish or egg and chips." The menus had not been prepared using any nutritional guidance tool to ensure people received a balanced diet suitable to their needs.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment process. In one person's care file there was a "Nutrition and hydration" care plan that stated the person needed prompting and sometimes assistance with feeding and drinking. There were instructions for the home to provide "adequate fluid intake and a balanced diet". Also for one care staff member to monitor the amount of food and drinks the person consumed using nutritional charts. We saw food and drink charts were completed on a daily basis for people at risk of poor nutrition but these had not been completed consistently to show how much food the person had consumed. We also found that charts were being completed retrospectively. For example, we looked at the charts used to record what drinks people had consumed. On two people's charts that we viewed at 3.20pm the last drink recorded was at 7am. We asked a staff member why the charts had not been completed. They told us, "I fill them in later." We asked how they knew what people had drunk. They responded, "I know the times in my head and what everybody drank." This meant we could not rely on the charts being accurate. We found there was no audit process in place to check the charts and what was written on them was accurate to ensure any risks to peoples' health were identified and minimised.

At lunch time we observed one person was assisted to eat and had been left for 10 minutes while the staff

member who had been supporting them answered a call bell. The person had not finished their meal. Another staff member came into the dining area and removed the person's meal without asking if they had finished it. The original staff member returned after 15 minutes and began to move the person from the dining room. We asked the staff member if the person had finished their meal and if they had been offered their pudding. The staff member did not respond but collected the person's pudding which they then supported the person to eat. From our observations, we could not be confident those people who needed assistance with meals were supported effectively consistently.

We were told that one person had difficulty swallowing which meant they were at risk of choking. The Speech and Language Therapist (SALT) team had been consulted for advice. Advice given was for the person to be provided with a pureed diet. We noted at lunchtime all of the food items were blended together as opposed to separately which denied the person the experience of enjoying the different flavours of food.

Another person required close monitoring when drinking because they were at risk of choking. Staff we spoke with understood the person's nutritional risks and the support they needed to make sure they had enough to drink. At lunchtime, we saw the person's food had been cut into small pieces and drinks they consumed were closely monitored in accordance with their care plan.

Care plans confirmed that people had access to healthcare services to meet their healthcare needs. Where specialist advice was required, we saw the home referred people to health professionals such as district nurses and dieticians. For example, one person was identified to have diabetes and required medicine to be given by the district nurse to maintain their health. We saw arrangements were in place for this to happen.

Is the service caring?

Our findings

We asked people if the staff at the home were caring. One person told us, "They don't show it so much, I can't get out of here." Another commented, "The treatment is not that good."

We observed staff were sometimes caring towards people but they had little time to spend with people and form relationships with them. Staff were very task orientated so only approached people when they needed to, for example, when providing a drink or assisting them to the bathroom. We asked one staff member if they had time to speak with people in their bedrooms. They told us, "Not every time. We are always busy." People were given drinks and a biscuit at set times during the day as opposed to when they wanted one. During the morning, we saw one staff member deliver a plate to each person's lap in the lounge and place a biscuit on it using their hands without asking the person if they wanted a biscuit. No choice of biscuit was offered.

The care staff we spoke with were not able to tell us in detail how people preferred their care and support to be delivered. We saw that people were rarely given the opportunity to make daily choices about their care. Assumptions were made about what drinks and food preferences people wanted based on previous decisions they had made.

We asked staff what made them caring. One staff member told us, "Making sure they (people) are safe, their rooms are tidy and always responding to their call." We asked this staff member if they always responded to call bells, they told us, if two staff were assisting a person with personal care, this was not always possible.

We saw the registered manager spent time with people who chose to sit in the dining area for company. These people clearly enjoyed the opportunity to sit and speak with the registered manager.

During the tour of the building we found care and attention had not been given to bedrooms to ensure people had a comfortable and pleasant environment to live in. For example, in one room there was an unpleasant odour, no door on the wardrobe and a thin quilt on the bed. The quilt had not been placed in the cover correctly so was doubled over in parts. There were brown stains on the quilt. The person's clothes were in a heap in the wardrobe including shirts and jackets. There was a mouse trap in the corner of the bedroom and no soap and towels and no call bell for the person to use. The provider told us the person emptied their wardrobe frequently themselves, however we could not see how the person was being supported to select their clothes each day and what arrangements there were to manage the person's behaviours.

In one room there was a person who was described in their care records as registered blind and deaf. They were cared for in bed. We found the pillowcase and sheets crumpled and ill fitting. A member of care staff came into the room and did not use the opportunity to straighten the sheets and put the pillowcase on the pillow properly. We saw the pillow was heavily stained. A chest of drawers had broken drawers. There was one thin bed cover on the bed and the person told us they had been "very cold". This had prompted the person to buy their own portable heater. They told us they were under the impression the heating was not

working in their room but this was working when we checked. We found there were hearing aids in a box on the chest of drawers which the person was not wearing. The person told us they did not know they were there. We saw in their care plan dated November 2015 there was an instruction for staff to make sure the person's hearing aids were working. However they had not ensured the person had been supported to put them in as appropriate. The provider told us the person did feel the cold and that the person could hear without their aids. However, it was not evident the use of the hearing aids had been discussed with the person and it was not apparent extra blankets had been offered to keep the person warm. The provider told us the person only liked their own blanket and bed linen and refused extra blankets because they preferred their room to be warm instead. The provider explained that it was a challenge to keep the room to the temperature the person wanted because of protective covers on the radiators.

We saw staff were usually respectful when they interacted with people and they addressed people by their preferred names. When we asked one person if staff were respectful towards them they told us, "Some are alright, some are ignorant." Relatives we spoke with told us, "[Person] has never said anything negative. I have never had any problems." They went on to explain that they thought staff were approachable.

We observed that people were appropriately dressed although staff did not always notice when people's dignity was compromised. For example, there was one person in the dining area sitting in their wheelchair with their clothes hunched up around the top of their legs. When a staff member approached the person they did not appear to notice. It was later when the person requested to be assisted to the bathroom their clothing was adjusted.

Families and friends were able to visit at any time but were discouraged from attending at mealtimes. These visits ensured people were supported to maintain relationships with those people who were important to them.

Is the service responsive?

Our findings

People's needs were assessed before they moved to the home unless they came to the home in an emergency situation. Care plans were developed from assessment information obtained to help staff ensure people's needs were met. These were in a standardised format and included information such as the person's personal care needs, skin care and how they should be supported to move safely. Care plans were not detailed and did not routinely contain information about people's personal preferences and were not person centred. For example, there was a 'personal hygiene' care plan for one person that described how many staff were required to support them. However, there was no information about their personal care preferences such as whether they preferred a bath or shower, how often, or whether they preferred a wet or dry shave etc. We found other care plans similar in that they contained limited detail regarding how people preferred to receive their care and support. This meant it was difficult for staff to learn about the person and gain the knowledge needed to ensure the person was at the centre of the care and support they received. We found that most people were not aware of their care plans or what was in them suggesting they had minimal involvement in contributing to them.

People told us because there were not enough staff on duty, they were not given choices about what time they got up in a morning. People told us they spent their days sitting around the home with rarely anything to do and could not go out. Staff had very limited time to spend with people. One person told us, "I am not doing anything; it's all their side all the time. I get tired of them carrying on. I don't do any jobs, I don't do anything. I don't go anywhere; they don't let you go anywhere." Another person told us, "I get up at 6 o'clock or before every day. It's stupid really because we have to sit around all day doing nothing. We don't have a choice when we get up."

We noted during the morning that five out of seven people in the lounge were dozing in their chairs suggesting they were still tired. They were not watching the television that was on. They had all been provided with blankets to keep them warm and comfortable and only stirred when a staff member approached them to offer a drink. We found from talking with staff that most people were being assisted to get up early in the morning by the night staff before the day staff started work. Some had been supported to get up as early as 5am. On the first day of our inspection we identified at 8am that 11 people were up and most were dressed. When we spoke with staff about this it became evident this was a daily routine. Staff told us it was always the same 11 people that were assisted up early and if they didn't get people up early they would not have time to complete all of their duties. One staff member told us, "If we start at 6am we won't be able to finish by 8am (when the day staff start) and do the washing and keep the home tidy." Another staff member told us, "Some are already awake when we go in. Sometimes some of them are still asleep. I think some of them get woken up." This practice demonstrated that people were not being treated as individuals and this did not promote person centred care.

One person with mental health needs appeared unsettled and told us they did not want to be at the home. When they were left alone, they began to shout out. A mental health care plan was not in place for this person stating how they usually presented and how staff should support them when they became anxious.

However, a member of staff went to them to provide them with reassurance which helped them to become calmer which showed they knew how to respond to calm the person.

We asked people if they were involved in planning their care. One person told us, "No, not really, they don't, I have tried everything." They went on to say "If you say anything they get nasty. I go upstairs and sit, you get frightened." Another person explained how staff did not listen to them when they became anxious. They told us, "I get frightened when the door (bedroom) is closed. I feel closed in, they won't leave it open at night because it's a fire door." The person explained to us they were able to have the door open during the day but they didn't like the darkness at night. They went on to tell us, "They don't listen, some of the night staff shout at you." It was not evident the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care.

We observed that the home was quiet during the day with very little activity to stimulate people both mentally and physically. Staff were too busy carrying out their duties to spend time interacting with people. Three people we spoke with told us they did not like living at the home. One person told us, "I am sitting here, not much to do when you are in here. You are sitting about more than anything." Another person told us, "They don't treat me as a person. They are very far away from that." Another person told us, "I sit here all day."

People had access to some social activities but these were not necessarily planned in accordance with their interests and preferences. A visitor told us, "They have a lady who comes in at least once a week and she hands out hand held instruments and she plays a lot of old tunes to them." A staff member told us, "On Wednesday and Friday there is a lady who comes in and does exercises to music for them. On Tuesday the hairdresser will come in and do their hair. On Sunday a Sister from the Roman Catholic church comes to do prayers with them in the morning. The other days they just sit in there and watch television. We try and do dominoes with them and playing cards with them but they don't want to do it." We asked this staff member if they knew anything about people's backgrounds and they told us "Yes some of them" and they were able to give examples. However, it was not evident this information was used when planning social activities. The provider told us other religions were not currently supported in the home because people had not expressed a wish for this.

The provider was in breach of Regulation 9 (1) (2) (3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Person-Centred Care

Relatives we spoke with were positive about their experience of the home and their relative's needs being met. One relative told us they were invited to care plan reviews when there was a social worker involved so they could contribute towards decisions about the person's care. Relatives felt the service was responsive to their family member's needs and had no complaints about the support provided. One relative told us, "[Person is happy as they will be anywhere." We asked them if the home was meeting their relative's needs. They told us, "I think so it is a pretty basic home I think they are meeting their needs. [Person] does not want to co-operate."

Information about how to raise a complaint was on display in the home. Relatives told us they were satisfied with the care their family member received and had not needed to make any complaints. They told us if they had any concerns they would raise them with the registered manager. One relative told us, "I haven't had any need to make any complaints as far as my Mum is concerned."

We asked staff what they would do if a person reported to them they were not happy. One staff member told us, "We have a daily book I would write it in there and reassure the person." This staff member was not

aware of the provider's complaint procedure which meant that concerns may not be appropriately escalated to the provider and manager. There was a book specifically to record any complaints but we saw there were no entries since 2014 although there had been concerns raised. Despite this we saw the provider had responded in a timely manner to a recent concern raised with them.

Is the service well-led?

Our findings

During previous inspections to this home we identified areas of non-compliance of the required regulations. This included those related to records, staffing, care and welfare, the premises, quality assurance and infection control. The provider had taken action over a number of months to address these areas of non-compliance and had made the necessary improvements by September 2014. We found during this inspection, the improvements made had not been sustained. We also identified additional areas of concern demonstrating the provider had not been able to maintain the level of care, support and services required to meet people's needs safely and effectively.

The provider did not have suitable systems and processes to monitor and improve the quality and safety of services provided to people. Systems to identify and manage risks related to the health, safety and welfare of people living in the home were not sufficient. There were no quality reviews or audit checks to identify any actions needed to drive improvement.

There were no processes and systems to seek the feedback of people who used the service. The registered manager told us they spoke with people and visitors on a regular basis which enabled them to identify anything people were not happy about. However, people we spoke with told us they were not happy about a number of things. There were no relative or resident meetings where people could contribute towards decisions made about the running of the home. People also had not been given the opportunity to complete satisfaction surveys so that the provider could identify what they achieved well or areas which required improvement.

There was no system to effectively involve people in their care which meant there was not a positive culture across the home that was person centred and inclusive. People did not feel listened to. Care plan records were not sufficiently detailed to support staff in delivering person centred care that was safe, appropriate and in accordance with people's preferences and wishes. Staff were not using care plans to ensure they delivered safe care in accordance with instructions.

There were examples of institutionalised care where people were supported at set times as opposed to times of their choice. People told us they wanted opportunities to exercise their independence and links with the community but we found support was not provided to enable them to do this.

Regular staff meetings did not take place so that staff could discuss issues relating to the home with the provider. Staff also had not been given opportunities to complete satisfaction surveys or attend regular supervision meetings where they could contribute their views on the running of the home and discuss their training and development needs.

A staff training schedule produced during the inspection by the provider identified gaps in staff training. It was not evident there was a process to organise training for staff in a timely manner to support staff in their roles. We identified potential risks in how staff managed moving and handling people, infection control, and supporting people with nutrition demonstrating the need to address staff training. The lack of staff training

and provider's understanding of the Mental Capacity Act meant there was no clear process to identify those people who lacked capacity so they could be appropriately supported. There was a risk that restrictions placed on people's care may not be lawful.

We identified several hazards and risks within the premises which required attention. These included broken furniture, a loose electrical socket, hot pipes and fire doors being wedged open around the home. These had not been identified in any maintenance log with any proposed actions to ensure they were addressed. On the third day of our visit in May the electrical socket in a person's bedroom and the hot pipes located next to a person's bed remained in need of attention despite these being concerns of high risk. The provider had not ensured swift action was taken to address them. We subsequently have been informed the electrical socket has been repaired. The provider advised they would make further contact with the maintenance person to address the hot pipes.

A visitor we spoke with told us, "The place seems to be clean enough. There seems to be an issue with the water in the sinks in the bedrooms." We checked the taps in peoples' rooms when we walked around the home. Some of the taps had been tightly turned off and would have been difficult for people to use. Some taps took some time to work when turned on and sometimes there was a delay before the water got hot enough to wash with. In one room there was no hot water at all and in others there was no cold water. The provider made arrangements for these issues to be addressed during our visit.

There was no fire risk assessment for the home and no personal evacuation plans for people to guide staff and the emergency services in an emergency situation. The provider did not have an effective system to make sure risks were routinely identified so that people were protected from the risks associated with the premises.

The facilities available in people's rooms were not in good repair. There were no action plans seen to ensure they were effectively addressed. For example, there were taps that did not work properly, heating that did not work properly and calls bells out of reach (in one case tied up). However, some action was taken by the provider on the second day of our inspection to address the taps that did not work and to address the rooms with inadequate heating.

A system to identify the ongoing dependency needs of people so the provider could assess how many staff were needed to support people safely and effectively was not in place. When we asked people about the staff they told us there were not enough of them around to support them. Comments included, "Staff are alright if you can find one" and "They are always too busy." We looked at the duty rotas for the home. These showed some staff were working in excess of 70 hours each week with some working seven days a week. The provider had not ensured the home was sufficiently covered without the need for staff to work excessive hours which could also impact on their health and effectiveness. There was no indication on duty rotas how many hours care staff were allocated to cleaning, catering and laundry duties. This meant the provider could not demonstrate there were sufficient hours allocated for these services as well as care hours. We found the staffing arrangements were not effective to meet people's needs. The provider acknowledged they needed more staff but stated they were reluctant to arrange for agency staff to work in the home because they didn't know the people who lived there and it placed extra pressure on the regular staff employed at the home.

Staff told us they would feel better supported by the provider if they had more staff. One staff member told us, "They do (support them), but they need to look for more staff. We told them, and they said we will continue looking for more staff."

Accidents, incidents and falls were recorded but there was no analysis of any incidents so that lessons could be learnt and any action needed could be taken to keep people safe. Some of these accidents were linked to moving and handling practice.

The registered manager was also the provider for the home. Whilst staff were generally positive about the registered manager, we received some negative comments from people who lived at the home. One person told us, "She can be alright at times but sometimes she can blow up." They went on to give an example of how they were told off in an unpleasant tone of voice when they had attempted to help another person. Another person told us, "I don't like it (the home); I would sooner be in prison. The manager talks to the staff like rubbish."

A relative told us they had noted there had been tensions amongst staff and the registered manager about the range of duties care staff were required to do. They explained how they thought this had impacted on the staff team. They told us, "When two or three things happen at the same time, they seem a little stressed at times. I have not had much experience in these places. I wonder whether staff are perhaps doing jobs they should not be doing." They went on to explain there had been a "confrontation" over cleaning when a care staff member felt they should be caring for people rather than sweeping the floor. Care staff told us the additional tasks they were required to complete such as cleaning, catering and laundry impacted on them being able to carry out their caring duties effectively.

A second relative told us the home was "Generally quiet." Then went on to say, "I know in the past [Registered Manager] has been criticised for being a bit brashIt is the odd occasion; basically she tends to raise her voice which is not appropriate. There has been an overall improvement to what it has been. It has been a lot quieter, more restrained."

The lack of good governance with the home meant the provider was in breach of Regulation 17 (1) (2) (a) (b) (c) (f) HSCA 2008 (RA) 2014 (Part 3) Good Governance

Staff we spoke with told us they were given clear direction each day about what duties they were required to carry out and what was expected of them. Staff spoke positively about working as a team and said they enjoyed working with the people in the home.

The registered manager understood their legal responsibility for submitting statutory notifications to us, such as incidents that affected the service or people who used the service so we could make sure they had been appropriately acted upon.

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 Suitable arrangements were not in place to ensure people received care in accordance with their needs and preferences to maintain their health and wellbeing. Regulation 9 (1) (2) (3) HSCA 2008 (RA) Regulations 2014.

The enforcement action we took:

Issuing NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not effectively identified, assessed and managed to ensure people were consistently safe. There were not enough suitably trained staff available to deliver care and support to people in a safe way. Regulation 12 (1) (2) HSCA 2008 (RA) Regulations 2014

The enforcement action we took:

Issuing NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not effective. This included records not always being sufficiently detailed and accurate to support safe and appropriate care. Regulation 17 (1) (2) (a) (b) (c) (f) HSCA (RA) Regulations 2014

The enforcement action we took:

Issuing NOP

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. Regulation 18 (1) (2) (a) HSCA 2008 (RA) Regulations 2014

The enforcement action we took:

Issuing NOP