Care Worldwide (Links) Ltd

The Links Care Centre

Inspection report

The Links
Kismet Gardens
Bradford
West Yorkshire
BD3 7NJ

Tel: 01274028590

Date of inspection visit:
19 July 2018
24 July 2018
31 July 2018

Date of publication:
03 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 19, 24 and 31 July 2018. Each day was unannounced.

The service provider registered with CQC on 8 February 2018. This was our first inspection of this location under the new care provider.

The Links Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service accommodates up to 85 people across five separate units each of which have separate adapted facilities. At the time of this inspection there were 80 people living at the home. The service specialises in providing nursing and personal care to adults living with mental health conditions.

The service had 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.

Risks were not always assessed and monitored to ensure people were kept safe. Our review of records, discussions with staff and tour of the environment demonstrated appropriate action had not always been taken to reduce risk. This included key risks such as falls, pressure sores, choking, behaviour that challenged and smoking.

Accidents and incidents were not always robustly analysed. Where lessons could be learned to improve the service and make the care people received safer; these were not always identified and addressed. Accidents and incidents were not being consistently investigated and followed up.

Robust systems were not in place to ensure people were protected from the risk of abuse. Procedures regarding the use of restraint needed improving to ensure staff only used restraint when it was absolutely necessary, proportionate and lawful.

The environment was not kept clean and was not safely maintained. Risks around fire safety had not been appropriately identified, assessed and mitigated. The provider had not considered people's individual needs when decorating and designing the environment.

Appropriate action was not always being taken to ensure equipment was safe and appropriate for peoples' needs.

Sufficient staff were not always deployed to meet people's needs. Staff were task orientated and did not always provide people with the support they needed. Agency staff often worked at the home but were not

always receiving the information they needed to deliver effective care.

Medicines management was not always safe and effective, which meant we could not be assured people always received their medicines as prescribed.

Staff told us and records showed that the training staff received needed to be improved.

Staff did not always support people in the least restrictive way possible; the policies and systems in the service do not support this practice.

People told us the food and drink they received was poor quality and did not always reflect their preferences. Risks relating to nutrition and hydration were poorly managed.

Some aspects of care delivery where not person centred. For example, meals and snacks were provided at set times which did not meet people's needs.

People told us they felt safe living at the service and they provided positive feedback about the staff who supported them.

We saw some staff had developed strong relationships with people. However, staff did not always recognise and intervene where people needed support. We also found some staff lacked awareness and consideration about the things that mattered to people.

People did not always have their privacy and dignity maintained and respected.

Staff involved and consulted a range of health and social care professionals to ensure people's healthcare needs were met. However, the advice given by these professionals was not always followed, put into practice or reflected in peoples care records.

People were not always provided with the information they needed to make informed choices about the care they received.

We saw no evidence of discrimination. However, staff did not always have the information they needed to meet people's diverse needs including those relating to disability, gender, ethnicity, faith and sexual orientation.

The care planning around end of life care needed improvement so that peoples' wishes were clearly recorded.

A complaints procedure was in place and complaints were investigated. However, it was not always clear that peoples' views had been listened to.

Robust systems were not in place to ensure risks to people's health and safety were assessed and mitigated. Key policies were not in place for areas such as smoking, drugs and alcohol. Where procedures were in place these were not always being followed.

People told us they enjoyed the activities which staff arranged for them but they were not always aware of the activities program. We were concerned that people with complex needs did not always have the opportunity to engage in meaningful occupation

Leadership and management of the service needed to improve. The provider's systems and processes did not enable them to effectively assess, monitor and improve the service and quality of care provided.

We found shortfalls in the care and service provided to people. We identified nine breaches of legal requirements. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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 health, safety and welfare were not assessed and mitigated. People were not always protected from the risk of abuse.

Accidents and incidents were not robustly reviewed, investigated and followed up to ensure lessons were learned for the future.

Staffing levels were insufficient to meet people's needs in a timely manner.

The environment was not kept clean or safely maintained.

Medicines were not always being managed in a safe and proper manner.

Is the service effective?

Inadequate

The service was not effective.

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us the food and drink was poor quality. Risks relating to nutrition and hydration were poorly managed.

Staff training was not always robust and up to date.

Advice from health professionals was sought but not always followed.

Aspects of the building were not safe, well maintained or suitable.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were friendly and caring and we saw this in some of our observations. However, some staff did not always

recognise and intervene where people needed support.

Peoples' privacy and dignity was not always maintained.

Choices and options were not always explained to people so they could make decisions about the care they received.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not accurate or up to date and did not reflect people's preferences.

Several aspects of the care provision were not personalised.

A complaints procedure was in place and complaints were investigated. However, it was not always clear that peoples' views had been listened to.

People's wishes for end of life care were not always clearly recorded.

Is the service well-led?

Inadequate

The service was not well-led

Leadership and management of the service was not effective.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

The quality and implementation of policies and procedures needed to be improved.

The Links Care Centre

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.

The inspection was undertaken due to an increase in notifications which raised concerns about the safety of the service, suitability of the environment and management of risk. During the inspection we reviewed the associated risks and how they had been managed.

This inspection took place on 19, 24 and 31 July 2018. Each day of the inspection was unannounced.

On 19 July the team consisted of two Adult Social Care Inspectors and a Pharmacist Inspector. A Legal Services Case Progression Manager also shadowed the inspection and spoke with people who used the service. On 24 July the team consisted of three Adult Social Care Inspectors and a Mental Health Nurse Specialist. On 31 July the team consisted of five Adult Social Care Inspectors.

Before the inspection we reviewed information available to us about this service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also spoke with the local authority Commissioning and safeguarding teams to gain their feedback about the service. We asked health professionals about their experience of working with the service. However, only one health professional provided a response.

During the inspection we spoke with 18 people who lived at the home. We also spoke with nine care assistants, six nurses, three team leaders, three regional managers, the clinical lead and the Registered Manager. We looked at twenty care plans, three staff files, ten peoples' medication records and other records relating to the management of the service including audits, meeting notes and maintenance records. We also carried out a tour of building. We used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also completed informal observations of care delivery and interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

We found there were not effective systems in place to assess, monitor and reduce risks to ensure people were kept safe. Risk assessments were not always correctly completed, comprehensive and fit for purpose. For example, one person's Malnutrition Universal Screening Tool (MUST) had been incorrectly completed. The most recent MUST assessed the person as being 'low risk.' If the MUST had been correctly completed the person would have been assessed as being 'high risk' and should have had additional measures put in place such as weekly weights and a fortified diet.

Accidents were recorded and a monthly analysis was completed. However, this did not always identify key trends and patterns so risks could be reduced. For example, incident forms showed one person had six falls between April and June 2018. The person had not been referred to the falls team and their care plans and risk assessments had not been updated to demonstrate appropriate action was being taken to reduce the future risk of falls. Another person suffered a burn injury. The incident had not been fully investigated and appropriate action taken to ensure they were safe. Their care records had also not been reviewed and updated following the incident. Another person had previously injured themselves on the radiator in their bedroom. On the first day of our inspection we found the radiator remained unsafe, however this was made secure before we left the home. We saw another person had an accident where an identified action on the incident report was that staff should ensure the persons' bed brakes were secure. This information was not included in the person's care file. We saw an occasion where staff had forgotten to apply this person's bed brakes. After we brought this to staff's attention they made a sign for the person's bedroom to remind staff to secure the bed brakes.

Incidents and accidents had not always been properly investigated and followed up. This meant we could not be assured that lessons were learned and improvements were put into practice. For example, we saw an incident report which showed a person had sustained a head wound and arm injury. It was not clear that appropriate medical attention had been sought. This had not been investigated. Staff told us this person had been referred to the falls team. However, when we reviewed records with care staff we could not find anything documented to corroborate this and to demonstrate appropriate action had been taken to protect this person from the risk of future falls.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate action was not always being taken to ensure equipment was safe and appropriate for peoples' needs. We saw one person was assessed as being at high risk of falling and had experienced a number of falls. They had a recliner chair in their bedroom, however staff told us it was no longer used because the person was at risk of falling out of it. This information was not recorded within the persons' care file to ensure this was highlighted to staff and despite the identified risk the chair remained in the person's bedroom. We raised this with the registered manager and they said the chair would be removed. For another person we saw a lap belt was not available for their specialist lounge chair meaning it was not safe for the person to use it. This was not recorded within their care file so staff knew this. Appropriate action had

also not been taken to ensure their wheelchair was safe and suitable for their needs despite the person previously injuring themselves on it. After we brought this to their attention the registered manager arranged for the wheelchair to be repaired and made a referral to a physiotherapist. However, we were concerned proactive and timely action had not been taken to ensure the safety of equipment.

Where people were at risk of developing pressure sores appropriate action had not always been taken to ensure risks relating to peoples' skin integrity were effectively managed. We saw one person had previously had pressure sores. We found six different care plans in relation to how to manage their skin integrity. This made it difficult to establish their specific skin care needs. None of the care plans identified that they used a pressure relieving mattress or what the correct setting of the mattress should be. On the second day of our inspection we saw their pressure reliving mattress was set on the wrong setting for their weight so would not be effective. Other pressure relieving equipment was also not in place or being used. The persons' care records stated they should have their position changed every two hours. We reviewed their repositioning records for July 2018 and saw two hourly positional changes had not been achieved on 14 days. This meant we were unable to confirm that appropriate action had been taken to reduce the risk of pressure sores.

Appropriate action had not always been taken to assess, monitor and reduce risks associated with choking. We saw one person's most recent choking risk assessment assessed them as being high risk. A swallowing assessment by a Speech and Language Therapist (SALT) stated they should be supervised at mealtimes. This advice was not reflected in the person's care records. During the second day of our inspection we saw this person was eating alone in their bedroom without staff supervision. A staff member told us, "This is usual for [them], we pop in and out to check [them] but we don't sit with [them] as [they] would get agitated." We raised our concerns with the registered manager. By the third day of our inspection we saw a swallowing care plan had been written. This identified the person should be supervised during meals and staff should eliminate high risk foods. However there was no advice or examples of what high risk foods were for this person. Staff also told us they were still not supervising this person during mealtimes. This meant we were not assured appropriate action was being taken to reduce this choking risk.

A number of people living at the home were at risk of not being able to maintain a safe and clean environment. We found the risks associated with this were not being appropriately managed. For example, one person's Deprivation of Liberty Safeguards (DoLS) assessment stated they needed help from staff to maintain a clean and safe living environment. We saw their bedroom was very unclean and extremely cluttered. It was also in a poor state of repair, for example, a large section of plasterboard above their bed was very damaged. There was a strong odour in the room and a large amount of flies. Staff told us they struggled to encourage this person to keep their room clean. One staff member told us, "We cannot go into room to clean as [person] blames staff, it is a danger, we found insects and mice". When we showed the bedroom to the registered manager they asked to leave because of the strong smell. They told us this person had capacity and if they did not want staff to go into their bedroom then staff couldn't. Despite the identified risk, staff's concerns and the poor condition of this person's room we found no clear and effective strategies to assist staff to monitor and manage this person's room. Care records suggested staff should support the person to clean their bedroom daily and store their possessions in a shed. Our observations and discussions with staff confirmed this was not happening. We concluded risks associated with this person's environment had not been appropriately monitored and reduced.

Risks around fire safety had not been appropriately identified, assessed and mitigated. For example, we identified there was a risk of at least three people smoking in their bedrooms. There were no smoking risk assessments in place to identify and manage these individual risks. From speaking with staff and the registered manager we were told this was a significant problem that they found difficult to control. A member of care staff told us, "[Person's name] smokes in his room, I don't know how to prevent it". We saw

burn marks on the wooden floor in this person's bedroom. A fire risk assessment had been completed by an external contractor which made no reference to the risk of people smoking in their bedrooms. The registered manager told us there was no specific smoking policy in place but there was information in the Residents Guide. We found this did not make it clear that people should not smoke in their bedrooms. The registered manager told us they were, "Unsure how I would enforce a [smoking] policy?" However they said they would update the Residents Guide to make the language more specific.

On the second day of our inspection we identified the fire doors in the Larkin Unit dining room and Hawking Unit lounge did not close properly. We raised this with the registered manager and saw these had been repaired on the third day of our inspection. However, this should have been identified and addressed before we raised our concerns.

Personal Emergency Evacuation Plans (PEEPs) were not always comprehensive and up to date. For example, one person's PEEP had not been reviewed since April 2017 and did not state how many staff were required to safely move them. On the third day of the inspection the registered manager said they had reviewed the majority of PEEPs and would complete the rest as a priority.

There was no protocol for people to sign in and out of the home when they accessed the local community. This meant staff were unsure who was in the building and would therefore be unable to relay accurate information to the fire service in case of fire.

Medicines were not always managed in a safe and proper way. We could not always be sure people received their medicines as prescribed. Some people were prescribed topical medicines such as creams. There were no body maps to guide staff where to apply topical medicines. We also saw one person had no medication administration records (MARs) in place and another person's record was signed by staff as being administered but the cream was unopened. This meant we could not be assured these medicines had been given as prescribed.

When people were prescribed medicines administered via a patch, there was no system in place to record the site of application. This meant we could not be sure the patch position was rotated in line with the manufacturer's guidance to prevent side effects.

We saw one person had missed some doses of their pain relieving medicine. The person was regularly away from the home during the day and staff were not following their medication policy for social leave.

A number of people were prescribed a powder to thicken fluids to help with swallowing difficulties. Information on fluid consistency was not available for all staff responsible for making drinks and there were no records to indicate when the thickener was used.

When people were given their medicines disguised in food or drink, there was documentation in place to show this was in their best interest. However, there was no information from a pharmacist or GP to inform staff on how to administer the medicines without reducing its effectiveness. This was not in line with the provider's medication policy.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were stored securely and where people were prescribed medicines to be given 'when

required', additional information to guide staff to administer these medicines safely was available.

Robust systems were not in place to ensure people were protected from the risk of abuse. We saw a number of examples where people's behaviours may have posed a risk of harm to others. We found a lack of clear information and effective strategies to demonstrate these risks were being managed. Potential safeguarding risks had not always been fully assessed and appropriate actions taken to reduce risk. For example, one person had been involved in multiple potential safeguarding incidents whilst accessing the local community. The registered managed told us this person was free to come and go from the home as they had full capacity. On the third day of our inspection we were unable to locate this person. Staff told us they must have gone into town. We established they did not have to sign out or tell staff when they left the home. This person had a missing persons procedure in place which stated before going out staff should remind them of the importance of returning, agree a time for them to return and note what they were wearing so an accurate description could be provided to the police if they did not return. It also stated staff should contact the police if they did not return after 12 hours. Without knowing this person had gone out staff were unable to take any of these measures to safeguard this person. The missing person's procedure also contained inaccurate information. It stated this person was not vulnerable whilst out in the community. However, the incidents and information within their care file suggested they were very vulnerable. This led us to conclude appropriate action was not being taken to protect this person.

We reviewed the log which was used to monitor safeguarding incidents. A number of key incidents had not been included on the log which demonstrated it was not effective. We were concerned this was because the registered manager did not always recognise safeguarding incidents. The training matrix showed 13 staff were overdue or had not completed safeguarding training. The PIR stated the registered manager and clinical lead had both attended training on the role of the manager in safeguarding. However, our review of records and discussions with them led us to conclude they had not fully understood this training because they did not always identify, recognise and respond to potential safeguarding risks.

Robust systems were not operated to ensure staff only used restraint when it was absolutely necessary, proportionate and lawful. Where restraint had been used we saw robust investigations were not always completed. For example, we saw an incident report from March 2018 where a person had displayed challenging behaviour. Staff had felt it was necessary to use restraint to keep this person and others safe. The incident form stated a full investigation and debrief had been completed. The debrief identified a number of learning points such as to improve staff understanding of de-escalation processes and restraint techniques. However, these had not yet been put into practice, despite it being four months since the initial incident. It was also not clear that staff's decision to use restraint had been thoroughly investigated. We could therefore not be assured that the method of restraint used was the least restrictive option available. We reviewed this person's care file and found no clear positive behavioural support strategies or a specific de-escalation plan. There was also no information about what alternative support staff may need to provide to ensure the person was kept safe if they presented with challenging behaviour such as changes to their moving and handling needs. This meant staff did not have the information they needed to protect this person from the risk of unlawful restraint and maintain safe practices.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall people told us they felt safe. One person told us, "I like living here and feel safe" and another person said "Yes I feel safe." Whilst another person told us, "I like living here, people won't hear me moaning, my room is almost self-contained. I have lots of friends here."

We found the environment of the home was poorly maintained and aspects of it were unsafe. For example, in the Larkin Unit dining room we found multiple bottles of cleaning fluid being stored on top of and inside the unlocked sideboard alongside bottles of cordial and plastic drinking cups. We were concerned the unsafe storage of these items posed a risk to the vulnerable people who lived on the unit, especially as some people had an identified risk of self-harm. We raised our concerns with the clinical lead and they ensured these items were moved to a more secure location.

We saw poor standards of cleanliness throughout the home. A number of bedrooms and communal areas where found to be dirty and unhygienic. For example, in one person's bedroom we found the plastic mattress cover on the bed was very dirty and a pile of dirty urine soaked clothes within the en-suite bathroom. The urine stains suggested they had been there a long time. The registered manager said the cleaner hadn't been in today but had cleaned yesterday. However, the deep layers of dirt on the windowsill and poor standards of cleanliness we saw indicated the room had not been thoroughly cleaned for some time.

We identified a number of poor infection control practices. For example during breakfast we saw staff holding toast in their hand to butter it before serving it to people; they were not wearing any protective gloves. We also saw a lack of appropriate hand washing facilities to ensure staff could practice good hand hygiene. For example, paper towels, hand soap and hand sanitizer in staff toilets were repeatedly found to be empty.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient staff were not always deployed to meet people's needs. Staffing levels were calculated by assessing people's dependencies. However, we saw evidence there were not always sufficient staff to meet peoples' specific needs. We saw staff were highly task orientated and provided little social or personal interaction to people. People were not always provided with emotional support when they needed it and appropriate action was not always taken to keep people safe because there were not enough staff. For example, we identified a person who at high risk of choking who was not being supervised during mealtimes as they should have been. Staff told us this was because there were not always sufficient staff on the unit to provide this support. One staff member said, "If there was an extra staff member on we probably would sit with [them]."

Staff told us there were not enough staff. One member of care staff told us, "There is not enough staff here. I feel it's unsafe and an accident waiting to happen." Another member of care staff told us, "The needs of the individuals on the unit have become profound. We're supposed to be out on the floor but then we've got all the other stuff we've got to keep up to date with."

We saw the service used a large number of agency staff. The registered manager told us they were actively recruiting to a number of permanent positions to reduce the use of agency. However, while agency staff were still being used we were concerned they were not being provided with sufficient information to ensure they could deliver safe and effective care. One agency nurse explained they were working on a particular unit for the first time. We saw they were trying to read care files to understand people's individual needs. However care files were very bulky, out of date and did not fully reflect peoples' needs. They told us, "I had a verbal handover from the night staff about any issues which had occurred over night but I didn't receive any more detailed information about each service user, like I get at other services. It's not very well organised here, you get no information on specific issues so I have had to quickly try and read lots of information in care plans to get to know peoples' needs." Other agency nurses also confirmed this to us.

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

We raised our concerns with the registered manager and on the third day of our inspection we saw they had taken some steps to respond to some of our concerns. We saw agency staff were being allocated to work on the same units to help improve the consistency of care. The registered manager had also introduced 'crib' sheets which provided an overview of peoples' individual needs so agency staff could quickly access key information. Agency staff told us they found these 'crib' sheets helpful. However, we found a number of key risks and important information were not included. For example, one person's 'crib' sheet did not identify their high risk of choking, that they required full staff support when eating or that they needed specific pressure relief equipment.

Overall safe recruitment procedures were in place. Staff files showed staff had to complete an application form, attend an interview, complete a disclosure and baring service check and provide references before they started work. In one file, the service had not obtained a reference from the person's current job in healthcare. However, for other staff appropriate references were in place.

Inadequate

Is the service effective?

Our findings

Risks relating to nutrition and hydration were not consistently assessed and reviewed. One person had two different choking risk assessments in place. One assessed them as being high risk whereas the other assessed them as being low risk. This meant we were unable to establish their risk of choking. We also saw contradictions between the advice given by a Speech and Language Therapist (SALT), their nutritional care plans, staff's description of the required care and what we saw was happening in practice. This meant we were unable to establish this person was having their specific nutritional needs met.

Appropriate action was not always being taken to respond to changes in peoples' weights. One person's weight charts showed they had been losing weight since March 2018. They had not been referred to a dietician and food and fluid monitoring charts were not being completed. By the third day of our inspection the clinical lead told us they had introduced food and fluid charts. But when we checked on the unit this was not the case. The persons' nutritional care plan had been written in December 2016 and stated staff should encourage hourly fluids and offer frequent fortified snacks. We did not see this happening in practice and were concerned appropriate action was not being taken to monitor this person's nutritional intake and respond to changes in their weight.

Appropriate action was not always being taken to ensure people who had a low weight received fortified foods. We asked staff if there was anything done to provide extra calories for people whose weight was low. They told us they added cream to drinks but when we looked in the fridge on the Bronte Unit there wasn't any cream available, despite people on that unit being at risk of weight loss. We also did not see cream being added to drinks when they were given out. We asked two care staff whether the people who had a low weight received any different food. Both told us everyone had the same meals apart from the meals that were pureed.

Where people were on nutrition and hydration monitoring charts we saw these were poorly completed. Staff told us one person was on fluid charts because they would forget to drink and were at risk of pressure sores. National Institute for Health and Care Excellence (NICE) Clinical Guidance states adults should have a daily intake of 30 to 35mls of fluid per kg of body weight. The most recent weight record meant this person's target fluid intake should be between 1710mls and 1995mls per day. We reviewed fluid intake charts for June and July 2018. No target fluid intake was recorded on the charts or within the person's care file. There was no evidence the charts had been reviewed to ensure they had received sufficient fluids. The charts showed they were consistently not receiving sufficient amounts of fluids. For example, on 20 June, 17 and 21 July 2018 it was recorded they only had a total of 200mls of fluid. This meant we were unable to establish they had consistently received sufficient to drink.

Where people required their fluids to be thickened to assist with swallowing we saw staff did not always have access to appropriate information. We saw one person was prescribed a thickening powder. We spoke with staff about this and they were unable to locate any records to show when the thickener was to be used or that the fluid consistency information was available to all staff making drinks. Staff told us this person had one scoop or more if they thought they needed it.

The presentation and service of food and drink was not always appropriate. On the second day of inspection on Larkin Unit we saw drinking water at meals was supplied to people from empty juice bottles. Staff told us water was always sent up from the kitchen in empty plastic bottles for people to drink. We drank some water from a juice bottle which had been served to people at breakfast. The water was warm and had a strong blackcurrant flavour. We showed this bottle to the clinical lead and asked them to smell it. They agreed this was not appropriate. They said, "There is no source of water up here that's why the water is tepid." We also saw during breakfast on the Hawking Unit that hot items, including porridge, bacon and baked beans were transported onto the unit in plastic bowls and serving dishes. There was no heated trolley in operation. Some people had this food up to 20 minutes after it arrived which meant it may have gone cold.

People told us the standard of food was poor and they did not always receive enough to eat and drink. Set meal and snack times were in place which people told us meant they did not always get food and drinks when they wanted. During lunch on the first day of our inspection we saw one person did not eat any of their main course. Staff did not encourage them to eat or offer an alternative meal choice. This person told us, "I don't really like the food. I had a takeaway last night which I enjoyed. They don't know how to cook the food I like." On the third day of our inspection another person told us, "Portion sizes are not big enough to feed a mouse, sometimes we can't get seconds as there is not enough to go around." Drinks trolleys went round each unit mid-morning and mid-afternoon. We saw snacks were not provided on the drinks trolleys. Staff told us snacks were not usually given out on drinks trolleys but these were available on the unit and from the main kitchen should people want them. Many people were at risk of losing weight and/or had mental health conditions which may have prevented them from remembering to eat. We were concerned these people were not being routinely encouraged to eat additional calories.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the necessary skills, experience and competence to ensure they delivered effective care. Staff told us they felt the training could be improved. One staff member told us, "There was not enough support or training when I came into post. I taught myself."

We reviewed the staff training matrix and saw a number of staff were overdue or had not completed training in key areas. For example, 20 staff had not completed training in the safe use of bedrails, 12 staff had not completed DoLS training and 11 staff were overdue or had not completed fire training. Seven of the eight nurses responsible for administering medicines had been trained in the safe administration and handling of medicines. However, only four nurses had received an annual competency assessment in the last 12 months. This meant the provider's medication policy was not being followed.

We saw evidence to show that a lack of robust training impacted upon people who used the service. For example, six of the nine nurses and 12 out of 53 carers had not received management of actual or potential aggression (MAPA) training. An additional 14 staff had not received updates to their MAPA training since 2016. We saw a number of incidents where various forms of restraint had been used by staff. Staff had not always recognised the actions they had taken had been a form of restraint and were not always able to demonstrate the method used had been the least restrictive option. This led us to conclude the training was not sufficiently robust. On the third day of our inspection the registered manager told us the provider had engaged an independent consultant to visit the service to analyse training needs and deliver staff training in relation to restraint and managing aggression.

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

2014.

We saw staff involved a range of health and social care professionals to help ensure peoples' healthcare needs were met. A health care professional told us referrals from the service were "generally timely" and that "most referrals are appropriate." They also said staff were friendly and welcoming of professionals when they visited the home. However, we saw advice from health professionals was not always reflected in peoples' care records to ensure staff followed it. For example, one person had a swallowing assessment completed by a SALT on 16 July 18. The advice stated they should be supervised at mealtimes. However, the person's nutritional care plan had last been updated on 23 May18 and did not reflect this advice. We saw the person was eating alone in their bedroom and was not being supervised. We were therefore not assured the SALT advice was being followed to ensure this person was protected from the risk of choking.

We also saw where staff had decided not to follow the advice given by health professionals a clear rationale was not always recorded. For example, one person was identified as being a high risk of choking. A SALT had identified the person should have their fluids thickened to help reduce this risk. However, the registered manager told us this person no longer had their fluids thickened because they were refusing to drink when their fluid were thickened. There was no information within the person's care records to show by whom and why this clinical decision had been made.

Where referrals for specialist advice had been made staff were not proactive in chasing up assessments. For example, staff requested an assessment for a specialist bed for one person due to the risk of falls. The referral had been made in April 2018 and the assessment had not been completed by the time of our inspection. Since the initial referral the person had a further six falls out of their bed between May and July 2018. We raised this with the registered manager and they said there had been funding issues which had slowed the process down. They were unable to show us they had escalated the assessment in light of the additional falls. Following our inspection the registered manager told us they had chased up this assessment.

We identified widespread concerns with the safety, suitability and maintenance of the building. For example, a person who lived at the home told us the lighting was not sufficient in the dining room on Hawking Unit. We checked and saw seven of the 12 ceiling lights were not working, which made the dining area dim and poorly lit. In the Larkin Unit dining room three of the eight ceiling lights were not working and two of the light fittings were broken. The clinical lead told us 90 light bulbs needed to be replaced across the home. They said the provider would not agree to replace them because they were too expensive. Many people living at the home had a high risk of falls and therefore needed suitable lighting to help reduce the risk of accidents. Other areas of the building were also not well maintained. For example, the walls in the dining room on Hawking Unit were scraped and cracked with plaster exposed in places and the dining room on the Larkin Unit was dirty and some of the furniture was very worn. Within people's bedrooms we saw examples of poor maintenance such as broken radiator guards, missing curtain poles, holes in plasterboard and broken furniture.

We also saw the provider had not considered people's individual needs when decorating and designing the environment. For example, one person was at high risk of injuring themselves in their bedroom. Appropriate action had not been taken to ensure their environment was safe and appropriate for their needs. We saw many people enjoyed spending time in the outside courtyard. Despite this being an important area for people, we saw it was not appropriately maintained. It was full of weeds and on the third day of our inspection we saw two occasions where a person was able to access a locked area from the courtyard. There were no staff around and the Inspector was concerned that if they had not been there to call for staff assistance then this person could have been trapped in this locked area without staff knowing.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes 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.

We were not always assured that staff acted in accordance with the principals of the MCA. For example, a DoLS Register was kept to help identify and track pending and approved DoLS authorisations. This showed expired DoLS had not been reapplied for in a timely manner. For example, the authorised DoLS for one person had expired on 22 May 2018 but was not reapplied for until 17 July 18. There was no rational recorded for why a timely renewal had not been sought within this person's care file or on the DoLS register. Following the introduction of the DoLS authorisation, this person's care plans had also not been updated to reflect this and ensure staff provided appropriate support. This meant we were unable to confirm staff had acted in accordance with the requirements of the MCA and associated codes of practice. We also saw not all staff had received training on DoLS and their knowledge and understanding of how the DoLS and MCA impacted on the day to day care they delivered was variable.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments of peoples' capacity to make decisions and consent to their care and treatment were not always clear, accurate and regularly reviewed. For example, we saw one person had limited verbal communication. We saw a lack of clear strategies to assist staff in communicating with them. Alternative communication options, such as the use of technology and visual communications aids, had not been procured. Their care file showed they were assessed as having capacity. However, their decision making and capacity to consent to planned care plan had not been completed. This meant there was not clear information about how staff were to obtain consent from this person and ensure they understood and agreed to their care and treatment.

Another person's care file contained contradictory information about their capacity to consent. Their care plans stated the person had the capacity to make decisions and choices. Whereas their DoLS authorisation stated they lacked capacity and were unable to maintain a safe and hygienic environment. We also saw that their capacity had not been assessed using a two stage functional test and there was no decision specific assessment of their capacity to maintain a safe living environment. This demonstrated that a full and proper assessment of this person's capacity had not been carried out by the home around key areas such as the ability to keep a safe environment.

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

Requires Improvement

Is the service caring?

Our findings

Peoples' privacy was not always respected. Vision panels were on some bedroom doors and we saw a number of these were kept open enabling anyone walking past to see directly into the persons' bedroom. We also saw bedroom doors were propped open when people were in their bedrooms. Care staff were unable to tell them why this was the case but said it was "usual." We also saw one person only had one curtain at their window. Another person had no bedroom door or curtain rail. This person told us they had pulled their door off two weeks ago. No other measures were in place to protect peoples' privacy whilst these were fixed. We saw monitoring charts were kept in unlocked drawers in the communal lounges on Larkin and Bronte Units. This meant they could be accessed by anyone entering these areas. One staff member told us, "They shouldn't be there, there is personal information in those files."

We found some staff lacked awareness and consideration about the things that mattered to people. On the first day of our inspection we saw a person had limited personal belongings in their bedroom. Staff told us their clothes were kept in a storeroom as this person kept putting them down the toilet. We saw their clothes were stuffed into a plastic box in a locked store cupboard. This showed a lack of respect for this person's belongings.

Staff did not always recognise and intervene where people needed support. A lot of people living at the home needed support and/or prompting from staff to ensure they had their personal care needs met. We saw this was not always being provided. For example, on the first day of our inspection we saw a person was wearing very dirty clothes and their hair was unkempt. They were not wearing anything on their feet, their toenails were dirty and very long and the soles of her feet were dirty. This person's care records showed there was a risk assessment for not wearing shoes and socks which said staff should regularly check their feet condition and report any concerns to the nurse in charge. Our findings showed this had not been the case and showed a lack of respect for this person. We raised our concerns with the registered manager and when we returned to the service we saw this person was wearing clean clothes and a pair of shoes. Staff told us they had started wearing the shoes in the last few days and had kept them on. We were concerned if we had not brought this to staff's attention then appropriate action may not have been taken.

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

We saw people were not always provided with important information to enable them to make informed choices about the care they received. For example, during mealtimes we saw people were not always offered choices or had the food options explained to them. On the first day of our inspection one person said, "I wish I knew what I was having for breakfast then I could say if I liked it or not." Another person said, "I don't know what we are having until the trolley comes in." This approach did not enable people to make informed decisions.

Care plans did not always contain complete and accurate information about key areas of people's lives. We found there was a particular lack of detail around people's life histories, interests, likes, dislikes, spiritual,

cultural and sexual needs. This meant we were not always able to evidence that people had been involved in developing their care plans. It also meant staff were not provided with comprehensive information to enable them to deliver personalised care. Although we saw no evidence to suggest anyone was discriminated against and no one told us anything to contradict this; we were concerned that staff did not have the information they needed to meet people's diverse needs including those related to disability, gender, ethnicity, faith and sexual orientation.

Where people's preferences had been assessed these did not always translate into personalised care. For example, we saw information within one person's care records to show that attending church services was very important to them. However there was no information to demonstrate they had been supported to attend church and staff told us this person did not go to church or have visits from a priest. This meant we were unable to demonstrate staff had supported, respected and met this person's religious needs.

During our observations we saw staff did not always consult and involve people in making decisions to ensure the care and support they provided met their needs. For example, during lunch on the first day of our inspection we saw a person was brought a cup of tea. They immediately pushed the cup away and said they wanted their drink in a striped cup. Staff took away the cup and brought them another cup of tea which was also not in a striped cup. The person pushed away the cup and shouted, "I am not drinking that it's not what I asked for." Their body language and dialogue that followed demonstrated they were annoyed staff had not listened to them. During breakfast on the second day of our inspection we saw a person begin to cry. They said they were upset because their coffee did not have sugar in it. A member of care staff took the coffee away and brought them a fresh cup with sugar in. However this person remained distressed. The staff member told us they did not know this person took sugar. At no point had the person been asked how they liked their coffee before it was served.

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

Despite the concerns we identified we saw some positive examples to show some staff did ensure people were listened to. For example, staff overheard one person mention that they would like to purchase a radio for their bedroom. We saw staff arranged for the person to be supported to go to the sports bar that afternoon so they could access the computer to order a radio.

Overall people told us they felt they were well cared for. One person told us, "Yeah I'm alright and looked after good. The staff are nice and the place is nice, it's just the outside that needs sorting." Another person said, "Ten years I've been here, too long! I am looked after ok though."

People provided the most positive feedback about the staff who cared for them. One person told us, "I am happy here, I am well looked after and staff are kind." Another person told us, "Staff, can't fault them but the food is not nice." Another person told us a particular staff member, "is a great help to me." Whilst another person told us, "Staff are helpful, chatty, friendly and playful." Peoples' feedback and our observations demonstrated staff had developed positive relationships with people and the permanent staff who worked at the service knew people well. One person who used the service told us, "I class [staff member name] as the brother I have never had." A healthcare professional who visited the service told us, "Staff appear to be caring and have a good rapport with the service users."

Our observations and discussions with staff showed that staff were unable to ensure people always received the emotional support they needed. We saw staff were very task focussed and did not have the time to spend quality time with people. One staff member told us, "I have no time to spend chatting with people.

People do not get good quality care or the support they deserve."

We saw examples where people needed staff assistance and emotional support but this was not provided. For example, we saw one person sat on the sofa in the Bronte Unit lounge crying. No staff were around. This person was unable to tell the Inspector what was wrong but held their hand which showed us this person wanted comfort. We reviewed this person's care file and saw they were assessed as being a high falls risk and at risk of putting objects in their mouth so needed staff observation to keep them safe.

Our discussions with the registered manager demonstrated they were passionate about promoting peoples' independence and wanted to ensure people retained control and choice over their lives as much as possible. Whilst this was positive, we were concerned they did not always balance this with ensuring potential risks to peoples' safety and welfare were effectively managed. For example, we identified concerns there was a lack of appropriate guidance in relation to how staff were to manage key issues such as the consumption of drugs and alcohol, smoking in bedrooms and bringing hazardous objects into the home. We were concerned from speaking with the registered manager and clinical lead that there was a culture of not managing people's behaviour and the risks they posed because some people had the capacity to make their own decisions. However, many people were living at the home because they were vulnerable and needed protection from harm. There was a lack of a clear therapeutic care model to support people and to demonstrate risks associated with potentially harmful behaviours had been discussed with people.

The registered manager told us the Hawking Unit was for people who were more independent and may not have required as much support from staff. Staff on the unit showed us there was an oven and hob within the kitchen on the unit. They told us this could be used by people to aid in the development of cooking skills. However due to problems with the equipment it was not safe or easy to operate. There was no extractor fan above the hob and people told us this had resulted in the fire alarm being set off. In addition, we observed the electric hob took over 5 minutes to heat up and was not easy to operate for people developing life skills. This meant people were not always receiving effective support to develop their independence.

Inadequate

Is the service responsive?

Our findings

Care records were not fully completed, accurate and kept up to date. Staff told us care records were not fit for purpose. One staff member told us they were, "Ashamed of the records." Whilst another staff member told us, "The paperwork is more for nursing. Things aren't written up properly. All the units seem to have different care plans, it's a mess."

We found significant and widespread concerns with 18 of the 20 care files we reviewed. We saw some care plans were very old and therefore did not reflect people's current needs and preferences. For example one person's nutritional care plan had been developed in 2013. However, since then they had been assessed as having a very high risk of choking and had a SALT assessment so a refresh of their nutritional care plan was important.

We found care plans lacked sufficient detail to determine what peoples' specific needs were in relation to key areas including mobility, challenging behaviour, pressure care, nutrition and equipment. For example, one persons' behaviours care plan stated they were physically challenging every day. The recorded level of need within their care plan had both moderate and high circled so it was not clear which was relevant. Information recorded within the care plan provided limited information such as 'staff to monitor safety'. This meant there were no clear strategies for how staff could manage this and reduce the risk of harm for this person and themselves. A staff member described the specific situations when the person would usually become agitated. However, there was nothing in the care records to identify these triggers to staff. We saw an incident had occurred in March 2018 where this person had injured a staff member which showed it was important staff had this information.

We found multiple examples where important information was not included in care plans and risk assessments or where these documents had not been reviewed and updated despite changes occurring. This meant staff were not always provided with the information they required to deliver personalised care. For example, we found conflicting information within one person's care records about their current moving and handling needs. Their mobility care plan stated they moved independently without equipment. An additional mobility plan stated they used a walking frame. However we saw and staff told us they now used a wheelchair. Another person had been admitted to the home on 13 July 2018. However, when we reviewed their care records on 19 July we saw these had not yet been fully completed. There was no information within the care records to show their needs with regards to mobility, continence, sleep or behaviour. Their behaviours chart showed they had been involved in incidents and staff would have therefore benefited from a care plan to assist them with managing this behaviour. Their Waterlow assessment had not been fully completed despite a referral being made to the tissue viability nurse due to ulcerated legs. This meant we were not assured staff had the information they needed to meet this person's needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned peoples' individual communication needs were not being met. We asked the registered

manager how they were implementing the requirements of the Accessible Information Standard. This requires them to ask, record, flag and share information about people's communication needs and take steps to ensure people receive information, which they can access and understand, and receive communication support if they need it. The registered manager told us they were not really confident with what the standards were but said they would "Google it" to get more information. They said it was important people should receive information in a format which they could understand. However, we saw evidence to show this was not always happening in practice. For example, information in one person's preadmission assessment showed that prior to moving into the home they had attempted to seriously harm themselves. Their mental health care plan stated their 'biggest frustration is [their] reduced ability to communicate.' We found a lack of strategies to assist staff in communicating with them. We spoke with a member of care staff about whether they used any specific communication tools. They said, "We don't have picture cards. I usually get [them] a pen and paper to write down what [they] wants to say but I don't think everyone does that, I just know it can work." The clinical lead told us, "SALT recommended flash cards so we are looking to source them as [they] get frustrated not being able to say and get [their] words out, we are also looking at electronic communication devices as [person] loves to write down." However, these had not been procured. The person had been assessed by a SALT on 16 July 2018. During the assessment the SALT had struggled to understand what this person was trying to tell them. The SALT identified this person would like a communication book with pictures to assist them in communicating. By the third day of our inspection staff told us this had been completed and the person "absolutely loves it."

Staff did not always have access to the information they required to ensure they could deliver personalised care. We saw incomplete care records in key areas such as current interests, social interests, spiritual, cultural and sexual needs. This meant staff were not provided with the information they needed to deliver individualised care. Staff told us about one person who had "Good days and bad days." Staff told us the level of support this person required varied depending on the type of day they were having. They were able to describe particular changes to their mood and appearance which indicated they were having a bad day. However, there was no information about this or the different levels of support they required within their care records.

The care provided was not always person centred. For example, meals and drinks were provided at set times each day. We saw this approach did not meet peoples' individual needs. Breakfast was served at 9.30am on every unit. At 9.15am on the second day of our inspection one person was waiting for the breakfast trolley and told us, "I have been up since quarter to six this morning. I have had a cup of tea when the tea trolley came round but I haven't had anything to eat." Another person said, "I am just waiting for my breakfast. I wish they would hurry up as I am starving." We asked if they had requested something to eat from staff earlier. This person laughed and said, "The trolley comes at half past. You can't have your breakfast any earlier than that." On the third day of our inspection another person told us they did not like having to wait such a long time from tea until breakfast. They said although a supper was brought around at 9.30pm this was rather late and many people either didn't feel like eating at that time or were already in bed.

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

The service's approach to end of life care needed to be improved. Staff were working towards obtaining the Gold Standard Framework. This is a national initiative which focuses on improving training, understanding and care planning to improve the quality of care people receive at the end of their life. No one was receiving end of life care at the time of the inspection. However, we found care planning around end of life care needed to be improved in case they did in the future. People's wishes were not always clearly recorded. This meant we were unable to evidence people had been consistently involved in planning the care they wanted

to receive at the end of their life. One person's end of life care plan had been partially completed. From the information recorded it stated a best interest meeting was required to discuss whether a Do Not Attempt Resuscitation order was needed. It was not clear from the information recorded whether this had been arranged. Other people had no information recorded regarding their end of life wishes. This put people at risk of not receiving the support they wanted when they reached the end of their life.

A complaints policy was in place and there were posters throughout the building explaining how people could complain. We saw there had been three complaints about the service since the new provider had taken over. There was evidence to show these had been investigated in a prompt manner. However one of the complaint records showed that although the registered manager had upheld the complaint about the lack of quality and variety of food there was no record of a formal discussion and apology to the person to explain what would be done differently in the future.

Annual reviews of care were held where people could discuss changes or improvements they wanted to the care they received. However, we saw issues people raised were not always followed up. For example, one person's review stated nothing was working, they no longer wanted to live at the home and wanted to live in their own flat. At the time of the inspection the person was still living at the home and it was not clear what action had been taken to address the issues they had raised. The actions section of the review form was blank and there was no further information recorded within their care records to show what actions had been taken. This meant we were unable to evidence this person had been listened to and their preferences respected.

People told us they enjoyed the activities on offer. Some of the comments included; "I like the singing activities, especially with Banjo Henry," "I liked it when we did Links Got Talent" and "I like drawing, painting, the exercise classes and when the hairdresser comes in." We saw a number of posters displayed around the service advertising various activities including karaoke afternoons and sing-a-longs. Staff had also planned a Mexican themed event which people told us they were looking forward to. There was a Sports Bar where people could go to socialise. It included a television, music system, pool table and a bar which served drinks and snacks. There was also a computer where people could access the internet. During our visit it was decorated to celebrate the World Cup and many people told us they had enjoyed watching the football games there.

We were concerned activities were not always inclusive and effectively promoted to ensure everyone had the opportunity to engage in meaningful occupation. Some people were unsure what activities were on offer. One person told us, "I don't know plans for this afternoon" whilst another person said, "It's boring doing nothing all day." We saw the weekly activity plan displayed in communal areas had not been updated for the week ahead. We also saw staff did not spend quality time with people who were unable or did not wish to participate in group based activities.

People were encouraged to engage in activities in the local community. A staff member told us that they supported people to visit the cinema each week. One person who used the service told us, "I can go out, I don't have to stay here all day." However, we were concerned people with more complex needs did not have as many opportunities to access the local community. For example, one person's care records showed they liked to visit local parks and attend church. Our discussions with staff and review of their activities logs showed this was not happening.

Inadequate

Is the service well-led?

Our findings

We found the systems in place to improve the service were not robust. This meant the quality and safety of the service provided was not being appropriately assessed, monitored and improved. We identified widespread concerns with the quality of care records. The registered manager had identified care records needed updating but had not taken timely and appropriate action to address the shortfalls. They told us it would take until Christmas 2018 to update care plans. However, during this time there was a risk of peoples' needs not being fully assessed and met because staff did not have the information they needed.

The registered manager told us they were reviewing and updating care records based on risk. They said they were starting with new admissions, people most at risk and who had been safeguarded. On the first day of our inspection we were given a person's care file as an example of a file that had been updated as they were a new admission. However we saw large sections of the care plans had not been completed. On the second day of our inspection we showed the clinical lead a care file as we had identified a number of the care plans were not fit for purpose. The clinical lead told us the "[Local Authority Commissioners] came in to review [person's] care plan and were appalled, so it should have been reviewed and updated by the team leader. We have not had chance to check yet to ensure this has been done to a high standard." Throughout the three days of our inspection we saw multiple other care files for people who were at high risk and been safeguarded and found their care records were also not fit for purpose. This led us to conclude that the systems in place to update, review and improve care records were not effective.

The registered manager told us only three care plans had been audited since February 2018. We looked at the care plan audits which showed a significant number of actions were required to bring these care plans up to standard. There was no evidence to show these actions had been completed. We saw a log was maintained of care plans and whether risk assessments were up to date. However this provided no insight into the quality of care records and the Priestley unit was missing from the matrix. The registered manager told us this was because a nurse had forgotten to save this information on the computer. This meant important information on whether these care plans and risk assessments were up to date was missing. This demonstrated failings in the systems designed to assess, monitor and improve the quality of care plans.

We found systems to assess, monitor and improve other aspects of the service were disorganised and ineffective. The quality assurance systems were limited in their effectiveness to ensure continuous improvement. We identified widespread failings in several areas which should have been addressed through the operation of robust systems of governance, audit and monitoring. For example, we found several areas of the building were not kept in a clean and hygienic state. This showed us the maintenance and infection control audits which took place were not sufficiently robust. The registered manager told us infection control audits should be completed every two months. However, the last audit had been completed in April 2018 which showed this timescale had not been achieved. When we returned for the third day of our inspection we saw this audit schedule had been increased to monthly.

We were unable to establish the chronology of pressure sores for three people. We requested a list of people who currently had pressure sores. The monitoring spreadsheet we were given only went up to April 2018.

After we raised this with the clinical lead they went around the units to update the spreadsheet for June and July. This demonstrated a lack of effective management oversight and proactive monitoring of pressure sores.

A regional manager employed by the provider told us a regional manager visited the home to complete a quality audit every 12 weeks. They said the service was currently at 80% compliance. We reviewed the findings of the July 2018 audit. This identified some of the concerns we had identified during our inspection, such as issues with care plans. However, we concluded this was not a robust audit. For example, care plans received a score of 69% which meant they were rated 'requires improvement'. However, we identified that issues with care records were much more serious. We found significant improvements were required to 18 of the 20 care files we reviewed. The audit scored the environment 100%, however we identified widespread concerns with the maintenance and cleanliness of the environment. The regional manager told us they had not uncovered the same amount of concerns as we had because they had only audited a small sample of documentation. This showed the audit was not fit for purpose.

Communication systems were not effective. The registered manager chaired a daily meeting at 11am with representatives from each unit. The meetings were used to discuss issues, concerns and key changes. We saw important information raised at this meeting was not always passed on to care staff. For example, on the third day of our inspection we observed the meeting and saw it was discussed that a person had moved units. When we spoke with care staff at 4pm they were not aware the person had moved to another unit. Staff repeatedly told us communication was poor. They said they were not provided with the information they needed to fulfil their role and were not consulted and involved in key developments. One staff member told us, "I don't feel listened to or valued." The agency staff who worked in the home told us they were worried that they did not always receive robust handovers and care staff said there was a breakdown of information between the nursing and care teams. A staff member told us, "A key issue is the handovers are just nurses so they are purely clinical so key issues regarding welfare are not being passed on. As care staff we don't get to know things or get an update from handover."

A record of people's weights was kept which showed changes from month to month. However no information was recorded to show changes in weights had been investigated to give assurance effective action had been taken. The record showed one person had lost 8.25kg in June and put on 7.30kg in July. During the 11am meeting on the first day of the inspection one an Inspector heard a staff member ask staff to check all abnormal weights. When we returned on the second day of our inspection this had still not been actioned and followed up. The registered manager said there had been issues with the scales accuracy but had not taken action to address this.

Robust systems were not in place to ensure risks to people's health and safety were assessed and mitigated. A number of people were known to use drugs and alcohol. The registered manager told us there was not a specific drugs and alcohol policy in place but said there was information within the Resident's Guide. However, we found this information was not clear. It said whilst staff did not encourage the use of alcohol or drugs this was a 'matter of personal choice.' This was open to interpretation and did not provide sufficient protection for staff or other vulnerable people living at the home. We also found similar concerns regarding a lack of appropriate guidance in relation to people smoking in bedrooms and bringing hazardous objects into the home.

The systems to analyse and review accidents and incidents was ineffective. It did not always identify and ensure appropriate action was being taken to mitigate the risk of future incidents. We were also concerned not all accidents and incidents were being recorded. We saw information had been repeatedly written on incident forms and in care records to say incident forms should only be completed if an injury had been

sustained or the person required medical attention. This advice was not in line with the provider's accident reporting and monitoring policy. This had not been identified and addressed as part of the accident and incident analysis. We also saw other examples where the provider's policies and procedures were not being followed in the home including policies on safeguarding and medicines management.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the third day of our inspection some measures had been implemented to try and address some failings we identified during days one and two of the inspection. However, we found these were reactive to our findings and were not sufficiently robust. For example, 'crib' sheets had been introduced to provide an overview of peoples' needs, rather than staff having to wade through the bulky care plans. These were not sufficiently detailed, did not provide staff with strategies for managing the risks and did not include all key risks. Senior management had an increased presence in the home and told us they were assisting updating care plans and risk assessments. However we found there was limited engagement on the units observing care and support.

People were not always kept informed about key events in the home. We saw people often knew what was happening on the unit they lived on. This showed us staff conversed with people about how the unit was operating. For example, our conversations with one person showed us they were aware that on a particular day there had been difficulties in getting a second care worker for their unit. On another unit a person explained they knew there had been an "incident" the night before, they said staff were dealing with it for them. However, appropriate systems were not in place to ensure people were aware of key information about the day to day operation of the wider home. People told us and we saw they were not informed about what was on the daily food menus until meals were served and the activities programme was not kept up to date and circulated to people so they knew what activities were on offer.

The registered manager told us residents meetings were held so people could discuss any improvements they wanted to make to the service. However, we found people were not always aware there were residents meetings. For example, one person told us they would like more activities to do in the home. When we asked them if they had raised this at residents' meetings they said, "Do they have those? I didn't no." Another person told us, "I do go to residents meetings but I couldn't tell you when they are." People's feedback about the quality and variety of food showed us they had not had their views listened to about this important issue. For example, one person told us, "I like scrambled eggs but they don't do it and the brown bread is too thin" and another person told us "Tinned fruit is my favourite, they used to do it a lot but not as often now." Whilst another person told us, "I love fried bread but they won't make it for me. I don't know why because it's dead easy to make. I will probably just have cereal today." We asked them what favourite cereal was and they said, "Crunchy nut cornflakes. But you can't have them here, so I will probably just have Weetabix." This showed us people were not truly involved in the decisions around how the home was run.

We found the service was open to working with other organisations in order to obtain and keep up to date with best practice. They had signed up to a number of local and national initiatives such as the 'react to red' scheme. This is a pressure ulcer prevention campaign which educates staff about how to reduce the risk of skin damage. However, we saw that risks relating to pressure sores were not always appropriately managed in the home. This showed us this best practice had not been fully put into practice across the service to help improve care quality.