Eagle Care Homes Limited

Eagle Care Home

Inspection report

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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

This inspection took place on 8 and 12 February 2016 and was unannounced. At the last inspection on 27 February 2015 we rated the service as 'Requires improvement' and identified four regulatory breaches which related to medicines, staffing levels, nutrition and good governance. Following the inspection the provider sent us an action plan which stated the breaches had been addressed. This inspection was to check improvements had been made and to review the ratings.

Eagle Care Home provides accommodation and personal care for up to 33 older people, some of who are living with dementia. Accommodation is provided in over two floors with communal areas, including three lounges and a dining room, on the ground floor. There were 27 people using the service when we visited on the first day and 26 people on the second day.

The home has a registered manager who has been in post for over two years and was present on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found there were not enough staff on duty during the day and at night to keep people safe and meet their needs. This had been raised at the previous inspection and although the provider told us staffing levels had been increased this had not been sustained. We found some staff were working excessively long hours which placed people at risk of unsafe care from staff who were tired. On the second day of our visit the area manager told us staffing levels had been increased but this was only as a result of our intervention.

Risks to people were not managed well. For example, we found three people had sustained several falls yet there were no risk management plans in place to show how people were being kept safe. Safeguarding incidents were not always recognised, dealt with or reported appropriately.

Medicines management was not always safe which meant people were at risk of not receiving their medicines when they needed them.

We found the home was not clean and infection control procedures were not being followed by staff.

People's nutritional needs and weight were not monitored or reviewed to make sure they were receiving sufficient to eat and drink. When we arrived in the morning people who were already up told us they were thirsty and hungry, yet had been given no drinks and had to wait until the cook came on duty for breakfast, which in two cases was three hours after people had got up.

The training matrix showed staff were up-to-date with most training, however a significant number had not received refresher training in fire safety and moving and handling. Systems were in place to ensure staff

received regular supervision and appraisals.

The registered manager was aware of the legislative requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Two people had DoLS authorisations and conditions applied to the authorisations had been implemented.

People had access to healthcare services although we found staff were not always prompt in contacting healthcare professionals when people's needs changed. Care was not planned or delivered to meet people's individual needs.

We observed some kind, caring and sensitive interactions between staff and people who used the service. However, we found examples which showed a lack of respect for people and compromised their dignity. Some activities were provided which we saw people enjoyed, yet there was little to occupy and interest people at other times.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved and any improvements made were not sustained.

Overall, we found significant shortfalls in the care and service provided to people. The regulatory breaches we identified at the inspection in February 2015 remained and further breaches were identified at this inspection. We identified seven breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 10 (dignity and respect), regulation 13 (safeguarding), regulation 14 (nutrition), regulation 9 (person-centred care) and regulation 17 (good governance).

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.

There were insufficient care staff deployed to ensure people's needs were met and they were kept safe. Staff recruitment processes ensured staff were suitable to work in the care service.

Medicines management was not always safe and effective, which meant people did not always receive their medicines as prescribed.

Risks to people's health, safety and welfare were not properly assessed and mitigated. Safeguarding incidents were not always recognised or reported.

The premises were not clean and effective infection control practices were not always implemented

Is the service effective?

Inadequate

The service was not effective.

People's weight and nutritional needs were not monitored effectively which meant people were at risk of not receiving enough to eat or drink.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation was being followed.

Staff received training and support through supervision and appraisal, however refresher training in fire safety and moving and handling was overdue.

People had access to healthcare services, however staff were not always prompt in contacting healthcare services when people's needs changed.

Is the service caring?

Inadequate

The service was not always caring.

We saw some caring and kind interactions between people and

staff. However, we observed practices which showed a lack of respect for people and compromised their dignity.

People's views were not sought or acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned or delivered to meet people's individual needs.

Although some activities were taking place, we found there was little to interest or occupy people other than the television

Complaints were dealt with in accordance with the home's complaints policy.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective leadership and management which coupled with poor governance systems meant issues were not identified or resolved.

Although quality assurance reports showed improvements had been made following the previous inspection in February 2015, these had not been maintained and issues we identified showed the service provision had deteriorated.

Eagle Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 8 and 12 February 2016 and was unannounced. On the second day we started the inspection at 6am so we could meet the night staff. Two inspectors and an expert by experience with experience of older people's services visited on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there were two inspectors. An inspection manager attended for the feedback session at the end of the inspection on the second day.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR on this occasion.

We spoke with18 people who were using the service, three relatives, five care staff, a domestic, the cook, the registered manager and the area manager.

We looked at 12 people's care records, eight staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection in February 2015 we found a regulatory breach in relation to staffing as there were insufficient staff to meet people's needs. Following the inspection the provider told us they had increased the staffing levels on days and nights and had amended the tool used to calculate staffing levels so it included the layout of the building and people's dependencies. At this inspection we found these improvements had not been sustained

Our observations showed there were insufficient staff on duty to keep people safe and meet their needs. On the first day of our inspection there was a team leader and three care staff on duty. One of the care staff told us they had started the previous week and were 'shadowing' another care staff member. The area manager and a staff member, who told us they worked as management support between two of the provider's homes, arrived during the morning. Yet despite these additional staff we saw people's needs were not met in a timely way.

The communal areas ran the full length of the building and we saw staff tried their best to attend to people who were sitting in these areas. However, there were often times when no staff were in the communal areas and we saw people left unattended tried to get out of their chairs unaided, one person was walking around looking for the toilet, another stood up distressed as they were uncomfortable from sitting and another person was calling, "Help me someone" after they had been incontinent while sat in their chair. We saw the new staff member went to assist a person who was walking away from their chair, they held their hand and were leading them. It was only when we intervened and asked if the person should have their walking frame that the team leader, who we were speaking with, quickly responded and brought the person's frame to them.

The registered manager told us the usual staffing levels were a team leader and three care staff from 8am to 10pm and two or three care staff on night duty from 10pm to 8am. When we asked the registered manager how staffing levels were calculated and why there were two staff on some nights and three staff on others, they said staffing was decided 'by discussion' and looking at people's dependencies. The registered manager said they used to have a staffing tool but this was no longer used. They acknowledged there were no records to evidence people's dependencies or to show how the levels had been calculated.

We looked at the duty rotas from 4 January to 7 February 2016 and found during that time occupancy levels had varied from 26 to 30 people using the service. We found on 23 of the 35 nights there were only two care staff on duty and on 22 days there were only three care staff on day duty including the team leader. We considered these staffing levels were unsafe and insufficient to meet people's needs. We found one staff member was routinely working 64 hours a week, on one occasion working 12 days in a row which included fourteen hour shifts. This staff member was responsible for leading the team and administering medicines. Another staff member worked 65 hours in their first week of employ and on their first shift, which was recorded on the rota as induction, worked as one of the two care staff on duty overnight. These unsafe practices placed people at risk from staff working excessive hours which may impact on their performance and safety to practice.

On the second day of our inspection the area manager told us the staffing levels had been increased by one care assistant on each shift and said agency staff were being used to maintain the increase until new staff were recruited. However, although there were three night staff on duty, we found the number of staff on day duty was the same as the first day of our inspection. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in February 2015 we found a regulatory breach in relation to medicines as there were no protocols for 'as required' medicines, discrepancies in stock levels and administration records were not always completed. Following the inspection the provider told us protocols were in place and audits were being carried out by the registered manager and area manager to ensure safe medicines management. At this inspection we found systems and processes in place to manage medicines were not always safe or effective.

We looked at the medicine administration records (MAR) with the team leader at 12.10pm. We found four people's medicines which the team leader told us had been administered that morning had not been signed for on the MAR. The team leader told us they usually signed the MAR straightaway after they had given the tablets but said they were interrupted several times during the medicine round. We saw this happening as the team leader had to break off repeatedly to answer the phone and assist staff with queries.

One person's MAR was handwritten and we found the entries were not double signed by another staff member which was in contravention of the provider's medicine policy. We found the MAR did not reflect the prescribing instructions of some medicines. For example, an analgesic (pain relieving) gel was prescribed three times a day yet the MAR showed it had been applied four times a day. A medicine to treat nausea was prescribed three times a day yet on the MAR it was highlighted to be given four times a day. The team leader told us the monitored dosage system (MDS) the person had brought in with them had finished the day before our inspection and showed us the new MDS. We saw one of the prescribed medicines was not included in the new MDS. When we asked the team leader about this they said they had not picked this up and did not know why the medicine was not included. This meant we could not be assured the person was receiving all their prescribed medicines.

We saw a number of people were prescribed 'as required' medicines. We asked the team leader if there were any protocols in place to guide staff as to when and how often to give these medicines. The team leader said there were none. When we spoke with the registered manager about this they showed us a separate file which contained protocols. However, the protocols did not cover all 'as required' medicines. For example, one person was prescribed three 'as required' medicines yet there was a protocol for only one of these. We also questioned why the protocols were kept separately from the MARs. Our discussions with the team leader showed although some protocols were in place staff were not aware of these and were not using them to ensure people were receiving their medicines as prescribed.

We found medicines were not always kept safely and securely. We saw analgesics were stored in the dining room in a safe with a keypad code. The team leader was struggling to open the safe and the cook came across and said, "Here, let me try, I know the code." We saw the team leader left the dining room to take medicines to a person in one of the lounges. Medicines were left out on the top of the medicine trolley and the safe where the analgesics were kept was left open. We found medicines for disposal and full sharps boxes were stored openly in an office which was unlocked. Although the office was locked by the registered manager when we brought this to their attention, this meant arrangements had not been made to ensure unauthorised people, including people who used the service and visitors to the home did not have access to medication. We also found the daily temperature of the medicines fridge had not been recorded since 26 January 2016. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Although staff told us they had received safeguarding training, we found staff we spoke with had a lack of understanding and knowledge of safeguarding and what constituted abuse. This was also evident from the records we reviewed which showed incidents which were clearly safeguarding matters had not been referred to the local authority safeguarding team or notified to the Commission. For example, the daily records for 7 February 2016 showed one person had pushed another person over, another entry stated one person had been very aggressive towards another person shouting and trying to push them over. In another person's daily records we saw staff had recorded, "(Name) was kicking and hitting another lady with their zimmer frame during a disagreement." and "Abrupt and snappy with other service users." At lunchtime we saw this person approach another individual who was sitting at the dining table. They refolded the person's serviette and re-laid their place setting. There was a verbal exchange between the two which ended in the person who was sitting at the table being sworn at. This left the person upset and they said, "She does this regular." The registered manager and area manager said they were not aware of these incidents. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risks to people were not managed safely or appropriately. Accident reports showed one person had had seven falls between 7 November 2015 and 2 February 2016, yet when we looked at their falls risk assessment they were assessed as at low risk of falls and although the risk assessment had been reviewed monthly up to 29 December 2015 there had been no change. There was no care plan in place to show what action had been taken to mitigate the risks to keep the person safe. Another person had sustained three serious injuries which had required hospitalisation following falls in February, May and October 2015. Accident records showed this person had had a further five falls between 11 November 2015 and 31 January 2016. Apart from a crash mat being placed next to the person's bed there was little evidence to show what action had been taken to prevent further falls and keep the person safe. Another person's care records showed they had been assessed as being at high risk of falls prior to their admission. Accident reports showed they had fallen four times in their bedroom over a two month period. All of the falls had been unwitnessed by staff. We asked the registered manager if a sensor mat had been put in place. This is a mat which is connected to the emergency call bell system to alert staff if someone is getting out of bed, so they can offer assistance quickly, to try and reduce the risk of someone falling. The registered manager told us there was no sensor mat in place and said they would talk to the family about this. It was not clear why a discussion with the family was necessary before putting equipment in place to reduce the risk of injury to this person. We saw the same person had an injury to their nose, yet we were not able to establish how this injury had occurred. One staff member told us the person had fallen, however we found no record of this injury and when we asked the registered manager they said they did not know how the injury had been sustained.

When we looked around the home we found the lighting in some of the bedrooms was poor with little light being emitted from the light bulbs. The care plan for one person, whose bedroom lighting was very dull, showed they had problems with their vision and had fallen three times in their bedroom in January 2016. People with deteriorating eye sight need good lighting levels and poorly illuminated areas could increase the risk of people falling.

In some bathrooms we saw the emergency call bells were at the opposite end of the room from the toilet. This meant if people required help when they were using the toilet they would not be able to summon assistance. We also noted the call bell alarm could not be heard outside of bedroom 36 and night staff we spoke with told us the call bells could not be heard when they were in rooms 25, 29 and 37. This meant if staff were in this area of the building they would not be able to hear the call bell sounding. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we looked around the building with the registered manager we found areas which were not clean and poor infection prevention practices. In the ground floor bathroom the foot pedal on the clinical waste bin did not work. The lid was not secure and fell off when we touched it. In the bin was a soiled incontinence pad which had not been bagged before it was put into the bin. This made the whole room smell of faeces. On the second day of inspection we saw incontinence pads had been disposed of in three separate clinical waste bins without being put into a disposal bag. This made the bins smell strongly of urine. The registered manager and area manager both told us incontinence pads should be placed in a disposal bag before they were put into the clinical waste bin. This meant staff were not following correct procedures.

We found two mattresses which smelt of stale urine and the registered manager agreed these had not been cleaned. There was also a commode pot in one room, which smelt of stale urine as soon as we lifted the lid.

There were 'push down' taps in some of the bedrooms which would not stay on unless continuous pressure was applied. This meant staff could not wash their hands effectively after delivering personal care. We saw a number of toilet bowls which were stained and looked dirty. This meant they had not been cleaned effectively. There was no soap or paper towels in one of the toilets and in one ensuite we found a sterile dressing on top of the toilet cistern. The registered manager agreed this was not acceptable. There were large black patches on the dining room floor. When we scraped these patches we found it was encrusted dirt. The lounge carpet in the patio lounge was faded and stained and looked unsightly. We also found dirty extractor fans, a dirty bath hoist, dirty shower chair and shower hose, dirty wheelchairs and a raised toilet seat which had rusty fixings so could not be cleaned effectively. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were in place. These ensured prospective staff completed an application form, detailed their employment history and qualifications. Checks on staff character to ensure they were suitable for the role were completed. This included obtaining a Disclosure and Baring Service (DBS) check, obtaining references and ensuring an interview was held. However we saw a reference for one staff member showed they had been subject to disciplinary proceedings, yet when we asked the registered manager if they had followed this up with the staff member or referee they said no.

Inadequate

Is the service effective?

Our findings

At our previous inspection in February 2015 we found a regulatory breach in relation to nutrition as we found people were not given the support they required to eat their meals and the mealtime experience was poor. Following the inspection the provider told us in their action plan that they had made improvements and introduced two mealtime sittings so people received the support they required. At this inspection we found these improvements had not been sustained.

On both days of the inspection we found people were not provided with drinks when they got up in the morning. On the first day we arrived at 8am and saw people sitting in the lounges without any drinks. One person said to us, "I'm dying for a drink, I'm very thirsty." Two other people told us they were thirsty and had not had a drink yet. At 8:50am both were given tea to drink, which had been poured from an insulated jug. One person said, "The tea's not right hot, I like my tea hot." This was not picked up by staff and although this person was given a second cup of tea that one was not to their liking either. On the second day we arrived at 6am and found five people up in the lounges, again no one had a drink. People told us they would like a drink, but it was only when we asked staff that drinks were brought, however, this was not for everyone. We saw one person who was in the lounge at 6am did not have a drink until 9.45am and another person who was up at the same time got their first drink at 10am.

On both mornings from the time we arrived up until breakfast was served at 8.55am we heard people saying they were hungry. Two people were in the dining room at 7.15am and one said, "I'm hungry. What are we waiting for? Are we having breakfast?" Responses from staff included, "The cook hasn't come yet" and "You're going to have breakfast shortly when the cook comes." At 7.40am when the person repeated that they were hungry and wanted something to eat, a staff member offered to make them some toast, the person said yes please and the staff member said they would bring it, but the toast never arrived.

We found mealtimes were task orientated and took little account of people's individual needs or preferences. On both mornings the cook arrived with the breakfast trolley at 8:55am. There was porridge and cereals on offer. The cook did not ask everyone what they wanted and served people with what they normally had. One person said, the milk to cornflake ratio was too high, and we saw they only had a small amount of cornflakes in their bowl. No one was offered seconds of porridge or cereal. The cook then produced a tray of toast which had been pre-spread with margarine. There were also hard boiled eggs in a large bowl, which had been taken out of their shells. People were then offered an egg and toast or toast and marmalade. When people chose toast and marmalade the marmalade was put on by the cook. No fruit juice or cold drinks were offered to people with their breakfast. After breakfast the cook asked each individual what they wanted for their lunch and tea from the two options available for each meal. There was no menu on display to inform people what was on offer for any of the meals that day.

At lunchtime the tables were set with tablecloths, placemats, cutlery, serviettes and plastic tumblers. People started to gather in the dining room at 12.15pm. The radiators in the dining room were not on and two people commented they were cold. Lunch was served at 12.50pm which meant some people had been waiting for over half an hour. One person started singing, "Why are we waiting?" A staff member told us

there were usually two sittings but said this hadn't happened due to a lack of communication. There were no condiments or sauces on the tables, although people were offered a choice of orange or blackcurrant squash to drink. People we spoke with could not remember what they had ordered for their lunch. There was soup to start followed by chicken casserole or corned beef and onion pie. The portions of chicken casserole were very small, with between two to six small pieces of chicken on people's plates. No one was offered second helpings even though some people had scraped their plates clean. We heard one person say, "Nice meal today, makes a change." One person didn't eat their hot lunch and was not offered any alternative. Instead they were asked if they wanted fruit which they didn't, so they just had a portion of ice cream for their meal. Another person was 35 minutes late due to care interventions. They were not given soup, just a hot meal which they sat and stared at for 15 minutes and didn't eat it or any pudding. One person who had poor eye sight was not offered any support from staff and we saw them eating vegetables and gravy with their fingers. At the end of the meal staff offered people wet wipes to clean their hands and one person commented, "This is a new thing."

Mid-morning and afternoon we saw people were served with hot drinks and biscuits and in the afternoon, were also offered Quality Street sweets. On being offered the Quality Street one person said, "This is a one off, but very welcome. Biscuits too – what's all this in aid of – don't usually get this but very welcome"

We spoke with the cook who told us they catered for a range of different diets, however, there was no list of special diets in the kitchen and the cook was not fully aware of people who were assessed as being nutritionally at risk. We asked the cook how they fortified people's diets. They told us they used full fat milk and added condensed milk to puddings. They also said they added butter to mashed potatoes, however, we established there was no butter and soft spread margarine was used, which does not have the same calorie or fat content as butter. We asked if they added cream to, for example, soups, mashed potatoes and custards. They told us they did not receive any cream. We asked if they had any information about fortifying people's diets. They looked in their file but there was no guidance available. We also spoke with one of the care staff who provided cover in the kitchen when the cook was off. They could tell us which people were having food supplements but did not know how to provide people with a fortified diet. This was a breach of the Regulation 14 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us five people had DoLS authorisations in place and applications had been made for nine other people. Two of the authorisations had conditions and we found these were being met.

The team leader told us one person received a medicine, an anti-depressant medicine, covertly and said the medicine was put in the person's coffee. We reviewed the care records for this person and found there was no legal framework in place which would allow this medicine to be administered covertly. Whilst we saw a record dated February 2015 where a GP and pharmacist had agreed an antibiotic could be administered covertly in this way, there was no evidence to show any discussions had taken place regarding the covert administration of the anti-depressant. National guidance, (Managing medicines in care homes - National

Institute for Health and Care Excellence (NICE) guidelines March 2014) was not being adhered to. There was no evidence of a best interest meeting, no evidence of a pharmacist's advice, no treatment plan, no instruction as to how to disguise the medicine and no plans to review the practice. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training matrix showed staff were up-to-date with most training although 14 of the 15 staff listed were overdue refresher training in fire safety and 10 staff were overdue refresher training in moving and handling. We looked at the induction records for three new staff and found these did not demonstrate a thorough induction process had taken place. For example, one staff member's induction programme had been signed off by the staff member but was undated and there was no signature of the inductor. This meant we could not establish if the staff member had successfully completed all parts of their induction. The induction records for the other two staff showed their induction had been completed in one day. The area manager told us none of the new staff were undertaking the Care Certificate as staff they recruited had national vocational qualifications (NVQ) in care. However, we found no evidence of these qualifications in the recruitment files we reviewed. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence which showed staff had received supervision and appraisals and the registered manager showed us these had been planned in for the coming year.

People's care records showed they had access to healthcare services such as GPs, district nurses, the community matron and optician. We saw the optician visiting on the first day of our inspection. However, we found professional healthcare advice was not always sought in a timely way. For example, on the first day of our visit we identified from diet and fluid intake charts that one person had had very little to eat or drink in the four days since admission. We raised this with the registered manager and area manager who then contacted the GP and speech and language therapy (SALT) team. When we visited on the second day we were advised this person had been admitted to hospital. We were concerned had we not brought this to the managers' attention this person would not have received the medical attention they required. A visitor told us, "Staff do take action and bring in the GP but only if I prompt them."

Inadequate

Is the service caring?

Our findings

Although we saw staff were caring, kind and compassionate with people, we also found some practices which undermined people's dignity and showed a lack of respect. For example, we saw one person who had gone to rest on their bed after lunch. The room was cold and the window had been left open. The person was lying on top of the bed and had pulled some of the counterpane over themselves to keep warm. They asked us for a drink, but the only drink they had been left with was a cold cup of tea. We saw another person in the dining room eating porridge which was all round their mouth and had run down their chin. They had no napkin and they were trying to wipe it away with their plastic apron. Although staff walked past this person on at least two occasions it was only when we brought this to their attention that staff helped the person wipe their mouth. We saw a further person unzipping their trousers in the lounge, exposing their underwear. There were no staff present to offer assistance. We asked the person what was wrong and they said their trousers were cutting into them. We went to find a member of staff to assist them.

At breakfast time we saw a staff member take one person their medicines. The person had just been given their breakfast. The staff member asked the person, "Do you want your tablets?" The person either didn't hear or didn't understand so the staff member asked again. The person still did not understand and said, "How much do I owe you?" At which point the cook leant across the table and with their face very close to the person's face raised their voice and said, "Do you want your tablets?" The person pulled back from the cook, looked upset and said no. The staff member then asked the person if they could put their eye drops in, to which the person replied, "No, I don't want anything in my eyes." All this took place while the person was trying to eat their breakfast and showed a lack of consideration and respect for the person and compromised their dignity.

We found people had not been supported to maintain good personal hygiene. We saw in the staff induction book the following statement, "When you can smell urine or faeces it means someone needs taking to the toilet and changing." However, we saw staff did not recognise or respond when these signs were evident. For example, one person was only taken to the toilet after we pointed out the heavy odour of faeces. We observed another person calling, "Help me someone" after they had been incontinent in their chair.

Care records we reviewed showed people were being showered in lukewarm water with the water temperature recorded as between 34 and 35°C. These temperatures were confirmed when we tested the water at the shower the registered manager told us people used. Given people's body temperature is around 37^{0}C we concluded the shower was not hot enough for people to use in comfort. We saw in one person's records an entry which stated, "(Name) had a shower, was screaming a little bit, staff reassured." The shower records for this person showed the water temperature to be 34^{0}C.

One person's care records showed they had a full set of dentures, yet there was there was no denture pot in their room for them to soak their teeth. In a double bedroom we saw there were two plastic tumblers each containing a toothbrush and toothpaste. We asked the registered manager how staff knew which toothbrush belonged to which individual. They said the plastic tumblers should be labelled, however, there were no labels in place.

We found aids to promote people's independence and help their orientation with time and place were lacking. For example, two of the three clocks in the lounges were not working and on several occasions people asked us the time. One clock also had the wrong date on and stated it was Monday August 10th. There were no signs to indicate bathrooms and toilets and we saw one person was struggling to find the toilet.

On both days of our inspection we found the communal areas of the home were cold, particularly in the morning. People who were sitting in these areas when we arrived told us they felt cold. There were no room thermometers, although, when we raised this with the registered manager they brought one from the office to check the temperature in the front lounge which was noticeably cooler than the other rooms. The temperature was 19 degrees centigrade. At lunchtime on the first day the dining room was cold and two people commented they felt cold. The radiators were off and we found they came on at 4pm. We saw people were sat in the dining room for at least two hours after lunch. We heard staff telling them from 2.45pm onwards, "It's nearly tea time." We saw some of the bed sheets were very thin and a lot of the towels were frayed and in a poor condition. This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people using the service were consulted about the way the home was managed and reviewed the monthly residents meeting minutes from February 2015. However, there was nothing documented about people's views. Minutes were repetitive stating, 'All present said they were happy with the current menu' and 'People reminded to wear well-fitting footwear' and 'Home clean and comfortable'. The care records we reviewed did not show how people or their representatives were involved in planning their care.

We observed, although staff were busy, they were caring, kind and patient in their interactions with people. They listened to people and spoke calmly with them providing reassurance. One staff member, who heard a person saying they were cold, said to them, "Come over here and put your hands on here (the radiator) it's lovely and warm." The person came over and put their hands on the radiator saying, "Oh, that's lovely on my hands." People told us they liked the staff. One person said, "Staff are all nice with me here". Another person told us, "It's okay here. Staff are okay too." A relative commented, "Staff work hard, are tolerant and lovely girls."

We saw people had made the following comments about staffing in the surveys completed in January 2016. "Find staff kind and caring" and "Staff are lovely and quite supportive" and "Always answer any questions."

Inadequate

Is the service responsive?

Our findings

We found care and support was not planned or delivered in a person-centred way to meet people's individual needs and preferences. We found many aspects of care were task orientated which meant people's individual needs were not taken into consideration. For example, on the first day we saw drinks being given out to people by a new member of staff. They gave a drink to one person who was slumped in a chair asleep. The person was not asked what they wanted to drink and the drink was left beside them untouched while the staff member took the drinks trolley to people in the other lounge. When the person awoke 50 minutes later they moved to sit in another chair and although there was a staff member in the room no one noticed the person had not had their drink.

Night staff told us they had to get up between 14 to 16 people before they finished their shift at 8am. Although staff told us they started getting people up at 6am we found there were five people up when we arrived at 6am on the second day of our visit, which showed people were getting up much earlier. Three of these people were asleep in their chairs. When one person was brought into the lounge at 6.55am they said to us, "Oh I am tired." Another person's care plan said they had to be 'one of the first to get up in the morning due to high risk of falls'. We concluded people were getting up at these early hours for the convenience of staff rather than as a result of personal preference or choice.

Although staff told us people had been individually assessed and prescribed continence products to meet their needs, we saw pads were kept centrally rather than in people's rooms and distributed communally. There was no information in people's care records to show the type of continence pad they used or how many they had been assigned. Staff we spoke with said, 'We all just know who has what pad' but could not explain how new staff would know when this information was not recorded. This meant people may not be receiving the care and support they needed to meet their individual continence requirements.

Care records we reviewed contained minimal information and did not reflect people's current needs or detail the support they required from staff. For example, one person's care plan for personal hygiene stated 'one staff to assist with personal hygiene' yet there was no detail about what assistance was required or what the person could do for themselves. One person was prescribed an analgesic patch and other pain relief yet there was no care plan in place to show how this person's pain was managed or where to apply their pain patch. We spoke with this person on the first day of our visit and they told us they were in pain and had not been sleeping well because of this. When staff had gone to replace the person's weekly analgesic patch that morning the previous patch was missing and staff were not able to determine when it had come off as there were no checks in place to ensure the patch was still there. The person and their visitor told us the patch kept coming off because staff put cream on where the patch was located. The person said they would prefer to have the patch on their thigh but said no one listened. When we went back on the second day the person had been seen by their GP who had reviewed their pain relief and agreed the patch could be applied to the person's thigh. The person told us their pain was much better now.

Care records showed some people were nutritionally at risk. However, we found staff were not accurately recording people's food and fluid intake. For example, we saw staff had recorded on one person's food chart

they had eaten chicken casserole at lunchtime, however, we had observed this person had only eaten tomato soup and two small spoonsful of fruit. We looked at the food and fluid charts for another person who had only recently moved into the home. These showed they had eaten and drunk very little for three days, yet there was nothing in their care records to show what action had been taken as a result of this. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activity programme was displayed in the home which showed a different activity each day. The registered manager told us the activity co-ordinator had left and they had recruited a replacement who had not yet started in post. We saw care staff were constantly busy and were not able to spend quality time with people. Although staff were kind and caring, we observed interactions with people were fleeting and usually centred around care tasks. There was little to occupy or interest people other than the televisions which were on in the lounges all day. One person commented it was 'too noisy'. Another person said, "Oh do stop shouting" when 'Come Dine with Me' was on at loud volume in the afternoon.

On the first day an additional staff member came in during the morning and used a World War 1 memory box on loan from the local museum as part of a reminiscence session and we saw some people enjoyed participating in this activity. We also saw some people had a manicure. Staff told us of previous visits to museums and Blackpool and said other activities that had taken place included chair exercises, movie and popcorn, cake decorating and summer events. We saw a notice displayed about monthly church services and communion.

We observed two people were quite active walking around the home and looking for something to do. One person spent a lot of time in the dining room and we saw them rubbing their hand over one of the dining room chair seats, arms and legs as if they were cleaning them. Another person spent time walking between the communal areas and found the telephone on the medicines trolley, but were quickly redirected by staff back to the lounge. There was a lack of stimulation and meaningful activity for these people.

In the surveys which had been completed in January 2016 by people using the service and relatives we saw the following comments had been made in relation to activities. "I never see any activities" and "Don't see much activities" and "More entertainment needed" and "Not enough activities" and "Service users enjoy sing-a-longs and should do more of these." A relative who visited almost daily said no activities had been done in the last 18 months. Another relative said there had been an activity person until recently, who played cards and games with people.

We saw the complaints procedure was displayed in the home. We looked at the complaints records and found only one complaint had been received since the last inspection in February 2015. The record showed the complaint had been investigated and a written response outlining the findings had been sent to the complainant.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who was present on both days of the inspection, as was the area manager. Following the last inspection in February 2015 the provider submitted an action plan which showed actions had been taken to address the regulatory breaches identified. This included increased staffing levels, protocols for 'as required' medicines, two sittings at mealtimes to improve people's dining experience and allow staff to provide support where needed and a full quality monitoring and audit system to ensure these improvements were sustained. The area manager also provided us with a copy of a progress report completed by an external consultant in July 2015 which concluded the service was compliant with the regulations which had been breached at the February 2015 inspection.

However, from the issues identified throughout this report it was evident that these improvements had not been sustained and the service provision had in fact deteriorated. Although a range of audits were undertaken we found these were limited in their scope and did not result in overall improvements. For example, the area manager told us medicine audits were carried out weekly by the registered manager or support manager. We saw these audits focused on only certain areas of medicines management and although the last audit had been carried out two weeks before our inspection none of the issues we identified had been picked up in the audit. Similarly when we looked at the care plan audits it was not clear whose care plans had been reviewed and where an issue had been identified there was no information to show whose responsibility it was to resolve the issue or the timescale for doing so. For example, an audit dated 11 January 2016 identified one person had no malnutrition universal screening tool (MUST) in their care file, there was nothing recorded to say what had been done about this and when we checked the person's care file we found the MUST form was blank. Their care plan dated September 2015 stated the MUST was to be completed monthly.

We asked for the audits of people's weights and were told people's weights were recorded in their care plans. This meant there was no managerial oversight of people's weights or system in place to monitor people's weights over time without going through each person's care plan. We asked to see the audits of falls, and were told no audits were in place. This meant no analysis of falls was taking place to see if any additional measures could be put in place to reduce the number of falls.

We asked the area manager for copies of the quality monitoring visits they undertook on behalf of the provider. They said they carried out regular audits but only had a report from their visit in January 2016 as all the other reports were archived at head office. They later provided us with an audit they had carried out in December 2015. Both reports lacked detail. The December visit report gave a long list of actions which should be taken by the manager and staff. These were generic rather than specific and there were no timescales for completion. Written at the bottom of the report it stated, 'This audit is more of a guide and check list to get you all started on the same wave length'. The January report was a further list of actions again with no timescales.

We found the staffing tool which the provider told us they had put in place following the last inspection was no longer being used. The registered manager and area manager said the reason for this was because the

tool had calculated very high staffing levels and indicated one to one staffing was needed. When we asked how staffing levels were determined without the tool both managers told us it was 'through discussion' and said dependencies were considered but they were unable to show us how people's dependencies had been determined. Although the area manager told us they had taken action to increase the staffing levels following the first day of our inspection this was as a direct result of our feedback and not as a result of the provider own governance systems. We saw people had made the following comments about staffing in the surveys completed in January 2016, 'More staff (needed) at times' and 'Understaffed, always very busy'. This showed concerns had been raised about staffing levels yet no action had been taken to address this until our inspection.

We saw accidents reports were reviewed monthly by the registered manager, although they acknowledged the audits were behind with the last one recorded in October 2015. We found the audit was limited as it only listed the accidents which had occurred during the month, the times and if there were any injuries. There was no analysis of the information to identify trends or themes or look at 'lessons learnt' to prevent recurrences. When we reviewed the accident and incident forms we found they were poorly completed and there was often no evidence to show what action had been taken. For example, an accident report from September 2015 showed a person had been found on the floor in their bedroom with the bed rails up on the bed. There was no information to show this accident had been investigated to establish if bed rails were suitable for this person and when we checked this person's care plan it showed bed rails were still in place. Another report dated September 2015 showed a person was found on the floor by their bed with injuries which required hospital treatment. The report showed the sensor mat had not activated when the person fell. There was no further detail to show this accident had been investigated or what action had been taken as a result to keep the person safe. When we looked at the accident audits completed since the last inspection we found the number of accident occurring each month varied greatly with only one accident recorded in July 2015 and 17 recorded in September 2015. This had not been identified or explored by either the registered manager or area manager.

We saw the results of a survey sent to relatives and people who used the service completed in December 2015 was on display in the hallway. The results had been presented as a bar chart, which we concluded would not be meaningful for people living with dementia or other cognitive impairment. We saw 'Activities' had been rated as good/excellent. When we looked at the three surveys which had been returned we saw the comments about activities were as follows; 'Hair and nails on a Tuesday' and 'Don't know' and 'Think it depends on the level of interest'. Given these comments it is difficult to see how a rating of good/excellent was given. We saw ten surveys which had been completed in January 2016. We saw people had commented on similar areas for improvement as we found during our visit. For example, needing more staff and activities.

When we visited on the second day the area manager told us they had taken immediate action following our feedback on the first day and had addressed all the issues we had mentioned and provided us with a list of actions they had given the registered manager to complete. However, we found the same issues occurring on the second day as we had witnessed on the first day. For example, no toilet roll in a bathroom used frequently by people who used the service, used continence pads not being bagged before staff disposed of them, people not receiving drinks when up early in the morning and lounges cold. This demonstrated the lack of effective governance systems in identifying and resolving issues which resulted in people receiving poor quality care. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.