Care Quality Commission

Mr & Mrs F Ruhomutally

Northgate House (Norwich)

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

Overall summary

We had carried out a previous inspection on 08 July 2014 where breaches were found of six regulations relating to the premises, cleanliness and infection control, meeting people's nutritional needs, supporting staff, assessing and monitoring the quality of the service and the reporting of deaths. We had issued a warning notice on 04 August 2014 in respect of the premises. We carried out a further inspection on 15 September 2014 to establish whether the warning notice had been complied with and we found that it had been. This inspection took place on 03 and 04 June 2015 and was unannounced. It was carried out to establish whether appropriate action had been taken to ensure the service complied with the regulations.

Northgate House is a residential home providing accommodation and care for up to 22 older people.

There is a registered manager in post who is also one of the joint owners of the home and is referred to as the provider throughout this report. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

At this inspection the provider was in breach of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Each of the areas that were found to be in breach during our July 2014 inspection were still in breach under the equivalent new regulations.

People held mixed views about the service whilst their family members were more positive. Whilst some people were satisfied with the care and support they received in the home, others were not.

People's safety had been compromised in a number of areas. The premises, both internally and externally, needed maintenance to ensure the welfare and safety of people living in and working in the home. Risks to people's welfare were not routinely reviewed and were not always acted upon. Staffing levels were not always adequate throughout all times of the day the day to ensure that people's needs could be met. Hazardous cleaning materials were left unsecured. Care plans did not contain enough detail for staff on how to look after people in accordance with their needs which put people at risk of poor or unsafe care. We found that medicines management arrangements and administration practices were not robust. We noted concerns regarding infection prevention and control measures in the home.

People were not receiving effective care. Training arrangements were haphazard and staff had not received the training and supervisory support they required to ensure they cared for people in a safe and effective way. People were not adequately assessed to identify if they were at risk of poor nutrition. Where health professionals had been involved in people's care their guidance was not always implemented.

People had mixed views about how caring the staff were. Whilst we observed that staff spoke in a respectful and friendly manner with people some day to day practices in the home were not respectful and did not uphold people's dignity.

The quality of the care records was poor. There were inconsistencies and they lacked detail about the health conditions people were living with and how staff needed to support them. There was little to occupy people's time in the home.

The service was poorly managed. There was very little monitoring of the quality of the service provided taking place. There was not a satisfactory complaints system in place. Where people's views had been sought, they had not been acted upon.

The overall rating for this provider is 'Inadequate'. This means that it is in 'Special measures.' Special measures in Adult Social Care provides a framework within which we can use our enforcement powers in response to inadequate care and can work with, or signpost to, other organisations in the system to help ensure improvements are made. Services in special measures are kept under review and, if we have not taken action to cancel the provider's registration, 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people's wellbeing were not routinely identified, reviewed and managed to ensure that people were kept as safe as possible.

People were not protected from risks associated relating to the premises or poor hygiene practices.

Medicines were not managed appropriately and staffing levels were not always able to meet people's needs in a timely manner.

Inadequate

Is the service effective?
The service was not effective.

People had little choice regarding their meals.

Staff training, induction and supervision arrangements were not robust.

Referrals to healthcare professionals were not always made. When guidance was received from healthcare professionals it was not always implemented.

Inadequate

Is the service caring?
The service was not caring.

Day to day practices in the home did not promote people's independence or dignity.

People were not involved in discussions about the care they required or their preferences in how their care was delivered.

Inadequate

Is the service responsive?
The service was not responsive.

People's needs were not always assessed and appropriately planned for in their care records.

Opportunities for people to participate in meaningful or social activities were severely restricted.

Inadequate

Is the service well-led?
The service was not well led.

There were widespread and significant shortfalls in the way the service was being managed.

There were few systems in place to monitor the safety and quality of the service people received.

The provider had not been effective in identifying issues and driving forward required changes and improvements.

Inadequate

Northgate House (Norwich)

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 03 and 04 June 2015 and was unannounced. The inspection team comprised of an inspector and an inspection manager.

During this inspection we spoke with seven people living in the home, relatives of two people, the provider and four care staff members.

We observed care and support being provided to people living in the home on both days of our inspection.

We looked at the care plans of six people and at records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of July 2014 found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to cleanliness and infection control. We had found that some carpets and commodes had not been appropriately cleaned. Whilst the provider had acted to rectify these specific concerns our June 2015 inspection found other areas of concern.

The provider had no processes in place to ensure that infection control risks were identified and acted upon. During this inspection we found that the seat of the bath chair lift in the downstairs bathroom had ingrained soiling. The baseplate was chipped and rusty. Several waste bins in bathrooms and bedrooms had no liners. We noted an unpleasant odour in an upstairs toilet. Chairs in the porch had stained seat cushions and we observed dirty wheelchairs. An upstairs bath had been resealed with a clear sealant, but the mouldy sealant below had not been removed and was visible. A large clinical waste bin was unlocked in an unsecured part of the front garden.

Staff told us they had run out of gloves and aprons for a four day period two weeks prior to our visit.

These failings meant that the provider was in breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of July 2014 found there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to the safety and suitability of the premises. A roof in the new kitchen extension was not watertight which resulted in water flooding onto the kitchen floor during heavy rain. The laundry flooring was a trip hazard and of a material unsuitable for use in a laundry. A warning notice was issued in relation to the breach of Regulation 15. We then carried out a further inspection In September 2014 and found that the provider had made the necessary improvements and we determined that they were no longer in breach of this regulation.

However, this June 2015 inspection again identified concerns in relation to the premises. The provider had no processes in place to ensure that premises related risks were identified and acted upon to ensure they were safe. One person's bedroom carpet was severely rucked up and posed a trip hazard for the person who mobilised with the aid of a walking frame. Several toilets without natural light had very dim lighting which posed a risk to people with visual impairments putting them at risk of accidents. A toilet in the main corridor had a screw protruding from the woodwork. There was a severely rusted radiator in one bathroom which had an abrasive surface.

These failings meant that the provider was in breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive safe care in the home because adequate steps were not taken to reduce the risks to people's welfare. One person had sustained several falls in a seven month period, but had not been referred to the local authority falls team. The provider told us this was because there was, "… no point as there is nothing they could do." Incident reports referred to the person as having been 'found on the floor in the lounge – they missed the chair' and 'found on the floor in the lounge – they said they lost their balance'. However, according to the person's care records they should have had a staff member with them when mobilising. We referred our concerns to the local authority's safeguarding team.

Another person who was cared for in bed had been identified as being at a very high risk of developing pressure areas. No pressure area risk assessments had been carried out since March 2012. A risk assessment dated December 2011 said the person required repositioning on their sides every two-three hours. Some staff members told us they repositioned this person every few hours but one staff member said this person wasn't regularly repositioned. There were no records to indicate the current risk to the person of pressure areas or how or when then the person was being repositioned. We referred our concerns to the local authority's safeguarding team.

Two people living in the home were living with diabetes and required insulin. There was no guidance for staff about what people's acceptable result range for blood glucose monitoring was or the physical symptoms that could indicate low or high blood glucose levels or what action should be taken. The provider told us what they thought people's acceptable blood glucose levels were. We saw from records that sometimes people had higher blood

Is the service safe?

glucose levels than the provider had told us was acceptable but we did not always find that staff had taken action. We referred our concerns to the local authority's safeguarding team.

For one person a note had been made that should their blood glucose level exceed a certain level, then an extra two units of insulin could be given. The provider told us that this note had been made by a nurse. However, the person had subsequently undergone a diabetes review with their GP who had amended their prescription. We found one instance where the extra two units of insulin had been given after the GP had amended the prescription. There were no records to advise staff whether the previous guidance was still relevant. We referred our concerns to the local authority's safeguarding team.

The fire list being used was not accurate in recording people's mobility levels. One person was recorded as being 'able' but the person required equipment and staff support to mobilise. There was no information about factors such as auditory, visual or cognitive impairments that people were living with. Inaccurate and insufficient information could result in people being at risk of not receiving the support they required from emergency services to evacuate the building in the event of an emergency.

These failings meant that the provider was in breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff required specific training relevant to the individual's needs before they could administer insulin to two people living at the home. Staff had not received this training. This put people at risks of receiving unsafe treatment which could be detrimental to their welfare. This concern was referred to the local authority's safeguarding team. Following their intervention, it was arranged for the community nursing team to administer insulin to people pending staff receiving the proper training and guidance they required.

This was a breach of Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they required them. One person said, "They're very regular with the medicines I need." However, another person told us how a staff member had tried to give them a tablet that was not theirs and refused to take it. The provider had subsequently confirmed to them that it wasn't their tablet. Had the person taken this medicine it could have placed them at risk of harm.

Some medicines required specific secure storage arrangements. The provider kept these medicines in a small portable safe which was unsecured within a larger locked cupboard. This arrangement did not meet the safe storage specifications for these medicines.

In the medicines cupboard there was a plastic bag containing a new delivery of one person's medicines following a review of their medicines by their GP. However, this delivery was not accounted for in the stock records of the home. The senior carer told us this was because they were waiting for the new Medicines Administration Record (MAR) which was due in with the next delivery. We asked to see the returned medicines book, but the provider told us this was not in the home and had been left at the pharmacy. Consequently we were unable to verify the arrangements we were told were in place in relation to unused medicines.

The failings we identified in relation to management of medicines meant that the provider was in breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they could wait for up to 15 minutes for staff to assist them during busy periods. One person told us, "I just can't wait that long when I need to go to the bathroom. And then I have to wait again for them to help me have a wash." Another person said, "There's not enough staff. Some people shout and shout but no-one comes and they end up trying to get up from their chair without help and sometimes they fall." On several occasions during our inspection no staff were in the vicinity of the lounge where most people spent much of their day. On the first day of our inspection there were two care staff on duty, the provider who was also doing the cooking and a cleaner. There were 18 people living in the home on this day. The care staff on duty were required to administer people's medicines, do the laundry, assist people with activities, serve meals and snacks as well as provide general care and support. The provider told us that they knew what people's needs were and did not use any dependency assessment tools to help determine what appropriate staffing numbers would be.

Inadequate

Is the service safe?

Staff told us there were not enough staff on duty on this day, but often there was a third care staff member who worked from 10am until 7pm which made things easier during these hours. Staff told us that when only two care staff members were on duty during the day it was almost impossible to ensure people received the care and attention they needed. They said that mornings were particularly busy with the medicines administration round co-inciding with the breakfast period. Of the 23 days prior to our visit there were 14 day shifts with only two care staff on duty. This was insufficient to ensure people's needs were met.

Adequate staff numbers were not always deployed to ensure people's needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people we spoke with told us that they felt safe in the home. One person told us, "I'm safe and feel looked after." However two people told us that some staff members shouted at them on occasion and sometimes ignored them. One of these two people told us, "I shouted back, so it's better now." Both people told us they didn't want to tell the provider about their concerns.

Staff we spoke with, including a new member of staff, understood about different types of abuse and were able to tell us about them and what action they would take if they had any concerns. They also understood they could inform external organisations such as the local authority or CQC if they had concerns that they did not think were being addressed satisfactorily within the service. However, the safeguarding issues and concerns we identified had not been identified by the staff or the provider.

On the first day of our inspection we found that numerous hazardous cleaning products and household substances such as bleach, toilet cleaner concentrate, wood stain, paint, spray adhesive and lighter fluid were unsecured in a storage room and a storage cupboard. A cleaner had left their trug of cleaning products on the floor of one person's room unattended. The substances posed a significant risk of harm to people if they were ingested accidentally. We brought this to the attention of the provider and on the second day of our visit we found that these hazardous products had been secured.

Before staff were employed the provider carried out the required recruitment checks, which included making a request for a criminal records checks for each member of staff, obtaining references and proof of identity. These checks are used to assist employers in making safe recruitment decisions.

Inadequate

Is the service effective?

Our findings

Our previous inspection of July 2014 found there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to meeting people's nutritional needs. Our July 2014 inspection had found that the service was not monitoring one person who was at risk of not eating enough. People had not been weighed regularly or assessed against a nutritional screening tool on a routine basis.

During this June 2015 inspection we found that people were being weighed monthly but other concerns remained. People's weights were not routinely assessed using a nutritional screening tool to identify if they were at risk of not eating or drinking enough. The provider told us they felt this was only necessary on an annual basis. This meant that trigger points for when further action might be required to support someone with their nutrition could be missed.

People were not given a choice in relation to food. One person told us that cereal was already in the bowl on the table when they arrived in the morning sometimes so they felt obliged to eat what they had been given. One person said, "There's a menu on the wall, but it's not kept to. Sometimes we get something different altogether." Another person told us that whilst they didn't automatically get a choice, something else would be provided if they asked. The provider told us that they knew people's preferences and made changes if someone had a known dislike of something in particular. People we spoke with confirmed this was the case.

Food was not always suitable for use due to it being in a poor condition or improperly stored which resulted in risks to people's health. In the kitchen extension the net of onions in use had a best before date of 12 April 2015. The few onions left had sprouted. The recently opened sack of potatoes showed that they were beginning to sprout and had softened. Sprouted potatoes contain glycoalkaloid solanine which can cause people to become poorly. We also observed open sacks of rice and sugar in a warm storage cupboard which could have resulted in contamination.

Appropriate equipment or crockery was not provided to assist people to eat their meals. One person was struggling to keep their food on their plate as they could only use one hand to hold cutlery. Much of their lunch had ended up on the table or the floor. A senior carer agreed that the person might benefit from a plate guard to stop their food from spilling off of their plate. One person told us that they often enjoyed a boiled egg, but no egg cup was provided. A friend had brought one in for them.

These failings meant that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of July 2014 found there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to supporting staff. We had identified that staff were not receiving appropriate training, supervisions or appraisals.

During this June 2015 inspection the provider told us that they were using a new training company. The provider was unable to give us an overall view of the training staff had received as the records kept were disorganised. Four of the seven staff members who administered medicines had received training in June 2014. However there were no certificates available for the remaining three staff. The provider had not carried out any competency testing to assure themselves that staff were safe to administer medicines to people.

The provider told us that their new training provider had provided food hygiene training prior to mid April 2015 but had not sent them the certificates.

We looked at the records for a new staff member who had been in post for two months and was supporting people living in the home. There was no induction plan for this person. The staff member told us they had completed training in moving and handling and safeguarding but that other training had yet to be completed. The provider told us this staff member would be doing an intensive training course covering a variety of topics, but this had not yet been arranged. This put people at risk of receiving unsafe or inappropriate care.

Staff told us that they did not receive appraisals or supervisions and that they did not receive the training that they needed. Some felt that whilst the provider assisted with people's day to day care they did not ensure that staff practices were safe or effective because they did not routinely monitor how staff carried out their work. Staff were not adequately supported to provide a good standard of care and support to the people living in the home.

Inadequate

Is the service effective?

These failings meant that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care plan stated that they were not for resuscitation. However there was no Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision in place. The provider told us that there had been a DNACPR decision in place when the person had been quite poorly but when they recovered the decision was no longer appropriate and it had been removed. They had failed to cancel the written instruction on the care plan. There was a risk that the person might not receive life sustaining treatment if there was poor communication between staff and health care professions in the event of an emergency.

Another person's care plan contained a risk assessment for alcohol consumption. The action stated was that the person was to take alcohol in moderation and to be supervised by staff. The provider told us that this was in the person's best interests. However, there was no evidence to show that the person lacked the capacity to make their own decision or that they had agreed to their rights being restricted in this way.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards. The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful.

The provider and some staff told us that everyone living in the home was able to make their own decisions about their care and support. However, other staff members told us that sometimes people's mental capacity fluctuated and they were not always able to make decisions themselves. One person's care plan stated that they were unable to choose their own clothes. Some staff members had undertaken training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and they demonstrated an awareness of the issues around people's capacity and to consider people's best interests when supporting them to make decisions. However, there were no mental capacity assessments in people's care plans relating to decisions being taken in people's best interests if they were unable to make decisions for themselves.

These failings meant that the provider was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the health records of people who used the service. We saw that care records included a section to record when people were visited, or attended visits, with healthcare professionals. People told us that unless they were poorly their health needs were not discussed with them but they were confident that if they were unwell that staff would make sure they got help. However, most people were not aware of the extent of specialist help that could be called upon. We found that one person should have been referred to the falls team and hadn't been. Another person might have benefitted from further advice from the dietician, but there were no records to show that further assistance had been sought. People living with diabetes did not always receive effective support in relation to their condition.

Inadequate

Is the service caring?

Our findings

One person said, "Staff are caring here." A second person told us that whilst some staff were very good not all staff were caring. They told us that one staff member had refused to assist them from the bathroom and were told that they would need to wait until the next shift started for assistance. The provider was unaware of this allegation. We referred this person's concerns to the local authority's safeguarding team. Two people told us that some staff members shouted at them on occasions.

People we spoke with told us they were not involved in the planning of their care and that no discussions were held with them about how they wished to be supported other than at the point of care being provided. Care plans did not show that people or their representatives had been consulted about their needs, wishes and preferences regarding how they would like their care or support to be given. There was little information about people's personal histories, preferences, likes or dislikes. However, some staff appeared to know people, their families and interests well and utilised this knowledge to speak with people in a friendly and caring manner.

Two people living in the home told us they had attended a meeting six weeks previously to obtain people's views and suggestions about the menu and activities, but nothing had changed as a result of this.

Staff explained how they respected and promoted people's dignity. However we saw that this was not always put into practice. Two people were dressed in clothing badly stained with food. Mid-morning and afternoon tea and coffee was served with a selection of biscuits. People were offered a choice of biscuits but were not given a plate to put them on. People were either eating the biscuits straight away or putting them directly on to tables, which was not hygienic. This was not promoting people's dignity. The provider told us, "There's no point giving people a plate because they can't hold a plate at the same time as their cup."

The environment didn't promote people's dignity or enhance their sense of well-being. One person's room had wallpaper peeling off the walls which had ripped in places and a double glazing window pane had blown and misted up. Other people's bedroom windows looked out onto unkempt areas of the grounds. Another person's privacy had been compromised because their room had been left unlocked whilst they were in hospital. Their belongings had not been secured.

Several people were sitting in the lounge at one point during our visit. The television was on but the volume was very low. One person told us, "I can hardly hear it so I just look at the pictures." They added that the remote control was "…locked away. It's all very secret." We asked a staff member to turn the volume up so people could hear the television. They told us that the remote control kept going missing so it was kept locked away and that people could ask if they wanted a different channel on. Some people spent considerable amounts of time watching the television and were disempowered by being unable to change channels or adjust the volume themselves.

These failings demonstrated that people were not treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During tea time we heard one person repeatedly calling out loudly from the lounge. We went to see what was happening and found the person sitting on their own, clearly distressed with no staff members in attendance. We were told this person had a tendency to call out in distress but there were no staff on hand to comfort them or provide reassurance. Staff were not always able to offer support and reassurance to people when they needed it because they were in a different part of the home and were unable to hear people calling out.

Inadequate

Is the service responsive?

Our findings

Staff did not have a good understanding of how to meet people's needs. People's individual care needs had not been adequately assessed or planned for. People's needs assessments and care plans did not always give enough clear or up to date information to ensure staff knew how to meet people's needs appropriately. Care plans contained inconsistencies that meant the type of support that was needed was unclear. Due to poor records staff would not be able to determine what health conditions people were living with and consequently what support they needed in respect of them. An entry in one person's care record in 2013 said the person had dementia and bipolar disorder but there were no further references to this. A hospital discharge letter dated 2014 made no reference to either of these conditions but stated that the person had epilepsy. There was no care plan in place to support staff to care for someone living with epilepsy or bipolar disorder. Staff we spoke with were not aware that this person had epilepsy. This meant that the person was at risk of not receiving the support they needed in the event they had a seizure.

There were no care plans to show how staff needed to support people living with diabetes. There was no guidance to show how people's nutritional or health needs were to be met.

Guidance within care plans was often vague. One person's dietary care plan had been reviewed in May 2015 and simply stated, 'Requires help, using spoon.' The nature of the help required wasn't specified. Another person's records stated they were to be, 'supported by pillows' but didn't state how the pillows needed to be positioned to support the person effectively. This person was living with a physical impairment and it was important that staff understood how to alleviate any discomfort they might have been experiencing.

Instructions from healthcare professionals which would require a change to the care and support people received were not always incorporated into people's care plans. This was sometimes because a relevant care plan, for example in relation to diabetes, had not been implemented in the first place. We also found advice from a dietician was kept in the kitchen and not also used to update the person's dietary care plan.

People's social needs were not being met. People living in the home told us they were bored and there was little to do. One person told us, "I'm okay here, but there's nothing to do. Every day is the same." This had been a recurrent theme from previous inspections. Staff were expected to support people with their interests or activities but there was little time in which to do this given the other tasks they were expected to carry out. The provider showed us an activities book but much of this referred to staff having conversations with people with little evidence of any activities taking place. One day we observed a staff member playing a board game with one person. Other than this we saw no social activities being undertaken. People were not supported to follow their interests or take part in social activities.

These failings meant that the provider was in breach of Regulation 9(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure in place that was publicised to people. It advised them how to make a complaint and whom they should contact. A suggestions and comments box was in the entrance hall but the provider told us no-one ever used it. However, there were no comment cards available nearby to make it easy for people to make their views known. Two people raised concerns with us about staff that they had not wanted to raise with the provider. They were reluctant to tell us why but were clearly uncomfortable about making their experiences known.

Inadequate

Is the service well-led?

Our findings

Our previous inspection of July 2014 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because effective systems were not in place to regularly assess and monitor the quality of the service.

Our July 2014 inspection identified that the provider had no system to ensure that adequate infection control measures were in place and that these were effectively monitored. During this inspection in June 2015 we found that there were no effective auditing systems in place to provide assurance that risks were being managed within the service and the quality of the service provided for people was robust. The provider was not proactive in identifying areas for improvement and relied upon responding to concerns raised by health or social care professionals on an issue by issue basis.

There were no medicines, premises or infection control audits to establish whether the systems in place in the home protected people from inappropriate or unsafe practices. Accident and incident recording was taking place, but no analysis had taken place to identify patterns or trends so that the risks of similar occurrences could be minimised in future and risks to people's safety reduced. Staff were not provided with supervision that reviewed the effectiveness of the care they provided to people. Care plans were not audited to ensure they contained up to date and relevant information to enable staff to support people appropriately.

Whilst a residents' meeting had been held on 16 April 2015 to obtain people's views and suggestions for improvement for meals and activities, there were no minutes of this meeting and no action plan had been developed to show what improvements would be made and within what timescale.

The provider did not have systems in place to identify or address issues that affected the quality of service people received or the risks they were exposed to. These failings meant that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our July 2014 inspection found a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 because the provider had not been notifying us regarding the deaths of people living in the home. Whilst the provider had now commenced notifying us of deaths they were not giving a description of the circumstances surrounding the death as required by the regulations. This was because they were using obsolete notification forms for deaths, injuries and safeguarding referrals. The provider had not ensured that they kept up date with legislative requirements. Consequently, they were still in breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Externally, maintenance was required to repair the low level wall surrounding the premises. The wooden picket fencing surrounding the flower beds was broken in places and had missing panels. An upturned soft chair was in the front garden. One part of the garden was considerably overgrown. Visible from the pavement to the rear garden, through a metal mesh fence, was a discarded mattress. One person's bedroom had cracks n a wall which had been filled, but the area had not been sanded down or painted and an abrasive surface had been left. An upstairs bathroom had broken tiles on the windowsill.

A bath chair lift had a label on it which indicated that a service had been due in February 2015. The provider told us it had been serviced at the same time as a hoist in March 2015. A service record had been provided for the hoist but not for the bath chair lift. There was at least one other hoist in the home and a stand aid. The provider told us that all lifting equipment had up to date servicing but was unable to provide documentation to confirm this. This presented a risk that people were being helped to mobilise with equipment that might not be safe.

The provider had not demonstrated good management by ensuring that the premises and equipment were properly maintained. The provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had received one complaint in the last year but did not have a complaints register. They were unable to provide any documentation regarding the complaint or how it had been responded to. Consequently, we were not satisfied that the provider had an adequate complaints system in place.

People told us they had recently been given a survey to complete, but it was too early to determine the findings

Inadequate

Is the service well-led?

from this. The survey from 2014 had only generated two responses, both of which mentioned the lack of social activities in the home. However, no action had been taken to improve this.

Relatives we spoke with and some people living in the service thought that the provider would act on their concerns if they had any. However other people living in the service and some staff felt that the provider was not responsive or open to change because when they raised concerns or made suggestions for improvement their comments were acknowledged but not acted upon. One person told us, “It makes no difference. Nothing changes here.”

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because adequate infection prevention and control measures were not in place. Regulation 12(2)(h)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because the provider had not ensured the safety of the premises. Regulation 12(2)(d)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because the provider had not assessed risks to the health and safety of service users and did not do all that was reasonably practicable to mitigate these risks. Regulation 12(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because the provider because medicines were not managed in a safe way. Regulation 12(2)(g)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient staff numbers were not always deployed to meet the needs of service users Regulation 18(1)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided for service users in a safe way because staff had not been trained to administer insulin. Regulation 12(2)(c)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of service users were not met because people did not always receive suitable food, were not offered choices and appropriate support was not provided. Regulation 14(4)(a)(c)(d)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive appropriate training, supervision or appraisal as was necessary for them to carry out their duties. Regulation 18(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not provide person centre care because people's care was not assessed or planned for to ensure their needs and preferences were met. Regulation 9(3)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to. Regulation 17(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider was not providing adequate information when notifying the Care Quality Commission of service user deaths. Regulation 16(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not managed the service to ensure that the premises and equipment were properly maintained. Regulation 15(e)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

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

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.