Mr Kevin Hall

Acorns Care Centre

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on 23, 26 February 2016 and 14 March 2016.

Acorns Care Centre is registered to provide accommodation and support for up to 39 older people. The service provides residential and nursing care as well as care for people living with dementia. The home provides single occupancy rooms with en-suite facilities, across three floors. There were two communal lounge areas located on the middle and top floor. The home had a large dining area on the ground floor. The home was serviced by one lift. At the time of the inspection there were 36 people living at the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We conducted a scheduled inspection of the home on 08 October 2013 when we found the service was non – compliant with cleanliness and infection control and assessing and monitoring the quality of service provision. A responsive inspection was conducted on 02 December 2013 and the service was found to be non-complaint with records. A further responsive inspection was scheduled and undertaken on 18 March 2014 when the service were found to be compliant with all areas inspected

During this inspection, we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to person-centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, receiving and acting on complaints, good governance and staffing. We are currently considering our enforcement options in relation to these regulatory breaches.

People told us they felt safe but expressed concerns regarding staffing levels. We found that there was not enough suitably trained and experienced staff on duty to meet people's social, emotional and physical needs. Staffing levels were not calculated using a formal calculation based on the needs of people using the service. We observed staff were ineffectively deployed which resulted in people's care needs not being met.

People's medication was not managed safely and effectively. Medication was not given as per prescriber's instructions and did not reflect best practice in some areas.

We identified serious concerns regarding risk management that we immediately fed back to the registered manager and we shared this information regarding our concerns with the local authorities safeguarding team and local commissioners to mitigate the risk of further harm occurring.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation

of Liberty Safeguards (DoLS). Mental Capacity assessments were not conducted. The registered manager had no oversight as to when Deprivation of Liberty Safeguards authorisations had been requested or granted. We found two granted authorisations which had expired. This meant that people were being deprived of their liberty unlawfully.

People told us the food was good but we found menus were not devised in conjunction with people at the service and was not reflective of people's preferences.

The environment did not meet good practice guidance for supporting people living with dementia.

We observed incidents when people's privacy and dignity was compromised and their confidentiality was breached. We also saw care records were kept in an unlocked cabinet in an unlocked office which was unattended by staff for large periods of the inspection.

Risk assessments and care plans were generic. People and their relatives had not been involved in initial assessments or reviews. People's biographical information, likes and dislikes wasn't captured to support person-centred care planning.

People were not supported to live full and active lives. There was no stimulation or attempts made to engage people in meaningful activity. People told us they would like the opportunity to go on trips but this had not been addressed by the management.

We were told that there had been no complaints received. We observed the complaint process was not visible within the home and we encountered difficulty obtaining a copy of the complaints policy. People living at the home told us they had expressed concerns and complaints but these had not been recorded or acted upon.

We found that there was no effective system in place to monitor and plan improvements to the service provided.

The provider did not have a system in place to assess the quality of the service. There were no audits carried out. We were told resident and staff meetings were conducted but there were no consistent records to determine actions identified during the meetings were followed up.

We identified significant shortfalls in the care provided to people at the home. This was linked to ineffective governance arrangements and leadership which resulted in the management having a lack of oversight regarding the home.

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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, they 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

People's risk assessments had either not been carried out or not fully completed. Individual risks to people who used the service were not consistently assessed and findings acted upon.

Medication was not always administered as prescribed.

The service had failed to deploy sufficient numbers of staff to meet people's needs and keep people safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training, support and supervision needed to enable them to support people effectively.

Mental capacity and restrictive screening assessments had not been carried out. Deprivation of Liberty Safeguards had been authorised but subsequently expired. People were being deprived of their liberty unlawfully.

The environment did not meet good practice guidance for supporting people living with dementia.

Food was plentiful and people appeared to enjoy their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives shared mixed experiences of the care and support received.

Some staff did not always interact with people who used the service in a manner which promoted their human rights and protected their privacy and dignity.

We did observe some positive interactions between staff and people who used the service.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have access to appropriate stimulation or activity to support people to live fulfilled and meaningful lives.

People and their representatives were not involved in an initial assessment or the ongoing planning of their care.

People's care records were not person centred, and were not reflective of people's preferences.

Peoples concerns and complaints had not always been listened to and acted upon. Complaints from people living at the home had not been recognised, investigated or recorded.

Is the service well-led?

Inadequate

The service was not well led.

The systems for checking the safety and quality of the service were ineffective or not in place, which placed people at risk.

The provider had failed to provide quality assurance or oversight of the home.

The service did not effectively demonstrate how the views of people who used the service and/or their representatives were sought.

Acorns Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was carried out on 23, 26 February and 14 March 2016. The visit was unannounced on 23 February 2016 and announced on 26 February 2016 and 14 March 2016. All the inspection visits were carried out by two adult social care inspectors and on 23 February 2016 a specialist advisor (SPA) supported the inspection. A SPA is a person with a specialist knowledge regarding the needs of the people in the type of service being inspected. Their role is to support the inspection. The SPA was a registered general nurse (RGN) with specialist experience in nursing and dementia care within nursing and residential care settings.

At the time of the inspection there were 36 people living at Acorns Care Centre. The home provides single occupancy rooms with en-suite facilities, across three floors.

Throughout the day, we observed care and treatment being delivered in people's rooms and communal areas, which included communal lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We asked people for their views about the service and facilities provided. During our inspection we spoke with the following people:

- 11 people who used the service
- four visiting relatives
- 12 members of staff, which included; the registered manager, three nursing staff, five carers, a volunteer, two students and a catering member of staff.

We looked at documentation including:
- eight care files and associated documentation
- six staff records including recruitment, training and supervision.
- five Medication Administration Records (MAR)
- audits and quality assurance

• variety of policies and procedures
• safety and maintenance certificates

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We liaised with external professionals including the local authority and Healthwatch. Environmental Health and Infection Control identified issues of concern which were considered during our inspection and are detailed within the body of the report. We also reviewed previous inspection reports and other information we held about the service.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe living at the Acorns Care Centre and we were told; "I feel quite safe here and looked after well." "I've never felt unsafe living here." "I feel quite safe here, I have my own bedroom." "I do feel safe but I sometimes wonder where all the staff might be during the day."

During the inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs. We were told staffing levels were not calculated using any formal method based on people's dependency. The registered manager told us; "If we have poorly people, we increase staff." We found that there were insufficient numbers of staff to meet people's needs and the staff on duty were ineffectively deployed. We heard people shouting for help and on occasions we were unable to find staff to assist people. We attended handover and noted staff were not deployed to the ground floor. This resulted in people being left for long periods of time on the ground floor with no staff presence to monitor their needs and ensure their safety.

People told us; "I don't really think there is enough staff on duty some days." "The staff are doing their best but they always seem very busy and rushing around." "I've sometimes had to wait a long time at night when I've needed the toilet and pressed my buzzer. I worry that I might have an accident if I have to wait too long."

We looked at call bells and saw that some people didn't have a call bell and other people had a call bell that was out of their reach which meant they would be unable to request assistance if needed. A relative told us they had raised this issue with the manager but we had observed their relative shouting that morning and had noted their call bell was out of their reach. This resulted in a member of the inspection team having to find a member of staff as there were no staff on the floor at the time. We were later informed that the person had been incontinent whilst waiting for assistance.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection, we looked at the care and support documentation foreight people who used the service. We did this to establish if people were receiving the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We found risks to people's health and welfare were not appropriately assessed and managed, which had resulted in avoidable harm. For example; we saw one person had a wound that was graded 1cm diameter. However, there was no documentation to support the wound dressing being changed as per the directions in the care plan and we noted that due to the care plan not being followed, the wound had grown in size to 2.5cm diameter. Review documentation indicated that there were signs of infection in the wound and although a swab had been taken of the wound, there were no results or clinical response documented.

We also saw a second person that had complex health care needs and had a chest infection at the time of inspection that was experiencing difficulty breathing. The person was slumped down in the bed and lying on

a hard plastic mattress. We noted that the person's risk of developing a pressure sore had been calculated incorrectly so we requested an urgent nursing review of the person and their needs. This then identified they were actually at 'very high risk' of developing a pressure sore. The National Institute for Health and Care Excellence (NICE) recommend that adults who have been assessed as being at high risk of developing a pressure ulcer should be offered and supported by staff to reposition themselves to minimise the risk of further skin breakdown. The person had the first signs of skin breakdown and had not been appropriately assessed and managed to mitigate the risk of this occurring.

We raised three safeguarding alerts to Wigan Local authority following our first day of inspection at Acorns Care Centre to alert them to our findings.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We saw that people were not being protected against the risks associated with medicines. We saw people were not receiving their medicines as prescribed and that the home did not have suitable arrangements in place to demonstrate that sufficient times were being maintained between doses. We observed nurses administering medicines after food that were prescribed before food and signing for medicines as having been given when they had not observed the person taking the medicines.

We saw practices within the home were not always safe. People were prescribed thickeners to thicken their fluids to help them drink without fear of choking or aspiration but staff failed to make records to show thickeners had been used. We saw that that thickeners' were left unattended, lids removed and accessible to people who were mobile which could increase the risk of them being consumed in an unsafe manner.

This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

The registered manager had also failed to take action when shortfalls had been identified by Environmental Health. During walk rounds of the premises, we observed fire exits blocked with boxes and refuse sacks, fire doors propped open with large cartons and external bins overflowing where the kitchen staff were observed crouching before returning to the kitchen to handle food. Clothes were observed hanging over handrails which would impede its intended use to support people with poor mobility to move safely through the home.

This was a breach of Regulation 15 (1)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises and equipment.

We also observed some high risk practices in relation to cross infection within the home. The home had a suction machine and on our first day of inspection, we noted that the machine did not have disposable suction liners. We requested that the machine was taken out of service whilst the correct equipment was obtained. However, on our third day of inspection we case tracked a person and it was documented in their daily record that the suction machine had been used on them. We asked the registered manager if disposable suction liners had been used and were told that the machine had been cleaned with soap and water. This meant that the registered manager was not maintaining standards of hygiene appropriate for the purpose to which the equipment was being used.

This was a breach of Regulation 15 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, premises and equipment.

Some staff members we spoke with had a good understanding of issues relating to safeguarding adults and whistleblowing. For example, one member of staff told us they had made a safeguarding alert when a person living at the home had been given a drink by their relative when the person was unable to have drinks due to their nutritional needs. However, another staff member had difficulty explaining types of abuse and was unsure of the procedure. This meant knowledge about safeguarding and whistleblowing was not consistent among staff. The service had a safeguarding adults' policy and procedure in place but it was a generic policy and did not contain local procedures or contact information for the local authority. This meant it was not clear for staff who they should report allegations of abuse to.

We looked at six staff files who had commenced work since the previous inspection. We saw that staff had been recruited safely and adequate checks had been carried out prior to them starting work. Safe recruitment checks were made. We found all pre-employment checks had been carried out as required. Staff had produced evidence of identification, had completed application forms with any gaps in employment explained, had provided employment references and a Disclosure and Barring (DBS) check had been undertaken.

Inadequate

Is the service effective?

Our findings

We asked people and their relatives if they thought staff were well trained and had the right skills to meet their needs. A person told us; "Staff don't seem to be well trained. They do something and it doesn't make sense." "A relative told us; "The nurses are okay but the carers don't always seem to know what they are doing. The nurses don't see it and the carers think it's okay."

We looked at the induction programme. The care certificate was not being undertaken and there was no induction framework to support new staff prepare for their role. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control. We spoke to two care staff that had recently been recruited and they confirmed that they had not received an induction or shadowed senior staff. They also told us that they had been in the staffing compliment from commencing in employment at the home. This meant that staff had not been adequately assessed or demonstrated the required level of competence to carry out their role unsupervised.

There was no training matrix to provide oversight as to what training was undertaken and inconsistent records were maintained. This made it difficult to establish what training had been attended. We looked at the staff files and saw that some work books had been completed. Topics included; infection control, food hygiene, basic first aid, communication, being a professional, confidentiality, record keeping and reporting, moving and handling and safeguarding. However, we identified gaps in the training offered. For example, there had been no mental capacity act (MCA) or deprivation of liberty safeguard (DoLS) training since 2013 to support staff to understand changes in legislation. There was no evidence of dementia, mental health, sensory difficulties, terminal illness or physical disabilities training being undertaken. Furthermore, the infection control audit on 01 December 2015 indicated that staff required up to date training to insert catheters and perform enteral feeding procedures within a month of the inspection control audit being conducted. However, at the time of the inspection the registered manager confirmed this had not been sourced.

We looked at supervision and appraisal but were only able to find two supervision records. The registered manager acknowledged that supervision had only commenced in January 2016 and these were the only supervisions that had been conducted. We ascertained from the registered manager that there had been no staff appraisals. This demonstrated that systems were not in place to support staff and make sure competencies were maintained. We saw that staff were supporting eight people with dementia and three people living with a sensory impairment. This meant that the registered manager had not taken appropriate steps to ensure that staff received appropriate training, support, supervision and appraisal as is necessary to carry out the duties they are employed to perform.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Staffing.

Staff demonstrated a basic understanding of the Mental Capacity Act 2005 and how people's ability to consent impacted on the care that was delivered. However, from our observations and information in people's care records; we saw that there were people living at the home that would be able to give consent to their care. We saw that people had consent forms in their care file but they had all been signed by staff. This meant that there was no means to ascertain that consent had been obtained from the person. We also saw that when staff were undertaking interventions they did not consistently ask people for their consent. For example; on one occasion when staff used the hoist they did not ask the person if they consented to the manoeuvre.

This was a breach of Regulation 11 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Need for consent.

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. We saw that there were no mental capacity assessments or restrictive practice screening tools in any of the care records we looked at. These assessments are required to determine whether a person may be subject to a deprivation of their liberty and require authorisation from the local authority.

We also found that the manager was unable to identify the people who were subject to Deprivation of Liberty Safeguards (DoLS). We noted that for two people that had a DoLS granted by the local authority that it had recently expired. The registered manager was unaware of this. The authority states that an application should be made at least 14 days prior to the expiry of the authorisation if the person is still identified as having their liberty restricted. This had not been done. There was no central system to monitor the submission of standard authorisation and the expiry of granted applications. The Care Quality Commission is required by law to monitor Deprivation of Liberty Safeguards and to report on what we find. The Deprivation of Liberty Safeguards provides a legal framework to protect people who need to be deprived of their liberty in their own best interests.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safeguarding service users from abuse and improper treatment.

We were unable to establish from people's care records whether people had good access to health and social care professionals. We saw details in the diary where appointments had been requested and a GP had attended but we were unable to establish what decisions had been made in relation to the person's care and treatment. We found care plans were not updated and accurate records were not maintained. This meant people's care records did not have a complete record of their health. We were told that only nurses completed the daily records and nursing staff acknowledged that records sometimes got missed because it was unachievable. Throughout the inspection we observed office doors left open and unattended for large periods of time. People's records were on the floor or desk and were not secure or stored in accordance with current legislation.

This was a breach of Regulation 17 (c) of the Health and Social Care Act 2008 (Regulated Activities); good governance.

We observed breakfast, lunch and evening meal. We saw at breakfast people were offered a choice of cereals, toast or a cooked breakfast. People received large portions and were offered a second portion if they finished what was on their plate. We received conflicting views about the food and choices. One person told us; "The food at least has always been very good and you get plenty of it." The second person said; "The food is lovely and we get plenty to eat." However, a third person told us that the meals were repetitive and that beans were frequently served. A fourth person said; ""The food is good but sometimes meal times are a bit rushed." There were no menus on display and people told us they did not know what the meal was until it was served. We did hear staff explaining what the meal was when it arrived and we observed that when a person asked for an alternative because they didn't like what was being served, this was accommodated.

We found that the design of the building was not in line with current national practice guidance for people living with dementia. There was no signage to orientate people to communal areas', bathroom facilities or bedrooms. During the inspection, we encountered difficulty orientating our way around the home. The home was not designed to enable people to navigate their way round independently and reasonable adjustments had not been made in line with current legislation and guidance.

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

Requires Improvement

Is the service caring?

Our findings

The people we spoke with provided mixed views as to how caring they found the staff. People told us; "The staff are lovely and caring." "The staff are great, we can have a banter with all of them." A person named a particular member of staff and said they always had time for them; they had 'a banter' and felt cared about. "The carers are doing their best and I can't knock them for that." "The staff are doing their best but they always seem very busy and rushing around." "I don't really see any of the staff until they bring me my meals and drinks. I don't think they have very much time to sit and talk though."

Relatives also told us conflicting views about the care their relative received. Two relatives said; "Care is second to none" and "Staff are caring and patient." Whilst a third relative told us; "Some of the staff are alright but it isn't consistent. Some have time for [person] whilst other's rush [person] and generally don't seem to care."

We found there were widespread and significant shortfalls in the home, which meant people's immediate and ongoing needs were not consistently met to demonstrate a caring culture. Whilst we found some staff had good intentions, they were not supported by the overall management or systems in the home to ensure that people were consistently treated with privacy, kindness, compassion, dignity and respect. For example, on the first day of our inspection we arrived to find that all the bedroom doors were wedged open which meant people's privacy, dignity and human rights were not being respected.

We saw staff did not consistently communicate respectfully with people and on occasion lacked empathy for the person or their situation. For example, we saw staff go in to a person's bedroom, turn their light on and did not speak to the person to orientate them to their surroundings. The staff were task focused and did not explain to the person what they were doing or why. They did not provide guidance or reassurance to the person and when we spoke to the person the staff member said; "The person doesn't communicate" as if this was okay to not communicate either. We also found, people's privacy and dignity was not always upheld. We observed staff undertaking hoist manoeuvres with females which resulted in their undergarments being visible to the males in the room. We also saw a male on the toilet and the staff member didn't attempt to close the door to maintain their privacy and dignity.

People were not always spoken to in a kind and caring way. We heard one person ask for their glasses and the staff member said; "We are getting them now. I'm putting your cardigan on. I can't do two things at once." The interaction was not caring and the communication was not respectful. We also witnessed staff did not consistently maintain people's confidentiality and on one occasion a member of staff discussed the risks and treatment plan of another person in front of a person living at the home. We found that all reasonable efforts were not being made to make sure that discussion about care and treatment and support only took place where it could not be overheard.

We found that people and their relatives were not involved in the planning of their care. Care records did not reflect peoples preferences with regard to how they wanted their care delivered. People and their relatives told us they had not been asked for their views or involved in care planning. One relative told us; "I don't

know anything about [person's] care planning. I worry about [person] because I don't think they do know [person's] needs." A person told us; "I haven't been involved but they don't register when I tell them things anyway. I am partially sighted and they treat me as if I can see." We observed occasions when people's preferences were not requested. For example; a person was sat in front of the television and the staff nurse went in to the room and changed the channel. The nurse did not ask the person whether they had been watching the programme or what channel they wanted on.

This was a breach of Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities); dignity and respect.

We observed throughout the inspection that people's relatives were able to visit without being unnecessarily restricted and there were no prescriptive visiting times at the home. We also observed and were told about some positive examples of how staff demonstrated that they cared for people living at the Acorns Care Centre. A relative told us [person] had never looked better than they had since living at the home and they felt that the staff would do anything to meet [person's] needs. A person told us, how a staff member 'had gone the extra mile' for them. They told us that they had had a funeral to attend but didn't have black shoes and the member of staff had gone to purchase them a pair of shoes on their day off. We were also told by people that a staff member purchased them all a birthday present and that they brought them in their favourite sweets and crisps. We saw one staff member returning from the shop having purchased crisps for a person living at the home who was bed bound when they had been told that their relative hadn't visited and brought them any the previous day. This demonstrated that care staff did show concern for people's wellbeing and took practical action to address this.

We also observed the registered manager give a person living at the home some costume jewellery items that they had obtained from their recent holiday. The person was observably excited and asked for assistance to get the items of jewellery on. As the registered manager assisted the person, they threw their arms around them and kept repeating "bling." It was an appropriate gesture that was observed to be reciprocated by the registered manager as they sat holding the person's hand and smiling. It was evident from these interactions that staff did care for the people living at the home but the lack of governance and systemic failings contributed to the occurrence of people's privacy and dignity being compromised and not consistently maintained.

Inadequate

Is the service responsive?

Our findings

We looked at eight care files to establish how people living at the home had their individual needs assessed. We could not find initial assessments about people's care and support needs in their records. During the inspection, we spoke to a person and their relative who told us that when they were admitted to the service an assessment of their needs had not been undertaken with their involvement. The person told us that they had not received a shower for three weeks following admission and when they requested a shower staff attempted to persuade them to have a bed bath instead. The person also had dietary preferences that weren't accommodated. This had resulted in them receiving care that did not meet their needs.

In all the care files we looked at, we could not see how people's biographical history had been captured. People's likes and dislikes, personal preferences and hobbies were not identified by the service to plan care and treatment. It was unclear from the care files who had capacity to agree to their support. However, it was evident from the care files that information had not been explored or gathered from families to guide staff to support people living at the home. This meant that staff would be unable to deliver care that was personal or met people's individual needs. It would also hinder staff engaging with people in a meaningful way. Care plans and reviews were signed by staff which meant the service was not including people in reviews of their ongoing care or supporting people to express and document their views or preferences following admission.

Throughout the inspection, we did not see any meaningful person-centred activities taking place. We asked people and their relatives what activities were undertaken. We were told by one person; "There isn't very much to do here during the day, every day feels the same sometimes." A second person said; "We do play bingo now and then but nothing much more happens if I'm being honest." A third person said; "A lady does some exercises with us on Wednesday and Thursday. We also have games under the table that we can play. We don't go on trips out though. I'd love to go to Blackpool." A fourth person said; "It suits me that there isn't much happening. I prefer to spend most of my time in my room and I don't really mix with the others." A relative told us; "I've been visiting [person] for a number of years now and there is never really any activities going on. I've noticed most people living here seem to just be sat around."

During our inspection, we observed people sat around and saw little stimulation offered to people living at the home. Some well-intentioned attempts were observed by staff in the lounge on the middle floor to play music and to engage people in singing. However, people on the ground floor remained in their bed with no interactions observed unless they were task focused interventions. For example; supporting people to attend meals or dispensing medication. We saw on the upper floor that a large proportion of people stayed in their bedrooms but we observed staff going in to people's rooms and speaking with them. We spoke with the registered manager about this and we were told the service had started to look at activities. As an initial step, we were told everybody had been signed up to 'ring and ride' to support people to access the local community. The home had also made links with the community knowledge officer and commenced exploring local dementia café's.

We found meetings were not consistently conducted with people and their relatives. A relative told us they visited daily and had never been invited to a meeting or observed posters to suggest a meeting was

scheduled. The registered manager acknowledged that the frequency of resident and relative meetings had reduced over the past year due the difficulty in recruiting nurses and the registered manager undertaking a dual role. They told us that a meeting had occurred in February 2016 and one relative had attended. It was unclear if the meeting had been publicised or was widely known prior to it occurring. Meeting minutes were not available to ascertain how people's views and suggestions were considered and acted on by the management. The registered manager told us that they had changed the meal time experience following a resident meeting. However, when this was explored further the registered manager was referring to a meeting that had occurred a few years earlier and it was established that it hadn't been discussed recently to ascertain it suited the current residents. There were no menu's or evidence that people's food and drink preferences were incorporated in to meal planning. The cooks decided what food to prepare every day.

This was a breach of Regulation 9 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014; person-centred care.

Throughout the inspection we encountered difficulty obtaining a copy of the complaints policy and procedure. It was not displayed around the home and we ascertained from all the people and their relatives spoken to that they had not been provided an individual copy for guidance.

We were told that no formal complaints had been received. There was no record of a complaint being received by the home in the complaints file. However, people we spoke with told us they had raised concerns and they had not been dealt with. This indicated to us that the complaints process was ineffective. One person told us; "it's appalling staying here. It's like a concentration camp. The bedrooms are freezing overnight. They always say that they will bring you more bedclothes but they never do. I have spoken to the manager about this and like everything else here it falls on deaf ears." A second person told us; "I just put up with this place as I haven't got many years left on this earth. It's a waste of time moaning about anything." A relative told us they had raised concerns regarding the height of [person's] bed and the registered manager hadn't approached them to discuss it. No record of any of these concerns or complaints was available in the home. This demonstrated that complaints were not being recorded or used to inform the future development of the service. We therefore found the service had failed to establish and operate effective systems for identifying, receiving, recording, handling, investigating and responding to complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014; receiving and acting on complaints

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People told us; "The manager is a nice person and easy to talk with." "The manager is approachable and responsible. I've found they've accepted when they've made a mistake and apologised."

We found the provider did not have a quality assurance system in place. Provider audits were not conducted and the provider was not available during the inspection visits to demonstrate they provided any service oversight or support to the registered manager. The registered manager acknowledged that they had not maintained the frequency of audits due to an absence of nurses. When we commenced our inspection, the registered manager told us they thought the care files were of a good standard and risk assessments and care plans were representative of people's needs. We found outcomes for people living at the home were poor and when we shared the concerns with the registered manager, we found that they were not aware of them. This demonstrated that they did not have effective oversight of the quality of the service.

The processes in place to monitor the performance of the service were inconsistently applied and were not effective in securing service improvements. Audits had failed to identify the concerns that we found during the inspection. We found the lack of strong leadership underpinned many of the failings we identified during our inspection. Poor communication systems, training, support, deployment and a lack of co-ordinated team work meant that outcomes for people living at the home were poor and staff had no governance arrangements in place to support them identifying what was occurring.

Risks to people using the service had not always been identified or effectively managed. For example, we saw a number of people's care plans and risk assessments that had not been reviewed to reflect people's changing needs. This had placed people at risk. Accident records indicated that 18 unwitnessed incidents had occurred between November 2015 to January 2016. We saw that there was no documentation to support fact finding had occurred at the time of the incident and there was no analysis of the findings undertaken to mitigate the risk of further occurrence. The registered manager was unable to demonstrate that lessons learned were undertaken or shared with the staff team. This meant that effective systems were not in place to analyse, respond or communicate to the staff team risks to the safety and welfare of Service Users to mitigate the risks to.people who use the service.

Staffing levels were not calculated using a dependency tool and we saw repeated examples of ineffective deployment which meant there was no staff presence on the ground floor placing people at risk of not having their needs met. Poor and inadequate record keeping meant that it was difficult to determine people were receiving the correct care and support. The registered manager acknowledged that they were not organised and there were files everywhere but had not implemented systems to address this.

This was a breach of Regulation (17) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, good governance.

A lack of engagement with people and their relatives meant that this was not addressed through reviews and people were not receiving care that was person-centred or based on their individual needs.

Staff were positive about the registered manager despite us identifying that there were limited mechanisms in place to support staff in their role. Staff said; "Our manager is fabulous. It's like a family. They are very nice." "I can't remember the last team meeting but the registered manager is approachable."

We were told that monthly staff meetings were conducted; however, we could only find the minutes from one meeting which was not dated and there were no actions identified during the meeting to enable us to track whether the registered manager had actioned or responded to issues raised. New staff in the service had not received a formal induction and we were told by two new staff that there was no information for new starters regarding conditions or things to be mindful of. Staff had not received regular training, supervision or appraisal to support them in their role.

We looked to see how the service sought the views and opinions of people who used the service and/or their representatives. For example, through the use of resident and relatives surveys or meetings. We were told that surveys had been sent two weeks prior to our inspection but the relatives we spoke with told us they had not received a survey. The registered manager was unable to indicate a time frame for analysing feedback and could not produce evidence that the views of people had previously been sought and used constructively to drive service improvement.

We found that the registered manager and provider had failed to establish effective systems or processes to effectively assess, monitor and mitigate risks. We found that they had failed to securely maintain records; and failed to seek and act on feedback.

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