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Benthorn Lodge

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 inspection took place on 20 July 2016 was unannounced.

This was a third comprehensive inspection carried out at Benthorn Lodge. At our previous comprehensive inspection carried out on 14 and 15 April 2016 we found the service to be in breach of ten regulations and received a rating of inadequate. Following our inspection in April 2016 the service was put into special measures.

Prior to this inspection we received concerns from the local authority about a lack of staffing and poor care practices which meant that people were not receiving the best possible care. Concerns were also raised in respect of poor management and leadership at the service.

Benthorn Lodge provides care and support for up to 20 older people who have physical and mental health needs. Most people living at the service have advanced dementia care needs. There were 11 people using the service when we inspected the service.

There was a manger in place but they had not registered with the Care Quality Commission (CQC). 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.

At the previous inspection we found that staff were not confident that any concerns they raised with the registered provider would be dealt with effectively. During this inspection we found two potential safeguarding incidents that had not been reported to the local safeguarding team and the Care Quality Commission. This meant that safeguarding concerns had not always been reported and escalated appropriately and placed people at risk of harm.

At the previous inspection we found that recruitment procedures were not robust and staffing levels were not adequate to meet the needs of people using the service, in a timely manner. During this visit we found that areas of concern in relation to the recruitment of staff had not been addressed. There remained insufficient numbers of suitably qualified, competent, skilled and experienced staff providing care or treatment to people.

People had not been protected against the risks associated with unsafe or unsuitable premises. At this inspection we saw that many areas of the premises had not been regularly maintained and showed that appropriate action to ensure people were safe through a regular programme of servicing and maintenance of the premises and equipment had not been carried out.

At our previous inspection we found that staff did not receive appropriate support and training to perform

their roles and responsibilities effectively. During this inspection we saw that although staff had completed distance learning courses, they did not always feel supported and some staff had not received formal supervision. There was no recognised induction programme in place for staff new to the service. During the previous inspection we found that people's consent to care and treatment had not been sought in line with current legislation and people were not supported to access healthcare facilities as needed. During this inspection we found that staff had completed some training courses, however no improvements had been made to the induction programme. In addition we saw that people's capacity to make decisions had not been assessed meaning that decisions were made for people without their involvement or consent. People did not have access to dental care to maintain their oral health needs.

During our last inspection we found that people were not always offered choices about their care and were not involved in decisions about their routines. In addition, people did not receive care that was responsive to their needs or focused on them as individuals. During this visit we found that although some improvements had been made, people did not always receive the care described in their care plan and in line with their preferences.

At the previous inspection there was no registered manager and the registered provider was running the service which had led to poor management and leadership. During this inspection we found there was a manager in post; however they had not yet registered with the Care Quality Commission (CQC). Staff told us the manager was not always visible at the service and said it was often difficult to contact him for support. Effective quality assurance systems were not in place to obtain feedback, monitor performance and manage risks on a regular basis.

These were continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were receiving their medicines as prescribed. Improvements had been made to the systems and processes in place for the safe administration, storage and recording of medicines.

Staff had received practical training in moving and handling. In addition, staff had completed distance learning courses in mandatory subjects. People had enough to eat and drink. Assistance was provided to those who needed help with eating and drinking, in a discreet and helpful manner. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required. However, we found that people did not have access to dental care on a regular basis.

We saw that staff treated people with kindness and patience. Improvements had been made to the storage of personal information and we found that people were treated with privacy and dignity.

A complaints procedure was in place to let people know how to raise concerns about the service if they needed to. The service had not received any complaints since the last inspection.

The overall rating for this service remains as inadequate and the service remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. 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 were not always protected from avoidable harm. Staff felt that people were not safe due to insufficient staffing levels and potential safeguarding concerns had not always been reported to the relevant authorities.

Risks to people were not in place for all areas of risk to ensure people were kept safe.

People were being put at risk because the premises had not been adequately maintained.

Recruitment practices were not robust and there were some gaps in staff employment checks.

There were insufficient experienced staff, a poor skill mix and insufficient staffing numbers to support people to remain safe.

Improvements had been made to the systems for the management of medicines.

Is the service effective?

Inadequate

The service was not effective.

There was no formal staff induction programme in place; however we saw that staff had completed some distance learning courses to help them to develop their skills and knowledge.

Formal supervision was not carried out for all staff to provide them with the support they needed to deliver good care.

The service was not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and people using the service could not be confident that their human rights would be respected and taken into account.

People were not supported to access dental facilities.

People received nutritious meals that met their dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported always to express their views and be actively involved in making decisions about their care, treatment and support.

Care was mainly task focused and did not take account of people's individual preferences.

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Staff treated people with kindness and respect. Improvements had been made to the storage of personal information to ensure confidentiality was maintained.

Is the service responsive?

Inadequate

The service was not responsive.

The service was not always flexible and receptive to people's individual needs and preferences.

There was a lack of stimulation and interaction between staff and people using the service. Meaningful activities were not provided which meant that people were not engaged adequately.

People's views were not regularly sought, listened to and used to drive improvement in the service.

Systems had been put in place so that people could raise concerns about the service.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager in place and this was having an impact on the leadership and direction for people living in the service and staff.

The registered provider failed to send an action plan to the Care Quality Commission following the previous inspection.

People were put at risk because systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment had not been consistently

undertaken.

Benthorn Lodge

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 20 July 2016 and was unannounced. The inspection was carried out by three adult social care inspectors; one of whom was a pharmacy inspector.

We checked the information we held about the service and the provider, such as notifications and any safeguarding or whistleblowing incidents which may have occurred. A notification is information about important events which the provider is required to send us by law.

In addition, we received concerning information from the local authority in relation to insufficient staffing, poor support for staff and a lack of leadership and management.

Following the previous inspection we did not receive an action plan to inform the Care Quality Commission how the service would address the concerns identified and how long this would take them to complete.

In addition, we asked for feedback from the local authority, which have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant most were not able to talk to us about their experiences.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two people who lived at the service and observed the care being provided to a number of other people during key points of the day, including lunch time and when medication was being

administered. We also spoke with one relative of a person using the service to determine their views of service delivery on behalf of their family member. In addition, we spoke with seven members of staff, including the registered provider, the manager, the administration manager and four care staff. We also spoke with one visiting healthcare professional.

We looked at four people's care files to see if their records were accurate and reflected their care and treatment needs. We also examined other records relating to the running of the service such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Inadequate

Is the service safe?

Our findings

During our previous inspection on 14 and 15 April 2016 we found that systems to report potential abuse and keep people safe were not in place. Staff felt that people were not always safe because of insufficient staffing numbers. They also told us they would not feel confident that any concerns they raised with the registered provider would be dealt with effectively. The registered provider had not reported potential safeguarding concerns to the relevant authorities.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

During this inspection Systems were not in place to ensure people were protected from abuse and avoidable harm. A staff member commented, "I know what safeguarding is, but because we haven't had any proper training on it, you can't be sure."

Staff were able to explain how they would recognise and report abuse. One staff member explained, "I know what abuse is and I would report it to the manager." However, another member of staff told us there had been a recent period of 1.5 weeks without the manager being present at the service. They said that during this time there was no one else to report their concerns to. They continued to say that they had received no information from the provider to say that they were able to contact the Care Quality Commission (CQC) or the local authority if they had any concerns. This meant that staff were not aware of who to report safeguarding concerns to in the absence of a manager and as a result this put people at risk.

We found that two incidents had occurred at the service since the last inspection, which were potential safeguarding concerns. We found that neither of the incidents had been reported to the Care Quality Commission. This placed people's safety at risk because systems were not effective in reporting safeguarding concerns and taking action to prevent further occurrence.

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

All the staff we spoke with told us they had completed a distance learning course in relation to safeguarding. However they felt this was very generic and they would benefit from the training being more applicable to the service to include local authority policies and contact names and numbers.

During our previous inspection on 14 and 15 April 2016 we found that people were not protected against the risks associated with unsafe or unsuitable premises. We found that many areas of the home were in a state of disrepair and service certificates for the premises and equipment had expired. In addition environmental checks had not been undertaken to identify areas of risk and protect people's safety.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

At this inspection we found that many of the areas we identified during our previous inspection as needing attention and repair had not been addressed to make the service safe. For example at our previous inspection we observed areas of damp in several areas of the home. In the office used by staff there was a large area of damp around the window sill. Staff showed us that towels were in place on the window sill and the printer to absorb water. We noted there was electronic equipment in use in this area. This had not been addressed and towels were still being used to absorb water. We also found that damp areas in the upstairs hallway had not been resolved.

We found that the spare room downstairs was in a state of disrepair. There was damage to the walls and a lack of decoration/fixtures and fittings. Broken items and discarded furniture were stacked in the room, along with supply of continence pads and cleaning materials, some of which were marked as hazardous or irritant. One spray bottle had the original label removed and 'bleach' hand written on it. This room was not locked at the time of our inspection making it accessible to people using the service. The manager later stated that this room should not be used to store cleaning chemicals and this was likely to have been attributed to night staff who undertake cleaning duties. He also stated that there should not have been bleach in the service at all and there was no Control of Substances Hazardous to Health (COSHH) safety data sheet for it. Safety data sheets for other chemicals were noted; however they were locked in the manager's office which meant staff did not have ready access to them if there was a spillage or accident with cleaning products.

On the first floor there was a stair lift that people could not call if it was at the opposite end to where a person was situated, therefore people would have to wait for staff if they wanted to use it. We discussed this with the manager who stated that remote controls had come with the stair lifts, but they were unsure what they were for. The manager told us he still had the remote controls and would be able to install them at the service.

The upstairs hallway had missing sections of skirting and the radiator cover was coming away from the wall. This meant that people could touch the radiator which put them at risk of scolding. The fire exit door off this landing opens directly onto a down-step. There was a lack of signage to direct people to a place of safety in the event of a fire once through the door.

During our inspection the weather was hot. We found that some bedrooms had no ventilation and were hot and stuffy. We found that temperatures in some bedrooms varied between 29 and 31 degrees and there were no fans in place to alleviate this. A staff member told us, "There are no management systems for the hot weather but staff have used their common sense." We saw that fans had been purchased for the communal areas and drinks and ice creams were offered regularly throughout the day.

Some toilet areas had clinical waste bins in place but they had no lids. The contents could be seen, making it accessible to people. There was missing tiling around the pipework and in one toilet area we found damage to the skirting board, and dirt and gaps in the wall were visible. This meant the areas were not easily cleanable and put people at risk of infection.

We saw that one bedroom door was wedged open with laundry boxes. Wedging fire doors open meant that

people may be put at risk if there was a fire at the service. We found a stand aid in another bedroom and the sling for this had a label that was frayed and the information on it was no longer readable. We also saw a broken picture frame with an exposed glass panel, as well as an extension lead and other items on the floor next to the sink. This put people at risk of harm and injury.

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

During this inspection we found that risks to people had not always been identified and managed safely. Staff were aware of people's risk assessments and understood why they were in place. One staff member commented, "Risk assessments are in place but I am not sure if or when they are updated." A second member of staff told us, "As a result of staffing, risk is not well managed." They told us that three people who try to stand on their own when they become anxious were not always supervised by staff, especially in the afternoon when there were only two staff. They told us one person had slid out of their chair one afternoon when there were no staff around to support them. Records we looked at supported this.

People had Personal Emergency Evacuation Plans (PEEP) in place, which were based on risk. We found that these were out of date and not reflective of peoples current needs. For example, one person was receiving end of life care and was being cared for in bed but the PEEPS did not reflect the change in circumstances. In addition we saw a fire register that was not reflective of the current occupancy of the service. This meant that in the event of a fire incorrect information may be given to the fire service delaying any actions taken. We found that the PEEPS did not provide details of people's bedrooms or where they were likely to be in the home. The manager showed us that the PEEP's were up to date on the electronic records system. However, this meant that the PEEP's would not be accessible to staff or the fire service in the event of a fire, which placed people's safety at risk. Not all staff were not able to describe the evacuation process.

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

During our previous inspection on 14 and 15 April 2016 we found that staffing levels were not always sufficient to meet people's care and support needs appropriately. A dependency tool used to assess the number of staff needed to provide care and support for people did not reflect the current dependency levels of people using the service. As a result we found staffing levels were not sufficient to meet people's care and this was having an impact on the quality of care received by people using the service.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

At this inspection we checked to see if improvements had been made. We found there continued to be insufficient numbers of staff available to keep people safe. A relative told us, "There's not really enough staff, there never has been. There are often only two staff and it takes two staff to take [relative] to the toilet. Something else could happen like a fall and nobody would know."

Staff told us that staffing numbers were inadequate. One member of staff told us, "We haven't got the staffing levels. There's days when there's just two carers." Another staff member said, "We've been rushing around so if somebody had an accident we wouldn't know. We do laundry, cleaning, change bins, change

pads. It puts pressure on us and is difficult."

The staff rotas demonstrated that on most occasions there were three staff on duty in the morning but only two staff on an afternoon and staff told us this was unsafe. One staff member commented, "Two staff is not enough and is not safe. When we are helping one person all the others are unsupervised." Another member of staff commented, "People aren't safe all the time, due to staffing. We've been rushing around so if somebody had an accident we wouldn't know."

A visiting healthcare professional told us that the service did not have enough staff and commented, "The girls are run ragged. They try really hard and do the best they can but they can't do everything that's expected of them."

We found that in addition to their care duties, staff also had to complete cleaning duties, the laundry and provide meaningful activities to people using the service. During our inspection we found that staff did not have the time to provide any activities. People were sat in chairs throughout the day, often asleep, and people being cared for in bed spent long periods of time with no interaction. This put them at risk of social isolation.

We asked to look at the dependency tool used to assess the staffing numbers against the needs of people using the service. We were told that this had not been updated since the previous inspection. The tool stated that four people using the service had high needs. However, electronic records we looked at showed that eight people had high needs. This meant the staffing numbers in place were not sufficient to meet people's needs and this was having an impact on the quality of care received by people using the service.

Our observations found that there was a demand on the staff, especially at each meal time to ensure everyone's needs were met in a timely manner considering the diversity of people using the service; from full dependency to people who needed verbal support to eat their meals so they could remain independent. For example, we observed one person who fell asleep whilst eating their lunch. Their meal lay in front of them for over half an hour before a staff member offered any support. At this time the person's meal was cold and the staff member did not offer to heat it up. This meant that people did not always receive the support they needed in a timely manner.

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

During our previous inspection on 14 and 15 April 2016 we found that recruitment procedures were not robust enough, to ensure only suitable staff were employed by the service. Staff files demonstrated that staff members had not always been safely recruited and appropriate steps had not been carried out, to ensure staff were of suitable character to work with vulnerable people.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we checked to see if improvements had been made. We saw that staff files had not been updated or amended following our previous inspection, with the exception of Disclosure and Barring Scheme (DBS) checks which had been printed and put into staff files. We saw a DBS check for one person

that had entries recorded within it. There was no evidence that these had been explored, risk assessed and managed by the provider to ensure the person was safe to work with vulnerable people.

Areas of concern that we found at the previous inspection had not been addressed by the registered provider. For example, the file for the maintenance person still only contained a DBS form and a training certificate. No further recruitment checks had been carried out for this person, including references.

Files were being prepared for new staff members; however these showed the same areas of concern that we identified at the previous inspection. For example, only five years' worth of employment history had been sought, despite our feedback at the previous inspection for a full employment history to be obtained.

Staff files demonstrated that staff members had not always been safely recruited and that appropriate steps had not been carried out, to ensure staff were of suitable character to work with vulnerable people.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our previous inspection on 14 and 15 April 2016 we found that people were not receiving their medicines as prescribed. Systems in place to ensure medicines were administered safely were not consistently followed. Stock levels were not consistent with medicines administered and some staff were giving medicines without completing medication training.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

During this inspection some people using the service regularly refused to take their medicines. However, there were no care plan in place to guide staff of the appropriate actions to take when this happens; such as how many doses could be missed before the person's doctor was informed.

We found that people were receiving of their medicines as prescribed. We looked in detail at the medicines and records for three people living in the home. Records were kept of medicines received into the home and given to people. There were no gaps on the administration records and any reasons for people not having their medicines were recorded. Clear records were made of when to give the next dose of medicines, to ensure that people got their medicines on time.
Some people had been prescribed medicines on a 'when required' basis. Information to show the staff how and when to administer these medicines, so that they are given in a clear and consistent way that meets people's individual needs, was kept at the service. They were detailed and specific to the individual.

We observed people being given their medicines by the care staff. We saw that safe procedures were followed. The administration records were referred to prior to the preparation and administration of the medicines, and the administration records were being signed after the medicines had been given. The member of staff we observed explained to people what it was they were giving to them and gave them the time that they needed to take their medicines.

People were supported to look after and take their medicines themselves when they wished to do so. Whilst staff were able to tell us what support people needed there was no documented assessments of the risks of

people looking after their own medicines nor the risks to other people living in the home. No care plans describing the support that they needed were available. This left these people at risk of not getting the help that they needed.

People were protected against being given medicines that they were allergic to. Their allergies were recorded on their administration records.

Medicines were being stored securely, and at the correct temperatures, for the protection of service users. Controlled drugs were stored and recorded correctly.

Inadequate

Is the service effective?

Our findings

During our previous inspection on 14 and 15 April 2016 we found that the training and development systems in place were ineffective. They failed to ensure that staff received the training they needed to care safely and appropriately for people using the service.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

At this inspection we checked to see if improvements had been made. There was no recognised national induction training programme for new staff. There were no staff new to the service at the time of this inspection who were able to tell us about their induction to the service. However, the manager confirmed with us that a new induction programme had not yet been implemented. A member of staff told us, "Training is overwhelming, they [distance learning courses] all just get thrown at you at once. We don't get all the training we'd like. How can we be a home that specialises in dementia when none of us have had proper dementia training?" A second staff member commented, "I've been given three or four distance learning packs and medication training." We found that staff had not all completed training in dementia care.

A visiting healthcare professional told us that staff were not always knowledgeable about people's health conditions. They said, "Staff don't question practice and are not allowed to think out of the box." They gave us an example of one person who had difficulty in walking. Staff had been told by senior staff this person must walk to their room. The district nurse said, "If [name of person] is struggling or tired the staff don't think to question what they have been told and use a wheelchair." This meant that some people may receive care and treatment that was not in line with best practice and could have an impact on people's specific conditions.

Records showed that one face-to-face training course in relation to Moving and handling had been recently completed. There were no further practical courses booked for staff.

The administration manager showed us that a number of distance learning courses were being completed by members of staff and a record was being maintained of these. The administration manager told us that this needed to be updated and a copy would be sent to the Care Quality Commission (CQC) following the inspection. This was not received by the CQC.

We were informed by staff that they had not received supervisions or an annual appraisal on a regular basis. Two staff members told us they had not received any supervision. We were unable to find any records to evidence these two staff members had received any formal supervision.

We saw evidence on the manager's computer that some staff members had received formal supervisions. However this was not regular and their supervisions were not accessible to them. There were no agreed actions or goals set for staff members.

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

People's consent to care was not always sought in line with legislation. During our previous inspection on 14 and 15 April 2016 we found that people's capacity to make their own specific decisions had not been assessed and there was no evidence that best interest meetings took place when specific decisions needed to be made or evidence that any least restrictive options were explored for any decisions about their care.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

At this inspection we checked to see if improvements had been made. We spoke with staff about MCA and DoLS .One staff member told us, "We don't get the time to read the care plans, so how can we respect people's best interests' or keep them safe." Another member of staff commented, "I don't know if anyone has had any best interest meetings. I'm not sure how we would go about it." Training records demonstrated that most staff, including the provider, had not completed training in relation to MCA and DoLS."

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).

The manager demonstrated a basic knowledge of the MCA and DoLS and confirmed that no one using the service had their capacity assessed or were subject to a DoLS application. They told us this was something they needed to complete as most people using the service had advanced dementia care needs.

However records demonstrated that people's capacity had not been assessed in line with the MCA, despite there being a number of people who lacked capacity and were having decisions made for them such as moving rooms and receiving medical interventions. This meant that decision may be made for people that were not n their best interests and in line with their wishes. We found that two best interests meetings had been held to ensure decisions had been made in people's best interests. These had been instigated by the local authority to ensure people received the right care and support to maintain their health and wellbeing.

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

During our previous inspection on 14 and 15 April 2016 we found that the service did not always support people to maintain good health and access healthcare services when required. People did not always have timely access to health care professionals to meet their specific health care needs. During the previous

inspection we found that one person had been in need of dental treatment and had been left in pain for three weeks before the service arranged for the persons family to take them to the dentist.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

At this inspection we checked to see if improvements had been made. We found there were no records to demonstrate that people received regular dental care. The manager and the registered provider confirmed that they were unable to access a domiciliary dental service so most people were not registered with a dentist. This meant that people were not able to access the dentist for regular checks and could not be assisted in maintaining their oral health.

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

One person was waiting to attend a hospital appointment on the day of our inspection. They confirmed that their family members were supporting them to attend the hospital and they had been assisted to get up early so they could attend their appointment on time. A relative told us, "If [relative] is poorly, then they ring for the doctor."

Records showed that people had been assisted to access optical care and where appropriate, referrals had been made to access additional healthcare support; for example, mental health intervention, and dieticians.

People told us they had enough to eat and drink and that they enjoyed the food provided. One person said, "I like the food. It's very good." Another person commented about their meal and said, "Lovely. It's lovely." A relative commented, "The food seems nice."

The main chef was on leave at the time of our inspection and the registered provider was cooking the meals every day for people at the service. We observed the registered provider offering people a choice of meal and snacks.

We observed drinks and snacks being provided throughout the day. The temperature was very high and people were given a choice of hot or cold drinks, as well as ice-creams if they wanted.

Care plans were in place for eating and drinking and there was information about people's dietary preferences. Care files contained information about people's nutritional screening such as a nutritional assessment and a record of their weight. We saw for one person who was being cared for in bed that a food and fluid chart was in place. This was up to date and had been fully completed.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection on 14 and 15 April 2016 we found that the service did not always support people to express their views and be actively involved in making decisions about their care, treatment and support.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

During this inspection we checked to see if improvements had been made. A relative commented, "I'm not really involved in [relatives] care. I think they do what they think is right, they never ask me." Staff told us that people or their relatives were not involved in the care planning process. One staff member told us, "Decisions are made for people not with them."

We found there were no arrangements in place to make sure that people, where they are able to, were involved in making decisions and planning their own care. Records showed no evidence that people and their families had not been involved in reviews of their care or had been involved in the decision making process. For example, we saw that one person had been ill recently and had been moved to a shared room. We were unable to find any information that either people that were sharing a room or their families had been consulted and involved in the decision. This meant that people were not consulted in decisions relating to their care and decisions made were not always with the persons consent.

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

During our previous inspection on 14 and 15 April 2016 we found that people could not be assured that information about them was treated confidentially and respected by staff. We found a staff handover book in the lounge on display that contained personal information about people and their care needs. In addition we found that people's privacy and dignity were not always respected by staff.

The registered provider failed to send us an action plan to inform the CQC how they were going to make improvements.

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

During this inspection we checked to see if improvements had been made. One staff member told us, "We try to make sure we keep all personal information safe and secure."

We found that personal information was being stored appropriately and we observed the staff handover book had been moved to a lockable cupboard to ensure it was stored securely, maintaining people's confidentiality.

We observed how staff maintained people's privacy and dignity. Staff gave us examples' of how they maintained people's dignity and respected their wishes. One staff member said, "We talk to people when we hoist, we cover people in a sling to preserve their dignity and we know people's favourite names and nicknames."

Staff had an understanding of the role they played to make sure people were respected. They explained how they knocked on people's doors before entering their bedrooms and always supported them in a private area, for example, their bedroom when providing personal care.

Throughout the day we observed that staff knocked on doors before entering rooms and ensured doors were shut when they assisted people with personal care.

We found that staff were kind and caring but had little time to spend with people. One person told us, "Yes the staff are very kind." A relative told us, "The girls are ever so nice with my [relative]. She is treated well, always presentable."

Staff were positive about relationships they had developed with people. One member of staff said, "I know people's needs because I know the people. We come to work for our residents and we love them, but when you get no support what can you do." A second staff member commented, "We try to make sure the residents are happy, they are our main priority. We like to make people comfortable and relaxed."

A healthcare professional told us, "The girls are very good. They are very caring but have little time to spend with people."

We observed staff when they were interacting with people. Staff were patient and kind when supporting people but were largely task rather than people focused. They provided support as and when required but social interaction with people was reserved primarily for when an activity took place, such as meal times. One staff member told us, "We struggle to find the time just to have a chat because we have so much to do." A second member of staff said, "Today I was told to empty all the bins in the bedrooms, rather than spend time with people." This meant that staff routines took priority which had an impact on the wellbeing and needs of people using the service.

We observed that staff addressed people by their preferred names and that support was provided in a kind and caring manner. We saw that people who lived at the service looked comfortable and relaxed in the company of care staff.

Inadequate

Is the service responsive?

Our findings

During our previous inspection on 14 and 15 April 2016 we found that there was a lack of stimulation and interaction between staff and people using the service and the provision of meaningful activities. People were not supported to follow their interests and take part in social activities. In addition people being cared for in bed were at risk of social isolation.

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

At this inspection we checked to see if improvements had been made. We found that people were not enabled to participate in activities that met their needs and reflected their preferences. A relative told us they visit the service regularly and said, "I rarely see any activities taking place. There is usually music or the TV on."

One staff member said, "We haven't had time to do an activity so we have had to just stick a DVD on." A second member of staff told us, "Quite often we are very busy and don't have time to do any activities. We did have a party last week and everybody enjoyed it."

We saw that people were offered limited opportunities for occupation beyond the television and music. We saw that staff were busy undertaking tasks, such as tidying up and the laundry, and had little time to spend with people. On the day of our inspection we observed that DVD's were playing continuously throughout the day and we saw no other meaningful activities taking place on the day of our inspection.

In people's rooms there were Personal Care Charts that provided staff with at-a-glance basic information about the person and their needs and wishes. We looked at one in depth and saw the quality of the information was not detailed and did not reflect the person's likes, dislikes and preferences. For example, the board had an area to record the person's hobbies and we saw staff had recorded, "Not interested." We saw that activities for people were recorded on the daily shift plans. We looked at these and found that the vast majority of these did not show that any activities had taken place.

People did not always receive personalised care that was responsive to their needs. Most people using the service were not able to tell us if the care they received was personalised and reflective of their needs. One relative told us, "I think everyone gets basic care but not much more than that."

Staff told us they tried to provide good quality care but it was often difficult to fully meet people's needs. They told us that care was task focused and not personalised and they explained that they were required to undertake cleaning duties, the laundry, a programme of activities and other tasks around the service. One staff member told us, "Sometimes people need emotional support but we just don't have time to do anything more than the basics." A second staff member told us, "Staffing makes it difficult to meet people's needs properly."

Care plans we looked at contained person-centred information, which staff needed to know to enable them to deliver personalised care. One staff member commented, "I haven't had time to read all the care plans." A second member of staff told us, "We can read the care plans and I know they get edited by [name of manager] or the team leader, but they are not always updated regularly."

The care plans we looked at gave information about people's care needs and recorded people's likes, dislikes and preferences. However, we found from our own observations that the care people received did not always match what was recorded in people's care plans. We saw that people were not supported to take part in their chosen or preferred activities and we found that most people using the service did not receive their preferred method of bathing. Records demonstrated that for most people this was a shower. However staff told us and records confirmed that most people only received a wash on a daily basis. There was no evidence to suggest that they had received this care in line with their wishes. We found that people did not therefore always receive person-centred care, in accordance with their own views and wishes.

Care plans were evaluated regularly but there was little evidence of the involvement of people or their relatives in the care planning or review process. One relative told us, "There have been no review meetings or care plan updates." A member of staff told us, "Reviews are done, I don't know if people's families are consulted. I've not seen residents being asked about their care plans."

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

During our previous inspection on 14 and 15 April 2016 we found that there was no system in place to receive, and investigate complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we checked to see if improvements had been made. A relative told us, "Yes I would make a complaint. My [relative] can't do it so I would."

We saw that a complaints procedure was in place and this gave the details of relevant contacts and outlined the time scale within which people should have their complaint responded to. This was on display in the main hallway.

The manager told us that the service had not received any complaints since our previous inspection.

Inadequate

Is the service well-led?

Our findings

During the previous inspection on 14 and 15 April 2016 we found there was a lack of management oversight of the service. The management of the service and systems in place were not effective or robust enough to ensure that risks relating to the health, safety and welfare of people using the service were responded to. The provider failed to submit an action plan outlining what actions they would take to address the range of concerns we had regarding the quality of service provided.

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

During this inspection we checked to see if improvements had been made. We found that numerous areas of concerns had not been addressed and rectified. In addition we saw that the local authority had an action plan in place to improve practice and safe guard people living at the service. We found that the action plan had not been actioned. This meant that the provider did not understand their responsibilities to continually assess, monitor and drive improvement at the service.

This inspection identified that there was no audit systems in place to identify when equipment and appliances used at the service required a service to ensure they were safe to use. There was no management oversight of the environment, a lack of environmental audits and no maintenance plan to ensure areas of risk that may be hazardous to people's safety and health were identified and rectified as soon as possible. We found that areas of concern and that had been identified at the previous inspection as unsafe had not been addressed to ensure people's safety was maintained.

We found that systems in place to assess people's needs and calculate the number of staff needed to meet those needs had not been effectively undertaken. The dependency tool did not accurately reflect the current dependency levels of people using the service and as a result we found staffing levels were not sufficient to meet people's care. This was having an impact on the quality of care received by people.

At this inspection we found that systems to ensure recruitment procedures were robust were not in place. Staff files were not audited or quality checked to ensure the correct process had been followed.

Staff felt unsupported in their roles and records demonstrated staff did not receive regular supervision and an annual appraisal. One staff member told us, "I don't feel well supported. We've worked hard and don't feel management do. It makes us demotivated." A second member of staff said, "If it wasn't for the residents I would leave. We get very little support and are not appreciated." In addition we found a lack of documentation to demonstrate that staff meetings were held on a regular basis. This meant that there were ineffective systems in place to ensure staff received feedback from the manager in a constructive and motivating way to improve their practice and drive improvement.

We found the culture at the service was not open and transparent. Staff told us they were not encouraged to give their views and ideas about the service by way of regular staff meetings, formal supervision and they felt

that communication was poor. A staff member commented, "We don't have team meetings and we never get told anything." Another member of staff said, "There has been no communication about how the service is moving forward. In my last supervision I raised that there has been no communication, there has been nothing since."

There was a manager in place but they had not yet registered with the Care Quality Commission. We received mixed views about the new management of the service. A staff member told us, "When he's here he's really good, you can talk to him." Another staff member said, "When [name of manager] is here and you have support it's ok, but this is not reliable." Staff told us that the manager was not a regular presence at the service and at times it was difficult to contact him. One staff said, "It's hard to get hold of [name of manager], you can't ring him." A second staff member told us, "Contact with [name of manager] is 50:50, some days you get no reply." Prior to this inspection we also received concerns from the local authority that when they had attended the service it was often to contact the manager, who was not always visible at the service. In addition, on the 20 June 2016 the stair lifts had broken and staff were reportedly carrying people up and down the stairs. The staff contacted the local authority to raise their concerns because they had been unable to contact the manager. This meant that leadership was not visible at the service and did not inspire staff to provide a quality service.

During this inspection we spoke with a healthcare professional who informed us about one person who had developed a grade two pressure sore and they had attended the service to dress the wound. They told us, "I never see the manager. Communication is poor." We fed this back to the manager who was unaware that the person had developed a pressure sore. This meant there was a lack of management awareness and oversight of people's conditions and events happening in the service. This also meant that reportable incidents that should be reported to the local authority or the Care Quality Commission would not be reported if the manager was unaware of them. We found this was the case and there were two incidents that had taken place at the service had not been reported to the Care Quality Commission.

We found that people, relatives and staff were not consulted regularly about the delivery of service. Record showed that there had been one relatives meeting had been held shortly after our previous inspection in April 2016 to inform them of the concerns found by the Care Quality Commission. There was a service satisfaction survey that had been undertaken at the start of 2015. Five responses were received and we found that relatives had raised areas of concern. There was no evidence that they had been analysed or used to improve the service.

We found there were a number of files that recorded quality checks such as safer food better business, cleaning schedules for night staff, walking handover sheets, kitchen daily and monthly cleaning checks and environmental audits. However there was no evidence in these files that they had been completed on a regular basis or what had been done as a result of these checks. There were no action plans in place to detail how issues raised would be dealt with. A toiletries audit had been carried out, but this did not make it clear if people had the items listed in stock, or if they needed to be purchased.

This showed that arrangements were not in place to monitor the quality of service provided to people, in order to drive continuous improvement and to keep people safe.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that was responsive to their needs or focused on them as individuals.

The enforcement action we took:

Notice of Proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment always not always sought in line with legislation and current guidance. People's capacity to make their own specific decisions had not been assessed and there was no evidence that best interest meetings took place when specific decisions needed to be made

The enforcement action we took:

Notice of Proposal to cancel providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not in place for all areas of risk, to ensure people were kept safe.

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to report potential abuse and keep people safe.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were being put at risk because the premises had not been adequately maintained.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The manager was not a visible presence at the service and was often un-contactable by staff. Effective quality assurance systems were not in place to obtain feedback, monitor performance and manage risks on a regular basis.

The enforcement action we took:

Notice of Proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not robust enough, to ensure only suitable staff were employed by the service.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's care and support needs safely.

The enforcement action we took:

Notice of proposal to cancel registration