Adiemus Care Limited

# Cerne Abbas

## Inspection report

Cerne Abbas
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Date of inspection visit: 8 July 2014
Date of publication: 02/12/2014

## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Inadequate |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

We 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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Cerne Abbas provides nursing care and accommodation for up to 56 people. At the time of the inspection there were 38 people living at the home. Since the inspection the home has now closed. The people living at the home were older people. People had mental health needs, complex health care needs or were living with dementia.

At our last inspection in 2013 we did not identify any concerns with the care provided to people who lived at the home.

The unannounced inspection was carried out over two days. At the time of the inspection there was not a registered manager in post. The register manager left in January 2013. Since that time there have been three acting managers but none had gone through the registration process. The current manager has submitted

# Summary of findings

an application to become the registered manager which is being considered. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

On the first day of the inspection there was a planned power cut at the home that lasted for seven hours. Whilst the electricity company had given ample notice of this the staff were not prepared. The lack of forward planning put people at risk of harm. The manager was on holiday, the senior member of staff designated to manage the home was not at the premises for the first two hours meaning there was no effective leadership. There were no extra staff on duty to support people during this time, no risk assessment or action plan to ensure people's needs were met in a safe manner.

On the second day of the inspection a project manager appointed by the provider as their representatives was present at the home.

On both inspection days we observed there was no activity for people to do, those who could, walked around, those who could not remained in bed or were left unsupported by staff in communal areas where they just sat. The interaction between staff and people living at the home was mainly around the staff tasks, such as assisting with personal care and support needs or assisting people to eat. We observed some people were left isolated as they could not call for help or company. One person who did ask for assistance was not provided with this for 15 minutes. One member of staff acknowledged their request but did not act. This meant staff did not support people in a caring and compassionate way.

The home was poorly maintained and put people at risk of harm. We observed areas of the home were not clean. Due to the lack of maintenance the home could not be effectively cleaned. This meant people were at risk of health acquired infections. For example, in some areas of the home there was no hot water. Specialised equipment used was in poor condition. The senior representative from the provider told us there were plans to refurbish parts of the building but they did not know when. The relatives we spoke with were aware of this.

People's care records outlined their needs and the risks they faced. These were not being consistently followed by staff. This meant people's needs were not being consistently met in the way they needed or wished.

There was insufficient evidence in people's care records that people had been consulted about their daily routines. For example, people were not consulted about what time they liked to get up in the morning. This meant people were not offered a choice about their personal preferences to receive care and support at the time of their choosing.

People's care plans had been identified as needing development. We found where improvements had been made to the care plans, staff were not following them. This meant people's care was not being delivered in accordance with their care plans.

People's rights to privacy and dignity were not always respected. We noted people had their door leading to communal corridors left open. In one instance, we observed from the corridor a person receiving personal care. This meant staff did not treat people with respect.

The home was in the process of a recruitment drive. The relatives and staff we spoke with shared their concerns about the lack of permanent staff and the impact this could have on people. We noted there were periods of time during the inspection where there was insufficient staff to meet peoples identified needs. This meant people were at risk of not having their needs met consistently.

There was a quality assurance audit at the home. This identified a number of areas that required improvement but there were weaknesses in the auditing systems.

We found the home was not consistently meeting the requirements of the Deprivation of Liberty Safeguards (DOLS) with systems to protect people's rights under the Mental Capacity Act 2005. (MCA) These systems were not being used as not all people living at the home had their capacity to make decisions considered. This meant people's individual rights were not being respected and adhered to.

We found numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe. The home was not clean in all areas which put people at risk of acquiring infections.

The environment was not maintained to ensure people's safety. People's care plans were not being consistently followed by staff which meant people were at risk of having unmet needs.

The records relating to medicines were not accurate and could not be relied on to ensure people had been given their medicines as prescribed.

**Is the service effective?**

Inadequate

The service was not effective. People did not consistently receive effective care and support to meet their needs. Staff were not deployed to ensure people's needs were met as planned.

People were not consulted about how they spend their day or given choices about their daily routines.

The home did not have adequate signage to help people orientate themselves and to enable independence as possible.

Staff had received some training to enable them to meet people's needs but this was not effective. Where there was a shortfall in staff training the provider had a plan in place to address this but this was not effective. The plans in place did not ensure people's needs were met at the time of the inspection.

People could see health and social care professional when required.

**Is the service caring?**

Inadequate

The home was not caring. The staff were not consistently caring towards people.

Staff did not always take time to ensure people were being supported in a caring and compassionate manner.

People or their representatives, were not always involved in decisions about their care and support.

**Is the service responsive?**

Inadequate

The service was not responsive. People did not receive care and support which was personalised to their wishes and responsive to their needs.

People did not receive any meaningful activities or occupation. People were isolated and left unsupported.

There was a system in place to listen to relatives concerns.

**Is the service well-led?**

Inadequate

The home was not well-led. People were placed at risk of inappropriate care because of the lack of good leadership and governance arrangements.

# Summary of findings

The management had a system to monitor and improve the service people received but this was not effective at driving standards up at the home.

Some staff felt supported and considered the service they offered was improving.

# Cerne Abbas

**Detailed findings**

## Background to this inspection

The inspection was carried out by one inspector and a specialist advisor who had experience of clinical health care needs. At the time of the inspection there were 38 people living at Cerne Abbas.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We spoke with professionals at the local authority such as the commissioners of care at the home and members of the Care Commission group.

During the day we spoke with seven people who used the service, five relatives, one senior representative of the provider, three senior members of staff and seven members of care staff.

We looked around the premises and observed care practices throughout the inspection. We reviewed seven people's care records and followed their care. This is 'pathway tracking' that aims to ensure people were receiving the care required. We also reviewed records held by the home relating to the running of the home such as environmental risk assessments, fire officer's reports and quality assurance monitoring audits.

Due to people's enduring mental health illness some people could not inform us how they experienced care at the service. We therefore carried out a Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they receive. The SOFI was difficult to fully utilise due to the other concerns within the home. Observations, where they took place, were from both the SOFI and general observations.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective? The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

# Is the service safe?

## Our findings

On the morning of the first day of the inspection there was a planned electrical power cut to the home. The home had been notified of this power cut by the electrical supplier some six weeks before the inspection. The home was in darkness. The internal electronically operated locked doors in place to ensure people were cared for in certain areas of the home, had failed and the doors were now open. We observed staff had put barriers dining room tables and chairs in front of access areas to prevent people leaving. However, this meant fire exits were blocked and the way tables and chairs had been placed posed a trip hazard.

The staff told us an onsite emergency generator was due to be started would provide electricity to the home. When the generator was started at approximately 9.40am only certain areas of the home received electricity. The generator had not been tested prior to the planned power cut to check that it was in good working order. One wing of the building, where up to eight highly dependent people were living, did not receive any electricity. In this area we noted a number of issues such as: there were no lights available; the fridge in the communal lounge was off; some people's air mattresses deflated and the emergency call buttons failed. This meant people were put at risk of falls in unlit corridors, people were at risk of harm as the equipment in place to relieve skin damage failed and the system that enabled people to call for help was rendered ineffective.

We noted there was no hot water, as the generator could not provide enough power to keep the boiler working. It was only when we talked with staff about hot water; did they consider the issue as there was no plan to address the issue. This demonstrated that people were put at unnecessary risk of harm as the provider had not effectively planned to keep people safe during the period with no electricity. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted on the second day of the inspection these areas still had no hot water. We also noted this was the case in some people's rooms. We spoke to staff about how they supported people to wash in these areas. They confirmed they carried bowls of hot water to complete the task. They told us the hot water had not been provided in these areas for some months. This demonstrated the hot water supply where designated hot water outlets were available were not in operation. Hot water is required to care for people appropriately and in the provision of the carrying on of the regulated activity.

We looked around the home to see how it was maintained. This included kitchenettes, lounges, bathrooms, people's rooms and the outside area. We found the premises were not being maintained in such a way as to ensure people's safety and welfare. For example, the home had two passenger lifts. One was out of order and the other required maintenance for its use because the call button being broken. We asked staff how they called for the lift. They told us they "stick a lead pencil into the call button"; they demonstrated this with a lead pencil. This put people who live and work at the home at risk of an electric shock as the call button switch would have been "live" to operate it. Staff told us this had been reported to the lift servicing company and to the provider but no action had been taken. We saw areas such as communal toilets and one communal bathroom were in poor decorative order with tiles missing from the walls. One relative told us "We have raised concerns about the decorative order in some parts of the home and have been told an update is planned". This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have served a warning notice in relation to the maintenance of the home to ensure that improvement takes place within an appropriate timescale.

On the first day of the inspection there was not enough staff on duty to safely support the needs of the people living at the home and to deal with the issues related to the electricity being off. Staff spent more time trying to address issues relating to the premises than supporting people. The staff were not adequately prepared or organised to ensure their skills and experience were utilised to meet people's needs. An example of this was that permanent staff, who knew people better, were deployed to monitor interconnecting doors, which due to the power failure were unlocked, whilst agency staff supported people with their care needs. This meant people were at risk of inconsistent care.

On the second day of the inspection, staff were not effectively deployed across the home to meet people's needs. People told us there were enough staff to support them; our observations did not correspond with what we were told. For example, we observed in one area two staff

were supporting eight people. People in this part of the home had complex needs with a diagnosis of dementia and behaviours that could challenge others. One person's care records instructed staff to ensure that the person was observed every 15 minutes to ensure their safety. We saw the person remained in bed at the furthest point away from the main lounge and staff office. We spoke with staff in this area who were aware of these instructions, but were unaware of the reasons why. They told us there were enough staff on duty to carry this out. We observed the person was regularly calling out for assistance but could not be heard by staff working in the lounge. We did not see staff enter the person's room to respond to the person's calls or observations as required. This is in breach of regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found significant problems with the cleanliness and hygiene of the home. The PIR told us 'the service was responsive to Clinical Commissioning Group report in relation to concerns over cleanliness and hygiene within the home during their monitoring visits.' We found the home and equipment were not clean, hygienic or well maintained. For example, we saw that some people's bedrooms en-suite bathrooms were dirty with dust and general grime, communal bathroom floors were dirty, lounge flooring was heavily stained in areas and there were food stuffs on the floor. Kitchenettes were not properly cleaned. Armchairs, wheelchairs and walking frames were not clean some were covered in general dirt and grime. Some parts of the home, especially Atrium, smelt of urine. We saw that the clinical waste bins outside of the home were unlocked and there was an accumulation of used continence aids and used plastic gloves. This demonstrated that the home was not being effectively cleaned which meant that people were at risk of health acquired infections through cross contamination. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have served a warning notice in relation to the cleanliness and infection control practices at the home to ensure that improvement takes place within an appropriate timescale.

People's medicines records were not reliable. For example, we observed one person living with dementia had two tablets in a dispensing pot on their table. We looked at the person's medicines administration records (MAR) we found they had been signed to confirm the person had taken the medicines. We asked the staff member if they had given the person their medicine to which they replied, yes. We asked the staff member to look at the medicines on the persons table; they confirmed it was the medication they had administered. The staff member told us the person must have put them back in the pot. We looked at the person's care records that did not evidence this was something the person had previously done. This meant the medicines administration records which were signed to say the person had taken the medicine were inaccurate. This is in breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they felt safe and did not have any concerns about their safety. The relatives we spoke with said they were not concerned about their loved ones' safety at the home but this was not what we found. People's care records illustrated the risks that they faced, but the plan of action to protect the person from these risks was not effective. For example, a person had fallen on two separate occasions on two consecutive days. The risk assessment had not been reviewed to look at any possible action that could have been taken to prevent further falls. Another person had a history of falls and had fallen at the home. The risk assessment and associated care plan did not consider what staff should do to minimise the risk. The plan did not seek to prevent the risk of further falls. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us, and records confirmed they had recently received training in safeguarding adults. The service had a policy in relation to safeguarding adults which identified the agencies to contact should staff have concerns. We spoke with two members of staff who were able to tell us how they would respond to allegations or incidents of abuse, but they were not clear about whom to report concerns to. This meant staff may not respond appropriately and in a timely fashion to any concerns raised putting people at risk of harm.

The system in place to assess people's capacity to make decisions about their own care was not being applied consistently. We looked at seven people's care records, only two contained reference to the person's mental capacity to make decisions. Not all staff had received training with regards to the MCA and DOL's. This is legislation which

Inadequate

# Is the service safe?

protects people who may not have the mental capacity to make decisions for themselves. Staff had some understanding of the issues and an action plan was in place to ensure all staff received training.

The PIR did not inform us that anyone had been deprived of their liberty. We noted that two people had their mental capacity assessed and following assessment a DOL's had been approved. We found appropriate records had been maintained that evidenced people important to the person and outside professionals had been consulted in the decision making process. We spoke with the representative of the provider who was aware of recent changes to the law regarding the DOL's and understood the need to reassess people living at the home in light of these changes. This meant there were systems in place to ensure people's legal rights were protected but these were not being consistently applied. Five of the seven care records did not consider people's capacity to make decision even when the records evidenced they were living with dementia. This is in breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

# Is the service effective?

## Our findings

There were insufficient signs and visual cues to enable people living with dementia to be as independent as possible. Staff told us it was a difficult building to get used to. People did not comment about how they oriented themselves when asked; many remained in their rooms or were supported to move around by staff. We observed there were areas of the building where people living with dementia were wandering around; there were no visual cues to assist a person back to communal areas. This meant people may experience anxiety and confusion due to the lack of visual clues to help them go where they wanted too.

The home monitored people's weight in line with their nutritional assessment. Care records showed that people's food and fluid intake was being monitored. For example, we noted one person had been assessed by a speech and language therapist and a safe eating plan had been developed. We spoke with two members of staff who worked with this person, both were aware of the safe eating plan but only one could tell us the contents of the plan and how to support the person safely at mealtimes. This meant there was a risk that the person may not be supported in an effective and consistent manner. We observed part of a meal time in one area and found there were insufficient staff to support some people at mealtimes; some were supported whilst others had to wait for up to 15 minutes until they received support. We saw people leave the dining table without receiving support, leaving their food uneaten. We saw staff did not encourage people to eat. We noted food was taken away from three people without staff enquiring if the person had finished. This meant people may become undernourished as they did not receive time and encouragement to eat their meal. This is in breach of regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported by staff that had received some training to enable them to meet people's needs. The PIR acknowledged there was a shortfall in staff training. We spoke to five staff who told us they had opportunities to update their skills through training. Two staff told us they had recently been asked to attend further training, as they needed to update their skills. We spoke to project manager of the service who told us that as a result of a recent audit, a plan had been drawn up to address the shortfalls identified. We looked at this audit and associated training plan. The training plan evidenced that training was planned but there were some significant gaps in the planning for example, three out of the six nursing staff who were responsible for leading the staff during their shifts had received or had planned dementia awareness training. Only 75% of care staff had received or had planned dementia awareness training. One member of nursing staff working nights had not received or had training planned in relation to dementia awareness, medication administration, medication awareness or pressure area care. This meant that the only senior staff member leading the night shift had not received or had training planned in key areas of their responsibility.

Staff told us, and duty rotas confirmed there was always a nurse on shift to support them. We spoke with agency staff who told us "There's always someone to go to" if they were unsure of how to support a person. Staff told us they had received regular supervision, some felt supported by the management of the home. However, a quality audit had identified staff were not receiving regular supervision, but there was no associated plan to address this issue. Staff also told us their concerns over the lack of permanent staff on duty. The relatives were also concerned about this issue. There was evidence of an on going recruitment drive in place. This demonstrated staff concerns over this issue had been listened too and action taken to address it. At the time of the inspection there was a recruitment drive in place to replace staff that had left. As a result of this the home was using a number of agency staff. The agency staff had received their training via their agency in areas such as, dementia care, food hygiene, diabetic care, manual handling. We spoke with five visiting relatives who told us that the staff understand people's needs.

People had their physical and mental health needs monitored. People's care records evidenced there were regular reviews of their health. People had access to healthcare professionals according to their specific needs. People told us if they needed to see a doctor or other health care professional the staff would arrange this. Three relatives told us staff ensure that people see a specialist health care advisor when needed. There were risk assessments in people's care records relating to skin care, mobility and nutritional needs. We saw where someone was assessed as being at high risk, action had been taken. For example where a person had been assessed as having a high risk of skin damage, specialist equipment was

Inadequate

# Is the service effective?

provided. There was little evidence people living at the home had been included in the reviews of their needs. We spoke to seven people and asked if they were consulted about their needs. One person told us “I leave it up to them (staff); they seem to know how I like to be treated”. Other people we spoke with could not comment about how they were consulted due to enduring mental health illness.

Inadequate

# Is the service caring?

## Our findings

People's privacy and dignity was not always respected. During the inspection people's doors to their rooms were open at all times. People's care records did not state they had chosen to have their doors open when they were in their rooms or in bed. We had to request that a member of staff close a bedroom door because a staff member was supporting a person with their personal care when we walked past.

People's personal information was not consistently treated as confidential. An example of this was when we found monitoring information such as people's food, fluid and observational records were in communal areas such as on tables or sideboards. This meant people's rights to privacy were not respected by staff and records were not kept in a confidential manner. The above is a breach of regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not consistently supported in a kind and caring manner. We spoke to three people in two areas of the home about how they experienced care. They told us staff were kind to them and that if they ask staff help them. Relatives we spoke with told us staff are kind and look after people well. One relative commented "the staff care for my loved one as well as I could; I have no concerns". Our observations did not correspond to what we were told. For example, we observed a person with no mobility or verbal communication had been supported to a small lounge facing a television that was not switched on; no other person was in the room. We saw one member of staff come into the room, approach the person from behind and recline the persons chair without speaking to them. Over a two hour period they were left in the room alone, facing the television. The person's care records stated they liked company. The records noted the person was 'a risk of isolation, liked company and should be observed every 15 minutes'. This did not take place. We spoke to one staff member about this person's needs. They told us that the person liked to watch television. We pointed out to them that there was no power to the television and that staff had left the person without considering this. Following our intervention staff arranged for the person to join other people in a different lounge. This meant people's social and emotional needs were not consistently met or considered. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home did not have adequate systems to ensure people were supported appropriately at the end of their life. The Clinical Commissioning Group manager told us they were concerned staff were not suitably trained and skilled to meet people's needs at the end of their life. Staff training records showed staff had not been suitably trained to meet people's end of life needs. We were not reassured that there were plans in place to ensure staff were going to be trained in supporting people at the end of their life.

People were able to express how they wished to be cared for at the end of their lives. For example, people's care records or those acting on their behalf evidenced people had been consulted about their wishes at the end of their life. Where appropriate a, "do not attempt pulmonary resuscitation" document had been placed in the person's care records which had been signed by a health care specialist.

Staff were aware of people's end of life wishes or knew where to find the information. We asked staff about what support they received when supporting someone at the end of their life. They told us that colleagues are around to talk to but were unaware of an organised approach to their support needs during this time. Two staff told us they were unaware of any support that would be offered to relatives, such as opportunities to stay with their loved one at this time. This meant staff were unclear of the support they and family members would receive when supporting and caring for a person at the end of their life.

One relative told us staff are very kind and go out of their way to make life enjoyable for the people they care for. They gave us an example of how staff often take people into the garden during their own breaks to give people some fresh air. They told us "This reassures me that staff are looking after my loved one well".

Inadequate

# Is the service responsive?

## Our findings

People did not consistently have choice about how they spent their day. We looked at the PIR that informed us 'residents have detailed care plans which as much as possible aim to reflect the

person's own views.' We asked three staff about people's daily routines in particular, if people can get up when they wished. Staff told us what people liked to eat and where they spent their day, but were less clear if this was by choice. One staff member told us: "I don't know what time people like to get up; I start at 7.30am, that's when people start to get up". People's care records did not inform about their preferred times to get up in the morning nor was there evidence they had been consulted as to their personal routines. This meant people's individual preferences were not considered, This is in breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were not always responsive to requests for support. We noted that a 2pm a person requested staff to help them to move from the dining table following their lunch which finished at about 1.30pm, staff ignored this request. The person then shouted to be assisted; a staff member responded "in a minute". At 2.10pm the person asked again for support as staff passed them. The staff member responded they would help later as the person needed a bandage changed. The person was supported into the lounge area at 2.15pm without having their bandage changed.

We observed a person with their nose flat on a side table; a staff member was sat in sight of this person. We asked the project manager why staff were not assisting the person. The project manager informed us that a staff member had gone to get a pillow as this is how the person liked to sleep. The staff member returned without a pillow and did not appear to be concerned with this person's sleeping position. The person's care records did not evidence this was how the person liked to sleep. They did not provide staff with guidance on how to respond to this persons needs nor did it indicate that a pillow, which due to the unique sleeping position may have posed a risk of suffocation, was the action to take to make the person comfortable. This meant that staff were not responsive to people's needs and did not have guidance on how to support people safely. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not provided with meaningful activities. We looked at a notice board that indicated what activities were planned but this was out of date by two weeks. We observed there was little for people to do. There was no organised activities provided by staff or equipment for people to interact with. This meant people either watched the television or walked around, others stayed in bed. We looked at people's care records relating to how they spent their time. People's social history was recorded which should have provided staff with guidance as to what people liked and what interested them. This demonstrated that whilst people's social needs were identified they were not provided with activities that meet these acknowledged needs. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were systems in place to share information and seek people's views about the running of the home. There were meetings for people's relatives, the last one being on 27 May 2014. A survey of relative's views of the service had also been carried out which raised issues such as, the cost of outside services (such as hairdressing and chiropody) and concerns that the home needed more occupational therapists. Relatives told us the acting manager was sharing more information with them but did not feel they could influence change. These systems enabled the home to monitor relatives satisfaction with the service provided.

We spoke with relatives about how they raise concerns with the manager. They told us in recent months they have been invited to attend relatives meetings to discuss any concerns and to be given information on the running of the home. One relative told us "things have improved recently; the manager is available to discuss issues and to help resolve our concerns". Another relative told us "the staff respond to concerns, I have never made a complaint because it's sorted out by staff". One person who expressed dissatisfaction with the service told us "things are not what they seem". We made the project manager aware of the person's comments who said they would speak with them. The staff did not demonstrate they had the skills to listen to people's concerns and take action to resolve them, for example one person commented there was nothing to do and they just sat around all day. We spoke to one member

Inadequate

# Is the service responsive?

of staff about how this person spends their time; they told us they watch television. They also told us the person always complains. This raised a concern about the staff ability to respond to need or review why this person complained.

Inadequate

# Is the service well-led?

## Our findings

The home was not well-led and there was poor evidence of leadership and governance being in place. There had been no registered manager since 1 January 2013. Since that time there had been three acting mangers; none of whom registered with the Care Quality Commission (CQC). A registered manager is a requirement of the home's registration with CQC. The current acting manager had submitted an application to become registered which was being considered by the CQC.

The provider had not ensured the home was effectively managed in the absence of the acting manager. Despite the advance notice of the power cut, the provider had not ensured they had addressed any issues in advance to ensure people were safely cared for. There were no risk assessments in relation to the power cut. The staff were poorly organised and did not have clear designated roles in order to ensure people's safety. We spoke with staff about what they had been told to expect on the day and if they had any briefing about what the power cut may mean to the safety of people living at the home. Staff told us that an existing emergency generator would ensure that the home was not affected. However, the home was severely affected as the emergency generator did not provide electricity to all areas of the home. Staff were not provided with leadership during this event. During the second day of the inspection a project manager appointed by the provider was present. We asked to view the risk assessment for the planned power cut but this was not available. We explained our concerns over the fitness of the building and infection control issues. The project manager explained that most of these issues were known about. These were evidenced in the quality and safety audit, the project manager told us the provider was aware of these concerns but no action had been taken The lack of environmental risk assessments and action to address these issues meant that safety was potentially compromised as a result.

We looked at the PIR which informed us that 'regular minuted resident meetings are held and the, findings or requests for improvement are acted upon', we saw no evidence to support this statement. The staff told us most people could not communicate their needs or participate in discussions about the home. There was no evidence of meetings taking place between the manager and people living at the home. This meant people living at the home were not enabled to comment on the service they received, or its development.

There were quality assurance systems to monitor care and plan on going improvements. We looked at the provider's monthly reviews of the service for May and June 2014. They had identified shortfalls in the service and indicated action had been taken to improve practice in some areas. We looked at a care plan audit that had taken place. The outcome of the audit stated that 'shortfalls in care planning had been addressed through staff supervision and meetings'. However we had noted that staff supervision was not happening and an action plan was in place to address this. The care records and associated risk assessments were ineffective at meeting people's needs and keeping them safe. This had not been brought out by the quality audit.

The provider's audit of the environment had not led to improvements. Although the audit acknowledged that many parts of the building needed improvements there was no action plan that stated when and how this would be achieved. Where concerns have been raised by external agencies, such as the fire safety officer, these had not been met. The fire officer being concerned that a fire route had been altered and was no longer effective and that there was insufficient equipment to safely assist people from the building as required. This meant the safety and wellbeing of people living at the home were still at risk due to the lack of progress in these areas. This is in breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a system in place to monitor accidents and incidents within the home. The manager had looked at these records and recorded and investigated what had happened. Senior staff had amended care plans based on the outcomes to prevent reoccurrence. However this system was ineffective as the plans to prevent reoccurrence did not provide staff with guidance on how to protect people or provide any learning from the monitoring carried out.

People, or those important to them, were not always involved in decisions that affected them. Prior to the inspection we spoke to professionals from the local authority. They told us they were concerned that people had been relocated from parts of the building due for

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renovation without consultation. We spoke to relatives about the building to gain their views. They told us they had been informed that parts were to be refurbished but did not know when; one person told us there had been plans for "over six months now" but they were not sure which area. One relative told us Atrium was being refurbished but again told us this had been on going for over six months. Relatives told us they had not been involved in any decisions about how the improvements were to be made, but they did have plenty of ideas. We spoke with the project manager who told us the provider was in consultation with the landlord about refurbishment of the home. They told us they had tried to move people out of Atrium in order to close the area. This had not worked as it had caused people distress and they were now looking at other options. This meant that not all people, or people important to them, had been consulted about decisions that may affect them. This is in breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>People's needs were assessed and care and treatment was planned. However not all care plans were effective. Care was not always delivered in line with people's individual care plan.<br><br>People were not provided with meaningful activities.<br><br>There were no effective arrangements in place to deal with foreseeable emergencies.<br><br>People were not supported to be able to eat and drink sufficient amounts to meet their needs.<br><br>.Regulation 9 (1)(b)(ii) (2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>People's privacy, dignity and independence were not respected.<br><br>People's views and experiences were not consistently taken into account in the way the service was provided and delivered in relation to their care.<br><br>Regulation 17 (1)(b)(d) (2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br><br>People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.<br><br>Records were not stored securely. |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>**There were times in the day when there were not enough qualified, skilled and experienced staff to meet people's needs.** |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>**Where people did not have the capacity to consent, the provider had not consistently acted in accordance with legal requirements.** |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>**The provider did not had an effective system to regularly assess and monitor the quality of service that people receive.** |

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br><br>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. |

**The enforcement action we took:**
A warning notice was issued to the provider requiring that they take action to ensure the premises is fit for purpose by 6 October 2014

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br><br>People were not protected from the risk of infection.<br><br>The home was not clean. |

**The enforcement action we took:**
A warning notice was issued to the provider requiring that they take action to ensure that the home is clean and people are protected against identifiable risks of acquiring an infection by 1 October 2014.