Mr & Mrs J P Robinson

Newland House

Inspection report

304-308 Norton Road
Stockton On Tees
County Durham
TS20 2PU

Tel: 01642535702

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 30 July and 2 August 2018 and was unannounced.

When we completed our previous inspection in December 2015 the service was rated good. At this inspection we found the service was no longer meeting all the required standards to retain this rating.

This is the first time the service has been rated Requires Improvement.

Newland House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Newland House can accommodate up to 30 people in a two-storey adapted building converted from three separate properties. One area of the building was specifically providing care to people living with dementia. There was a passenger lift and a stair lift to provide access between floors. At the time of our inspection there were 16 people using the service.

There was a registered manager in post however at the time of our inspection they had been absent for two months and it was anticipated that they would not return for another two months. 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. In the absence of the registered manager the assistant manager was providing management cover with the support of the provider's son.

Following the first day of the inspection we had a number of concerns which were shared with the provider. We invited them to submit an interim action plan to outline how they intended to address these concerns and we received this within the required timescale.

There was insufficient management support in place in the absence of the registered manager and staff morale was low. The assistant manager did not have knowledge of all processes and systems necessary to oversee the day to day running of the service. Audits and quality checks were not identifying the concerns we found during the inspection.

Some people did not have risk assessments in place to provide staff with information on how to manage and minimise all identified risks.

We looked at the systems in place for medicines management and found they did not always keep people safe.

Although fire equipment was tested we did not see any evidence of fire drills taking place.

There were insufficient staff on duty. Although basic care needs were met staff were rushed and did not have enough time to speak with people or engage in any activities. Care staff were also expected to do laundry, prepare and serve food from 1pm onwards every day and clean the service one day a week when domestic staff were not working.

People were not adequately supported to maintain a healthy diet. Up to date information on special dietary needs was not always available to staff. The mealtime experience was task orientated and staff did not always encourage people to eat before taking food away. Food and fluid records were not fully completed or reviewed.

People were not always treated with dignity. Staff spoke to people kindly and patiently during care interactions but had little time to do so when care was not being delivered.

There were no activities taking place. People were left sitting in lounge areas with no stimulation or interaction for most of the day. We were told that sometimes staff would sing with people but we did not witness this and it was not an activity tailored to individual needs.

Staff had completed all training the provider had identified as essential but they did not have additional training to meet the specific needs of the people living at the service. We have made a recommendation about this.

There were dementia friendly signs around the building, however the service had not been decorated in a dementia friendly way. There was no interactive equipment or sensory objects available to provide stimulation and reduce anxiety in people living with dementia. We have made a recommendation about this.

Staff understood people's needs and how they liked to be supported but this was not reflected in detail within care plans. Care plans contained generic task focussed information and had not been updated when reviews had identified changes in care needs.

We saw some evidence that complaints were investigated in line with the provider's complaint's policy but we did not see records of all complaints people had made.

Checks were carried out around the service to ensure the premises and equipment were safe to use.

Safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Staff had knowledge of safeguarding and were aware of the action to take if they had concerns.

Appropriate authorisation was requested to ensure people were protected against unlawful deprivation of liberty and staff supported people in the least restrictive way possible. Some people had conditions added to these authorisations but records of how these conditions were being met were not always completed.

We saw evidence in care plans to show the service worked with external healthcare professionals to maintain people's health and we received some positive feedback from visiting health and social care professionals.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely for people.

Risk assessments were not always in place, up to date or accurate.

There were not enough staff to adequately meet people's needs.

There were no recorded fire drills.

Appropriate checks had been undertaken before staff began work.

Is the service effective?

Requires Improvement

The service was not always effective.

Essential staff training was up to date but staff had not received specialist training to meet the needs of the people they were supporting.

People's nutritional and hydration needs were not always appropriately monitored.

DoLS authorisations were appropriately applied for and kept up to date. Records of how conditions were being met were not complete.

The building had some dementia friendly signage but there were no other adaptations to the building to provide stimulation for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we found the staff team were kind and caring in some of their interactions with people they were too busy to give people sufficient attention throughout the day.

People were not always treated with dignity.

People were encouraged to maintain relationships with friends and family with visitors made welcome throughout the day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were task based and did not contain details of people's life history, like and dislikes. Care was not tailored to the individual and some practices were institutionalised.

There were no activities taking place on a regular basis. People were sitting in lounge areas for most of the day with little stimulation.

Some complaints were investigated but we did not find records of other complaints we were told had been made.

Is the service well-led?

Inadequate

The service was not well-ed.

Staff did not feel supported and there was a lack of management oversight within the home at the time of our inspection.

There was no effective system of audits in place.

Records were not up to date, accurate or complete.

There was no evidence of feedback being successfully sought from people and no links with the local community.

Newland House

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 24 and 30 July and 2 August 2018 and the first day was unannounced.

The inspection team consisted of two adult social care inspectors, a medicines inspector and a specialist professional advisor, in this case a nurse.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local authority commissioners for the service and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with five people who lived at the service and three relatives. We looked at four care plans and medicine administration records (MARs) along with other aspects of medicine management across the home. We spoke with ten members of staff, including the assistant manager, care staff, maintenance staff and kitchen staff. We looked at four staff files, including recruitment records.

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

We also spoke with two visiting health and social care professionals and completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

We found that some people did not have specific risk assessments in place for their individual needs. The absence of these documents meant staff did not have the information necessary to minimise risk and keep people safe. Some of the risk assessments that were present were generic and not specific to the individual needs of the person.

Recognised tools were used to calculate people's risk level for things such as developing pressure sores and weight loss. However, these records were not being kept up to date and were not always an accurate reflection of people's risk level. One person who had been consistently losing weight had not had their risk level calculated since 21 February 2018, so appropriate actions had not been taken to reflect their current level of risk.

Appropriate referrals were not always made if a risk was identified. One person was regularly losing weight over a three-and-a-half-month period. We checked with the assistant manager who confirmed that no referral had been made to the person's GP, the speech and language team or a dietician. A referral was made following our feedback.

Some emergency plans were in place however these were not always up to date or complete. We saw that some people's personal emergency evacuation plans were not up to date and therefore did not match their current needs. The winter contingency plan was on display in the main entrance to the home despite it being August and there having been a recent heatwave. There was a hot weather contingency plan in place however there was no written record of what actions had been taken to implement this during a recent heat wave. Details such as what temperature would trigger implementation of the plan was not included making it less clear to staff exactly when action should be taken.

The provider's fire safety policy stated fire drills should take place every six months and involve people who use the service if possible. Staff had been trained on horizontal and vertical evacuation so they knew the principles of evacuating people away from a fire, however, there was no record of regular fire drills taking place. Given the complex layout of the building and limited staff numbers drills were particularly important to ensure people could be evacuated within a safe timescale. Between 7pm and 9pm there were only three staff (two care staff and one senior) providing care for 16 people, some of whom require 2:1 support. It was a particular concern that drills had not taken place to establish how three staff would be able to respond in an emergency situation.

Accidents and incidents were recorded. A falls analysis had been done by the registered manager but this was not up to date and had not been completed since February 2018. This analysis was of individual's falls and therefore did not look for patterns of falls occurring in certain areas of the home or at certain times of the day. One person had fallen several times and there was no record of any action being taken to address this.

The service used an electronic medicines administration record system (e-MAR). We found that whilst all the

oral medicines records were correct there were several issues with the application of and records for topical medicines.

Topical Medicines Administration Records (TMAR) were in place to guide staff on the application of creams and moisturisers, however records we looked at were not always clear. We found duplicate recordings of applications on these documents, as well as on the e-MAR system. One cream had not been applied at the frequency prescribed. The records showed that the cream had been applied regularly twice daily from the TMAR; however, this was not reflected in the amount of cream used.

One person who had been prescribed a topical cream was seen scratching the area where cream should have been applied. A member of staff told us that when they supported the person with personal care after lunch the area they had scratched was bleeding. Records confirmed that the cream had not been applied earlier in the day. Therefore, topical medicines were not being applied as prescribed.

We saw that controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored and signed for when they were administered, however, the home was not following their own policy in relation to stock checks as these were not being completed regularly.

We looked at how the home managed the application of patches used to administer medicine through people's skin and found they were not following their current medicines policy. Staff were not rotating one person's patch as per manufacturer's instructions.

We looked at how the home managed medicines to be given 'when required'. The home used when required protocols to guide staff on when to administer these medicines, however, these were not always detailed enough for staff for follow. Therefore, we could not be sure staff had sufficient information to administer when required medicine appropriately.

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

We observed, and staff confirmed, there were not enough staff to meet more than basic care needs. Staff we spoke with told us people's needs had increased but staffing levels had not and therefore staffing was an issue. As well as providing care and support to people, care staff were responsible for all laundry and for preparing and serving food once the kitchen staff left at 1pm each day. One member of staff told us, "It's quite difficult but we're doing our best. It's been raised with [registered manager] when they were in, but they said there's enough staff." Another member of staff said, "Things have been getting harder and harder, there's just not enough staff. I can't spend time with people and I find it very upsetting."

Dependency calculations were done for each individual but we were told by the assistant manager that these were not used to calculate staffing levels. This meant there was no evidence to show how the number of staff had been decided upon and whether this figure was appropriate to meet people's needs and keep them safe.

We saw that one member of staff was providing support to eight people in the area of the building specifically for people who were living with dementia. These people were sitting in two small interlinking lounge areas. The staff member was trying to encourage people with drinks, complete daily notes and support people with their personal care needs. Two people in this area required two to one support as they needed to use a hoist for transfers. If the staff member needed assistance they had to ring a call bell and

wait for support to arrive. One person in this side of the building was very distressed and needed constant reassurance due to their low mood and another person could be verbally aggressive. We observed the staff member working hard to juggle the demands of the role but it was almost impossible for them to spend any quality time with people. When they tried to look at photographs with one person, someone else needed support almost immediately.

We looked at the daily records for the people in the area of the home for people living with dementia. At 10:50am we saw that all food and fluid charts had not been completed to show people's breakfast and only three of the eight people were recorded as having been to the toilet by this time on the morning. The staff member was busy providing support and had been unable to update records. This meant there was a risk of inaccurate recording as there were not enough staff to update records in a timely way.

On the third day of our inspection we observed a person in one of the lounge areas shouting staff for help and trying to stand unaided when they were not able to do so. We had to alert staff to this as there was nobody in the area to provide the necessary support.

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

Information was on display informing staff and visitors how to raise any safeguarding concerns with the local authority. Staff were aware of the action to take if they were concerned about anyone being abused. One member of staff told us, "If I was worried about someone I'd go to a senior or the manager. I know the signs to look for, if people are withdrawn, bruised or stop eating. I'd go to the proprietor and if I thought nothing was happening I'd go to the authorities, to CQC or the police if I had to." Records showed that appropriate referrals had been made to the local authority safeguarding team.

On the first day of our inspection we could enter through the main door to the building as this was unlocked. An internal door could be accessed by a simple push button entry. The internal codes to the building were clearly displayed on a sign in the entrance hall meaning all areas of the building could be accessed from the street. This lack of security was pointed out straight away and when we returned on subsequent visits doors were locked and codes had been removed.

On the second day of our inspection the laundry was untidy with a large, open tub of washing powder on the floor in the laundry. The laundry was not locked and the washing powder was therefore easily accessible to people using the service. When we checked the records for control of substances hazardous to health (COSHH) the information relating to the washing powder was not available. This meant staff did not have all the relevant information to provide to healthcare professionals if a person had come into contact with this substance. We raised this with the assistant manager and when we returned to the home we found the laundry was better organised, the powder was now kept locked away and the COSHH information was available.

The provider's recruitment procedures minimised the risk of unsuitable staff being employed. Proof of identify and written references were sought, and a Disclosure and Barring Service (DBS) check carried out before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people from working with children and adults.

People we spoke with thought staff kept them safe. Relatives were also happy that their loved ones were safe. On relative told us, "I think she's kept safe but staff don't have time for much more." Other relatives told

us, "They have done a good job of keeping [name] safe while they've been here. We have no concerns about that."

Communal areas of the home were clean and tidy with no unpleasant smells. Staff wore protective clothing such as aprons and gloves to prevent the spread of infection and there were signs in toilets to remind staff to wash their hands. The kitchen had been awarded a five-star hygiene rating by the environmental health officer and was clean and tidy. Hot food temperatures were taken at lunchtime but on the first day of our inspection this was not being done by care staff who prepared hot food at tea time. We pointed this out to kitchen staff and the assistant manager who confirmed these checks would now be done on all hot food.

Regular maintenance checks, servicing and repairs were carried out. These included daily, weekly, quarterly, and annual checks of the premises and equipment, such as fire equipment, water temperatures, wheelchairs and hoists. Other required inspections such as gas safety and electrical hardwiring had also been done.

Requires Improvement

Is the service effective?

Our findings

People gave mixed feedback about the quality of the food. One person told us, "The food's not good. The chips were hard and I struggled to eat them. The Irish Stew is my favourite. Sometimes it's ok." Another person said, "The food is good and we get drinks all the time."

Inaccurate information about a person's dietary requirements was displayed in the kitchen on the first day of our inspection. We pointed this out to the assistant manager and included this in our action plan request. When we returned on the second day the information had not been updated and the assistant manager told us the information was correct. We referred them to the person's care records and information from their SALT assessment. The assistant manager then acknowledged the mistake and corrected it. The person's care records contained conflicting information on their nutrition and hydration needs including whether they required thickened fluids. There was also a lack of clear guidance to inform staff how people's diabetes was to be managed through diet. This meant people were at risk of being given incorrect food that may impact on their health and wellbeing.

Care staff prepared and served food after kitchen staff left at 1pm. This was an additional burden on staff resources and although trained in food hygiene, only four staff had received nutrition training. Food hygiene training does not include guidance on special dietary requirements such as different textures and food suitable for people with diabetes.

We observed staff were very busy at lunch time and this meant people were not given the necessary support and encouragement to eat their meals. One person was given a plate of food but was sitting with their head on the table. Staff left the food in front of the person then came to clear the uneaten meal away and offered them some dessert. Mealtimes were very quiet with little atmosphere. There was limited interaction between people using the service and staff did not have time to engage in or encourage conversation.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the amount of food eaten but this was not consistent and there were gaps in recording food after lunch and tea times. Fluid intake charts were very basic. Charts were not being analysed. There was no guidance on what people's fluid intake should be or what action to take if this was not achieved. This meant people's fluid intake was not effectively monitored, even during a spell of very hot weather, leaving them at risk of dehydration.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the training staff had received. Mandatory training was up to date. Mandatory training is training that the provider thinks is necessary to support people safely. This also included training on equality and diversity. However, specialist training in areas such as end of life care, depression and incontinence training had only been undertaken by three or four staff. This meant that staff may not have all the necessary skills to meet the specific needs of the individuals they were supporting. When the PIR was

completed by the registered manager in January 2018 they stated, 'This year we are not only conducting mandatory training but have resourced excellent new courses that are wellbeing of the elderly, further dementia awareness and end of life care as we feel that the more knowledge the care staff have enables them to pass this on in their care practices and when talking to residents.' Requests for additional training had also been made by staff within their supervision sessions. We saw no evidence that this training had taken place and the assistant manager confirmed that no training was scheduled.

We recommend that the provider ensures staff have access to additional training to meet the specific needs of people living at Newland House.

People's needs were assessed before they moved into the home to make sure the staff were able to care for the person and had the equipment to ensure people's safety and comfort.

There had been some adaptation to the environment to make it more suitable for people living with dementia. People had their photograph on their bedroom door with a picture symbol to identify it as a bedroom. Lounges, dining areas, toilets and bathrooms also had dementia friendly signage to identify them. There were also some decorative pictures in the dining room to identify it as a place to sit and eat. The lounges and corridors in the dementia area of the home had not been adapted to tailor them more to the needs of people living with dementia. Although one person had a small box of toys, there was nothing available to engage and stimulate other people such as activity boards or twiddle muffs. A social care professional told us, "The premises could do with more areas for people with dementia. The building itself means there are limited options but they could do a bit more."

We recommend the provider consults current best practice guidelines on providing a stimulating environment for people living with dementia.

People were supported to access external professionals to maintain and promote their health. However, care plans contained very limited information on the involvement of professionals such as GPs and district nurses.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the records of one person with a condition on their DoLS relating to their religious needs being met and found the records were not complete. We fed this back to the assistant manager who said they would look at an alternative way to record how the condition was being met. They acknowledged that a separate record for this would make it easier to review and would also act as a prompt for staff to ensure the condition was regularly met.

We saw that DoLS authorisations had been applied for appropriately and records were up to date and well

organised. We saw that people with a DoLS in place had relevant person's representatives (RPR). RPRs represent people and provide independent support. A record was being kept of RPR visits. There were records of capacity assessments and best interest decisions were made when necessary. We also saw records to say that people with capacity to do so had consented to their care and treatment.

Staff received regular supervisions but annual appraisals were overdue. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The assistant manager confirmed the appraisals would be done as soon as possible.

Requires Improvement

Is the service caring?

Our findings

Care was rushed at times and dignity was compromised because of the limited staff numbers. We saw one person being administered ear drops whilst eating their lunch and given tablets from a spoon between mouthfuls of lunch. In the dementia area of the home people were being asked if they needed the toilet loudly across a room as there was only one member of staff supporting eight people.

One member of staff told us, "Some people need new clothes but have no family. [Person's name] has put on weight and their clothes don't fit them. They need longer skirts. We've asked [registered manager] to get them some clothes but they haven't. It isn't dignified." One of the other people using the service also commented about this person's clothes stating, "Look at [name] their clothes are always too short." We observed this person sitting in a chair in the lounge pulling at their skirt to try to cover their legs. We raised this with the assistant manager and they told us they had bought new clothes for the person but they didn't fit anymore and they had not had time to buy more. Following the inspection, we checked that new clothes had been bought for this person and were assured they had been.

A relative we spoke with told us the laundry standards were "terrible" and said that other people were sometimes wearing their relative's clothes. On a recent hospital visit their family member's underwear was discoloured due to poor laundering. They told us, "It was awful to see. If it was your [family member] how would you feel?"

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

Relatives did not always feel they were involved in their loved one's care and felt communication needed to improve. One relative told us, "I was involved in [family member's] care plan initially but there was a review meeting with social services and I wasn't told about it or involved. I'm an active part of [family member's] care and communication definitely could be better."

People told us staff were kind and we observed staff were very caring but staff numbers meant they were unable to spend the necessary time with people. One person told us, "Staff are alright with me but they're very busy." Another person said, "It's great. The staff do more than they should I suppose." There were periods when we observed staff had limited interaction with people due to the demands of meeting basic support needs. Staff we spoke with were aware of this and some were visibly upset by it. One member of staff told us, "We have no time to sit with people. I go home and feel guilty as it's your role as a carer. I feel totally deflated."

We saw some positive interactions between staff and people they supported. Staff explained what they were doing when supporting a person using the hoist so they could move to the dining room for lunch. They were kind and patient and involved the person as much as possible.

An external health professional told us, "Staff are always caring and attentive. They know all about [name]

and keep me informed of any medical appointments."

A visiting social care professional told us, "Staff here are very caring, they know people really well. When I visit they will always pass me on to the member of staff who knows a person best so they can answer any questions."

A relative we spoke with told us, "Staff think a lot about [family member]. It's like a little family. They do try their best and I can't fault them for what they do but [family member] is not being stimulated, nothing goes on."

Information about how people could access advocacy services was on display. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at did not contain personalised information about people's support needs. Care plans were brief and task based, with very limited information about people's life history, likes and dislikes. We observed a member of staff supporting one person at lunchtime and they were able to tell us lots of information about the person's life history as they had known them when they were younger. When we looked in this person's care file none of the life history was included. We fed this back to the assistant manager who told us they had never seen this type of information included in care plans and they were not familiar with person-centred care planning. Person-centred care planning is a way of helping someone to plan their life and support, focusing on what's important to them.

The staff numbers meant that care was not always delivered in a person-centred way. Between 7pm and 9pm daily the lower staff numbers meant that people had to sit together in one lounge so staff could safely monitor them. This meant people's choices during this time were being limited. There was only a cook on duty until 1pm meaning it was difficult for people to choose to have lunch after this time. There was a bath rota in place that identified which day people were offered a bath. These routines were institutionalised and did not take into account the individual wishes of the person.

Throughout the inspection we observed three people sitting in one of the lounge areas for most of the day. Other than mealtimes there was very little staff interaction and no stimulation. Two of the people were sleeping most of the time and the third person told us there was nothing much to do other than watch television. When we spoke to this person the Jeremy Kyle Show, a talk show that often shows people being confrontational, was on television and they told us they didn't like it. We went to ask staff to change the channel and when they came into the lounge they turned to another channel without asking what anyone wanted to watch or whether people wanted the television on at all. A fourth person had left the room and we found them sitting in the dining room very upset. They told us they had left the lounge as the programme had upset them so much. They found the families fighting very distressing and had been moved to tears.

The provider did not employ an activities co-ordinator. Staff told us they did their best to entertain people but they didn't have enough time. One member of staff told us, "We don't have an activities co-ordinator. They left in April and we've had nothing since. We do try but it's difficult. We struggle to find the time. If we get things out to start an activity we're called away to help support someone else and have to put it all away again." Another member of staff said, "I wish we had more time and more staff on so we could do more activities. I like to do hair and nails. We need time to sit with people, reminiscing and talking to them. It's part of our caring role." The only activity that seemed to take place regularly was a sing-a-long. Staff and people we spoke with confirmed that they would often put music on and sing and dance on an evening. Although it was a positive that staff did try something to entertain people, this limited activity would not be suitable for everyone or meet everyone's needs.

One person told us, "[Name] usually comes on a Monday and helps people with singing but she hasn't been for a few weeks now. We used to have a singer with a guitar but he doesn't come now. People sleep a lot here." A relative told us, "There needs to be a lot more activities. The activities co-ordinator's gone and

nothing goes on now."

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

People's needs and plans of care were reviewed at least once a month to ensure they reflected people's current support needs and preferences. However, information about changes to need and support was often recorded in the review section and care plans were not always updated to reflect this. Some care plans had not been rewritten to reflect up to date support needs since 2016.

The provider had systems in place for investigating and responding to complaints and the policy was on display in a communal area. We saw records to show that complaints had been addressed by the registered manager and a response sent to the person who had raised the complaint. However, it was noted that specific details of the disciplinary action taken against staff had been disclosed in the response letter and greater care must be taken to avoid breaching staff confidentiality. One of the relatives we spoke with told us they had made a complaint to the registered manager and we did not see any written record of this. They told us, "I didn't like the way [registered manager] dealt with my complaint. They spoke to me about it in front of other people which just wasn't appropriate." As this complaint had been raised with the registered manager we were not able to follow this up in their absence.

We saw in the care records that end of life care plans were in place for people, with terminal and life limiting illnesses. Other than practical information about funeral arrangements these did not contain detailed information on how a person wished to be cared for at the end of their life to ensure their final wishes were respected. We were told that people were often reluctant to discuss this but this was not being clearly documented. Staff had not received end of life training which would assist them when writing meaningful care plans.

Where appropriate, care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to resuscitate them. These were up to date and kept in the front of care files so they were easily accessible to staff in an emergency.

Inadequate

Is the service well-led?

Our findings

The information in people's care plans was not accurate or up to date. It did not accurately reflect all needs and therefore staff did not have access to all relevant information about a person. Daily records were not always complete and food and fluid charts were not accurately maintained.

There was no effective audit system in place. The lack of management oversight of the service meant there was no understanding of what areas required work. Every month, between three and seven care plans were being audited but the issues we had found were not being picked up by this process. One of the care files we looked at had scored 100% in the most recent audit, carried out in June 2018, but at that time the records were not accurate or up to date. For example, missing risk assessments had not been identified. Health and safety audits had not identified that open washing powder was kept in an unlocked laundry room or that, prior to our feedback, people could easily access the building from the street.

We looked at the processes for auditing medicines within in the home and found there was no audit cycle in place. An audit had been carried out in February 2018 by the e-MAR provider but did not encompass all aspects of medicines managements. We did not see evidence of any internal audits or management checks in place to ensure the safe use of medicines.

The assistant manager had management responsibility whilst the registered manager was absent but they struggled to locate some of the information we needed during the inspection. They did not fully understand the electronic MAR system and were not able to run all the medicines reports we requested. They were at the service three or four days a week and although they had support with some tasks from the provider's son, staff told us they did not always feel they had adequate support. A relative we spoke with told us, "I think [assistant manager] has a good heart but they are not very communicative and they are very stretched."

Staff meetings had previously taken place but the recent management situation meant these were not happening on a regular basis.

Staff told us they found the registered manager unapproachable when they were on duty and morale was generally low. Comments included, "It's alright, I liked it better when I first started. We don't see the manager much. There's no-one to go to if you have a problem. We need leadership", "We're a good staff team and we get on really well but the manager is never here. We don't know who to go to and it impacts on us" and "The service is not well led. When I go home I feel like I haven't been able to help people the way I want to. I am so frustrated. There are issues and we've been left high and dry."

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

Although some statutory notifications were sent to CQC in line with the Care Quality Commission (Registration) Regulations 2009, this was not always the case. We saw that on one occasion a serious injury

had not been reported to us. The assistant manager was not aware they should have submitted this notification to us.

We recommend the registered manager and provider familiarise themselves with the circumstances when they need to make notifications to CQC by consulting the relevant regulations.

The assistant manager told us feedback was invited through questionnaires and we saw the blank forms next to the visitor's signing in book. However, we were told there had been a poor response to this. No alternative way of seeking feedback had been considered. A family member we spoke with told us, I've never been invited to a relatives' meeting. They started a newsletter but that's stopped. I've never been asked for my feedback."

There was very little evidence of any involvement in the community. There were not enough staff to take people out on a regular basis and there was no evidence of any visits from community groups. We were told that a school choir had come into the service once, but that had been a long time ago.

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 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 RA Regulations 2014 Person-centred care People were not receiving care which was person-centred or reflected personal preferences. Regulation 9(1) People's individual needs were not being met in relation to the provision of activities and social stimulation. Regulation 9(3)(b)

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not being appropriately assessed and staff did not have all necessary information to mitigate risk. Regulation 12(2)(a)(b) There were not adequate systems in place for medicines management. As a result people's medicines were not always administered correctly. Regulation 12(2)(b)(g)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration intake was not being accurately monitored to reduce risk of dehydration or weight loss. Appropriate action was not taken when people were found to be losing weight. Regulation 14(4)(a) People were not always provided with adequate support and encouragement to eat their meals. Regulation 14(4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective system of audits in place. This lack of management oversight meant issues we identified had not been picked up by the provider. Regulation 17(2)(a) Records relating to the care and treatment of people using the service were not complete, accurate or up to date. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified staff were deployed to fully meet people's care needs. This had impacted on staff's ability to provide care in line with the fundamental standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18(1) The provider did not have a system in place to accurately determine the number of staff required. Regulation 18(2)(a)