M D Homes

Northwood Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 23 and 30 September 2016. The inspection was conducted in response to concerning information received by the Care Quality Commission. We last carried out an inspection at the service on 29 September 2015. We found that the service required improvement in both safe and responsive. These issues related to insufficient hours allocated to people in order to pursue their interests and hobbies and inadequate safety measures with regard to the fire evacuation plan and inadequate individual risk assessments in place for people. At this inspection we found people remained at risk of inadequate safety measures and inconsistency of care and support provided to people.

Northwood Nursing Home is registered to provide accommodation and support for up to 35 people with health conditions, age related frailty and people living with dementia. It also provides nursing care. At the time of our inspection there were 30 people living in the home.

Although there was a manager in post they are not yet registered with the Care Quality Commission to manage the service. We were informed that they had submitted an application to become the manager in July 2016. 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.

People appeared unkempt and the support provided for their personal hygiene needs was not of a consistently good standard. People were placed at risk from pressure relieving equipment which was not being monitored effectively.

Recruitment processes were not always consistent in ensuring staff employed at the service were suitable to carry out their responsibilities and meet people`s needs. For some of whom English was not their first language we found they did not always understand the questions we asked them or what we were saying to them. The majority of the people who lived at the home had limited communication and therefore it was difficult to fully assess how this impacted on their health and welfare. We also noted that people were not required to complete a numeracy and literacy test in all cases prior to them commencing employment at the home.

The majority of staff understood how to promote and protect people's rights and maintain their privacy and dignity. However, we observed several instances where members of staff failed to respect people's privacy or dignity.

Engagement with activities and hobbies was limited. Loud music was playing in conjunction with a television within the main communal lounge area. We observed people were uninterested in either option and staff made no attempt to engage with people or offer people alternative choices of activities.

People's care plans lacked detail or accurate information relating to people's care and were not subject to regular review. Care plans were not person centred, and did not always contain sufficient detail to ensure

they reflected people's current needs and choices.

People were supported to take their medicines by appropriately trained staff. However, we found the process for the administration of medicines was not consistently safe.

Staff received support through induction and a training schedule with a mixture of E learning and face to face training. However training was not consistently effective in providing staff with the appropriate skills to help them meet the needs of the people who lived at the service. Staff told us that some of the training was completed at home and we could not be assured that staff were competent following completion of the training, especially for people whom English is their second language.

The service was not consistently well led and had not identified many of the issues we found during the course of our inspection. Where areas of concern had been identified appropriate actions had not been put in place to address these. Records were not completed in a timely way. Some of the staff were positive about their experience of working at the home while others were less positive.

The risk assessments in place were not personalised or detailed enough to support staff to keep people safe.

People's consent was not always obtained prior to care and support being delivered. We found that not all staff understood the principles of the Mental Capacity Act. We found that people's human rights had been unlawfully restricted. Staff did not always support people to make decisions and follow the legal requirements outlined in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).

Staff told us people were able to choose their own meals and the meal choices were completed the day before. There were no snacks or drinks for people to freely access because tea and coffee was only provided during set times during the daytime and evenings. The quality of the food we observed being served to people was of a poor quality and people who chose to have a vegetarian diet were given meals containing meat.

There was little engagement between staff and people who used the service and the care provided was very 'task orientated'. Some people who were more able had developed relationships with staff who treated them kindly.

Staff were knowledgeable about safeguarding procedures and we saw that they had received training. They were able to tell us what actions they took to keep people safe from possible abuse. However during our visit we observed one person being restrained and restricted from moving freely around the home.

People had access to health care professionals to make sure they received care and treatment to meet their individual healthcare needs. Staff supported people to maintain their health where possible.

There were systems in place for recording, investigating and responding to complaints. People and their family members knew who to speak to if they wanted to raise a concern.

The systems in place to monitor and review the quality of care provided failed to identify aspects of people's care which placed them at risk of harm.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in

special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and wellbeing were not always managed effectively to maintain their safety.

People's medicines were not always managed safely or effectively.

The recruitment process was not consistently robust due to some staff being appointed who had a limited command of English.

Although staff received training in safeguarding and knew how to report any concerns regarding possible abuse, we observed one person being restrained unlawfully

There were sufficient staff members to meet people's needs safely and in a timely way.

Is the service effective?

Inadequate

The service was not effective.

Training was not always effective due to poor practice.

Staff were aware of the need to obtain consent but only some of the staff knew about the principles of the Mental Capacity Act. People rights were not always respected and restrictions imposed unlawfully.

People had a limited choice of food and healthy and nutritious snacks were not provided regularly. Mealtimes were not a sociable experience but task orientated. Fluids were not offered regularly.

People had access to health and social care professionals to help maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive personalised care and support that met their individual needs and wishes.

We observed staff to be kind and caring. However, people were not always given choices.

People's privacy and dignity was not always protected and maintained.

People were supported to develop relationships with staff when possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were detailed but were not always personalised and reflective of people's individual needs and did not clearly demonstrate how people wanted to be supported.

Engagement and activities were not always planned around individual interests and abilities and did not support people's preferences.

People were supported to raise concerns or issues about the service and these were dealt with through the complaints policy

Is the service well-led?

Inadequate

The service was not well led.

The overall quality and monitoring of the service had not been effective in identifying many of the issues we identified as part of our inspection.

There were systems in place to audit aspects of the service but these were not always acted upon to improve the service to people

Records were not consistently maintained.

Staff were clear about their roles and responsibilities and received some support.

Northwood Nursing Home

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 was carried out in response to concerns we had received and was carried out by one inspector, one specialist advisor and one expert by experience. An expert by experience is a person who has experience in this type of service. This was to help facilitate the inspection and make sure that people who used the service and staff members were able to talk with us. A specialist advisor is a person who has the professional skills and knowledge in this type of service. We visited the service on the 23 and 30 September 2016.

The provider had completed a Provider Information Return (PIR) in advance of our inspection. This is a document that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who used the service, four relatives, seven care staff, a member of the activity staff, the deputy manager, the manager and regional area manager. We contacted family members and relatives to obtain feedback and also sought feedback from health and social care professional's familiar with the service. We looked at seven care plans, four staff files, complaints, records relating to food and fluid monitoring and other information which related to the overall monitoring of the service.

Inadequate

Is the service safe?

Our findings

People who lived at the home had mixed views with regard to if they felt safe. One person told us "I know that staff are around if I need them but I don't really need much help as I just get on with things myself." Another person told us, "I have to wait for up to 10 minutes for someone to come and help me get out of bed in the mornings and that is not acceptable and it makes me feel anxious and sometimes I use my call bell and they come in and switch it off but then don't come back for ages."

During visits on both 23 and 30 September 2016 we observed that people were not always kept safe. We saw that three people had ill- fitted and loose slippers. Two people were wearing slippers that were too big which caused them to slip off the back of their feet. We saw that this made it difficult for them to walk and placed them at risk of falling.

We observed that call bells were out of people's reach. For example, we saw that in three bedrooms where people were being cared for in their bed, the call bell was placed behind the person's head, under their bedding and one bell had been left hanging down onto the floor. In one of the bedrooms the call bell was unplugged. We were told that these people were checked 'hourly' to ensure their safety. However we found that the records for one person failed to confirm that they been checked hourly from 6 a.m. up until 12pm on 30 September 2016 and another person's records failed to confirm that they had been checked from 6 a.m. until 10.30 a.m. On 30 September 2016. One person we spoke to told us "The day staff are more caring than the night staff. Day staff 8 out of 10. Night staff 6 out of 10. During the night the staff turn off my call point or refuse to respond to it."

We saw that in addition to moving and handling risk assessments there were some general risk assessments in place for other aspects within the home. For example, for risks associated with fire risk assessments and the environment to help to keep people safe. There were, however, no risk assessments in place in relation to areas such as personal care, medicines, vulnerability to abuse or behaviour in some of the care plans we reviewed despite these being relevant to people.

People who were at risk of developing pressure sores were placed at increased risk due to pressure relieving equipment not being used safely. For example, some pressure relieving mattresses are set in accordance with people's weight. We found 3 out of 13 mattresses were set incorrectly. For example, one person weight was recorded as 44kgs but the setting for their pressure relieving mattress setting was found to be for people who weighed between 46kgs - 80kgs. We saw that one person's risk assessment stated that they should be on a mattress setting of between 80-108kgs. However the 'resident's pressure relieving log' recorded this person was on a mattresses setting for between 46kgs-80kgs. And a further person was on a mattress that was set for people who weighed between 46kgs-80kgs but their weight was recorded as 86.7kgs. This placed the person at risk of developing pressure ulcers.

Staff did not always demonstrate a good understanding of the needs people living with dementia and how to keep them safe. For example, with behaviour that may place them or others at risk. We observed that two staff members chatted between themselves in the main lounge area of the home when an incident occurred

between two people, one person was shouting at another person. The staff member turned around and said, "Stop that" calling the person by their name. They failed to engage or support either person using any distraction techniques. It took a further five minutes for the staff members to respond to the situation, placing both people at risk of harm.

People medicines were not always managed safely. We found there was an appropriate system in place for the ordering and disposal of medicines and found that medicines were stored correctly in a suitable secure storage facility . The stock balances we checked corresponded to the records. Staff had received training in the safe administration of medicines and had their competencies checked. However we found that the staff member responsible for administering medicines to people on 30 September failed to provide essential information to us with regard to the common side effects associated with the medicines they were administering to people. This included statins and blood pressure medicines. They were also unable to confirm the names of the two people who they had just administered their medicines to. This placed people at risk of harm of not receiving their medicines safely.

Due to the ineffective systems in place to keep people safe this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us, and we saw that, they had received training about how to recognise and report abuse and how to protect people from harm. Staff demonstrated that they knew how to identify and report potential abuse. For example, staff told us that people living at the service were observed for any unexplained bruising or any changes in their behaviours which may be signs of potential abuse. Staff were confident that any concerns reported to the manager would be effectively dealt with to make sure people were safe. However, we observed one staff member physically restrain a person by their wrists in order to prevent them from getting up from their chair. This was unlawful restraint. The incident was reported to the manager for their immediate attention and a safeguarding alert was also raised with the local authority.

The process for the safe and effective recruitment of staff was not robust or consistent. Staff told us they did not start working at the service until they had all their pre-employments checks completed by the manager. These included completion of an application form, an interview, a criminal records check and written references. These checks were in place to help to ensure that staff employed to support people were suitable for the roles they were being employed for. However, we could not be assured about how effective the checks were as we found that when speaking with staff who English was not their first language they could not always respond to our questions without the assistance of a colleague to interpret. We checked this person's record of interview and found that the manager had recorded that this person had 'Limited vocabulary, hence would have communication issues. Would initially require intense close mentorship without responsibilities.' We spoke to the manager about this as we were concerned if people who used the service said something to the staff members they may not be fully understood and this could place people at risk of harm. We were informed that several staff had enrolled on English language courses which they attended outside of their working hours. However this was only after they had been appointed and were working at the home.

One staff member told us that "Communication is a problem with some of the newer staff as they cannot understand basic instructions. I think some of the people who live here find it hard to understand them because of the language barrier." One person who lived at the home told us "I get fed up with trying to explain myself to the new staff sometimes as they don't understand what I am saying."

People were not always recruited with the necessary communication skills to provide safe care and treatment to people. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated

Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People were not always supported to eat and drink a range of healthy and nutritious foods. We observed that snacks were not readily available for people to access freely. Some of the staff said people could have a snack if they requested one. Other staff members said people were given tea or coffee and biscuits mid-morning and mid-afternoon. The manager told us snacks could not be left out because some people would "Just take them all." However this practice prevented people from being given the choice to eat and drink when they wished and meant people were reliant on staff offering them or them requesting a snack or a drink. We saw that people were only served drinks at specific times of the day

We observed the lunchtime meal on both visits and found that people were not always provided with support in a dignified and respectful manner. The meals were plated up by the cook in the main kitchen area, placed on wooden shelves with no means of maintaining the food at the required temperature. This meant that people were prevented from being offered both a choice of portion size or preferences of vegetables. There were also no menus on the table to remind people what they have chosen.

On the first day of our visit we observed one staff member assisting two people at the same time to eat their meal. We also saw one staff member assisted a person with their meal without any interaction or explanation of what the meal consisted of or asking the person if they were enjoying it. On the second day of our visit we observed one person was being assisted to eat their meal with utensils that were too big for their mouth and for the person to comfortably enjoy the food. On the same day we were also observed a staff member used the same utensils for the savoury meal as for the desert when supporting a person with their lunch. This meant that people were not supported in a dignified and respectful way.

We looked at the menus and choices provided to people. We were told by the manager that all the meat provided at the home was 'Halal' meat. A further discussion was held with regard to how people made an informed choice with regard to the consumption of this type of meat. We asked for evidence which confirmed everyone who lived at the home had been consulted with regard to this practice and had consented to the consumption of halal meat. This included 23 out of the 30 people who the manager stated had been assessed as lacking capacity to consent, for the use of bedrails, personal care, a photograph, sharing medical records and a medical examination. However the manager was unable to produce any evidence or documentation to support this decision. They informed us that this information was provided as part of the initial assessment for people when they moved into Northwood Nursing Home.

We looked at the pre-admission assessment dated 17 June 2016 for one person. We saw that under the heading of 'Nutrition' it stated 'Explain- halal food served'. The record stated 'Has their own teeth, eats a normal diet and drinks normal fluids.' However there was no reference to any discussion being held with this person regarding the explanation about halal meat. The assessment also stated that this person lacked capacity to consent. However there was no record that a best interest meeting had been held with regard to this practice. This demonstrated a lack of choice and respect and also prevented people and their relatives from making an informed choice about the type of meat they consumed.

We found that one person's care plan stated that they required a vegetarian diet but had been given chicken on three separate occasions during September 2016. The food records also demonstrated that this person was given 'spaghetti meat' on 30 August 2016.This action showed a disregard for this person's dietary choices and was disrespectful. We looked at the meal provided to this person during our visit saw that the main meal consisted of hash browns, chips, mashed potato and baked beans with no vegetables provided but three types of potato.

We saw from records that people were weighed monthly unless there were concerns about people's weight and in which case they were weighed weekly. Overall people had sustained their weights and where people had lost weight, this was monitored. However, we saw that food and fluid monitoring records were not always completed in a timely way. For example one person's chart dated 23 September 2016 only had one entry of 'tea' at 7 a.m. and no further entries had been recorded until 1 p.m. where the entry stated 'water' without any indication of the amount of fluid the person had consumed. Staff told us they completed the charts when they had time usually toward the end of their shift. This meant that we could not be assured of the accuracy of the records.

Due to people's choices and preferences not being upheld and their nutritional needs not being met we found that this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they had received an induction and that they had on-going training. Training records provided to us by the manager demonstrated that staff had received training in moving and handling, fire safety, safeguarding adults, infection control, mental capacity, health and safety and food hygiene. However we found that not all staff had received training in keys areas to support people with enduring mental health needs which included bi-polar affective disorder, and a mental illness diagnosis of schizophrenia.

Training records we looked at demonstrated that epilepsy training was considered by the provider as an annual course. Records showed that only 12 out of 30 staff had received epilepsy training and none of these 12 staff had received training since January 2015. Staff spoken with were unable to sufficiently explain what types of epilepsy people could suffer from and what action they would take, in practice on how to identify the type of fit and how best to support the person during a seizure.

Some of the staff told us they felt supported by the management team, while other staff members told us they did not always feel supported. One staff member said, "I think the [registered] manager should be more pro-active with some of the staff who don't do as much as they should." We saw that staff had intermittent supervisions and an annual appraisal. However, some of the records we saw did not demonstrate effective supervisions and were incomplete. The supervision records provided showed the most recent supervision of staff were completed in March 2016. We spoke to the manager about this but they were unable to give us an explanation why this was. One staff member told us, "If I have a question I find one of the seniors to ask them for help, the [registered] manager is often too busy." Another staff member said, "The manager spends a lot of time in their office but not on the floor."

Some people could not tell us if staff always asked them before they provided the support people needed due to their limited communication abilities. Staff spoken with told us they did always obtain people's consent before supporting them. However, we observed that this was not always the case. On four occasions we saw staff taking people by the hand and leading them from one area to another without explaining where they were taking them. Consent had been recorded in people's care plans and where appropriate relatives had been involved in the process where they had the legal right to do so.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that people had restrictions applied to their freedom without having DoLS authorisations in place for these. For example, two people who chose to smoke cigarettes were prevented from freely accessing these due to a restriction being imposed by the home. We saw that cigarettes were provided at set periods of time throughout the day by staff. A staff member told us that this was, "Because the person would smoke the whole packet at once." However there was no evidence within this persons care plan that their capacity to consent had been assessed and there was no evidence that consideration had been given as to whether a Deprivation of Liberty (DOLS) application was required to the Local Authority in relation to this restriction.

We looked at the care plan for the other person whose cigarette consumption was restricted and witnessed a staff member stating to this person, "If you don't eat your pudding up you won't have your cigarette." This was comment was both abusive and inappropriate. This incident was passed onto the manager for their immediate attention. There was no evidence within to confirm that this person's capacity had been assessed or a Deprivation of Liberty (DOLS) had been applied for to the local Authority in relation to this restriction

Due to people's liberty and choices being restricted we found that this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain their health and records of health related appointments or any medical interventions were recorded in people's care plans. Staff told us and records confirmed that they made referrals to relevant healthcare professionals should the need arise including GP appointments. One person told us they had seen the chiropodist recently. Staff also told us that they made appointments for people to be seen by the chiropodist or dentist when required. People were supported to attend Hospital appointments if family members were not available to support. This showed that people received support from healthcare professionals to help maintain their health.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always promoted. We saw some examples of staff caring for people but on several occasions throughout both our visits were saw that the care provided was often basic and functional. On arrival at the home on both the 23 September and 30 September 2016 we observed the same person lying back in a recliner chair scantily clad and with no blankets provided to maintain this person's dignity and privacy. We observed staff on both occasions walk straight pass this person without noticing that they were dressed inappropriately. We had to raise this issue on both occasions with the manager for their immediate attention. This demonstrated that people's dignity and privacy was not always respected or maintained.

People were not consistently cared for in a way that demonstrated staff respected people's choices or followed their personalised care plans. The lack of attention to detail meant that people were sometimes left in an undignified manner. One person told us, "They put me to bed between 6p.m and 7.pm every night when I would like to go to bed between 9p.m to 10p.m." This person also stated, "Apart from my bed time they do meet my needs. I go to bed when they want me to go to bed not when I want to. I eat when they want me to."

We found that some areas of the home were in a state of disrepair. This included communal areas where the walls were badly chipped and the paint was flaking off. We also found some of the areas which were carpeted were badly worn. One relative told us, "The rooms are in need of redecoration, the curtains are thin and old." This meant that the people lived in an environment that was not always maintained to an acceptable standard.

We saw that five out of seven people who were seated in the main lounge area of the home appeared dishevelled, unkempt and with greasy hair that had not been combed. We saw that three people had foot wear on that was ill fitted. We saw another person had not been shaved and had dried food on their clothing. Another person had bare feet with excessively long yellow toe nails that would could prove uncomfortable if they wore shoes or slippers.

Due to people not receiving the care and support that met their needs and people's preferences not being upheld, we found that this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five out of seven people we spoke with could not recall having been involved in planning or reviews of their care plan and four knew little about what their own care plans contained. One person said, "I do not know about my care plan." One person told us, "I helped write my care plan."

Private and confidential records relating to people's care and support were securely maintained in lockable offices. Staff were able to demonstrate that they were aware of the need to protect people's private and personal information. This helped ensure that people's personal information was treated confidentially and respected.

Requires Improvement

Is the service responsive?

Our findings

Not everyone at the home was able to tell us if they were happy with the support they received. However two family members raised concerns about how responsive the service was to meeting people's needs. For example one relative told us, "My relative always liked to go out for a walk and enjoyed pottering around in the garden. However this rarely happens as the garden area needs some attention and there are not always people to take them around the garden as there are some areas of the garden that are slippy and could cause my [family member] to fall."

People were encouraged to participate in activities. However we found these did not always reflect people's needs. One person told us, "I like sewing arts and craft and doing things. None of this takes place here." We found that care plans did not always include information about people's hobbies and the type of social activities they enjoyed. For example, we observed in the main lounge the television was on but there was also music playing. People were not engaged with what was on and the volume was loud drowned any potential for communication or conversation. There was no attempt from the staff members present to change it, or ask people what they would like to listen to. We saw that on both our visits that the activity in the morning was painting, which was well attended, although the materials and subject matter was infantile and could be further developed to reflect people's individual interests and be more age appropriate. One person told us "There are some activities but nothing that I really like. They do not create an individual activities package for me."

The activity programme for the afternoon was room visits however was no evidence from the individual activity records that these visits took place on either the 23 or 30 September 2016. We saw from the training records that there were no specific training courses provided for activity staff in order to further develop their skills. The current activity programme did not provide specific activities to engage or support people with dementia. We were told that people had the opportunity to go out on trips to the local parks and cafe's although one person told us that they had been unable take part in the most recent outing as there was not enough room for their wheelchair.

One relative told us, "There are not enough activities and not much at all at the weekends." We found there was little stimulation or interaction from staff for people who lived with dementia. There were no visual prompts or objects available that could stimulate and engage people. We noted that staff did not provide any activities or engagement for people who were cared for in bed. One staff member told us "This rarely happened as staff are too busy." Another staff member told us, "When we have time we sit and chat to people individually."

People's care plans contained information about how they needed to be supported. However, care and support was not always provided in accordance with their care plans. Some care plans were more detailed than others. In the case of three of the care plans we reviewed they did not contain specific information for example about people's preferred times for getting up and going to bed and whether people preferred their bedroom door left open or preferred it closed.

People's care plans lacked detail or accurate information relating to people's care and were not subject to regular review, no background or social history to support staff to understand the person better in six out of nine care plans. Each care plan contained a basic list of the tasks that care staff would follow when providing support, and some information in relation to continence, mobility, communication and diet. However this information was not person-centred and did not provide enough detail to enable staff to carry out tasks consistently and safely. From our observations we saw that staff often provided only basic and functional care and this was not always in accordance with their care plans.

We were unable to see from the bathing records that people had received regular baths or showers in line with their preferences in their care plans or through promoting good hygiene. This included three people whose records failed to confirm that they had received a bath or shower since August 2016. One person told us "I like to have a shower or bath once or twice a week but there isn't always time for staff the staff to help me." Records we looked at for a person who was being looked after in bed could not demonstrate when they last had a bath or shower, during the period between 25 and 30 September 2016. The care plan stated that their preference was to have a bath once a week. This meant that people's personal hygiene needs were not always respected.

We found that the environment, in particular for people living with dementia, was not well maintained and was in need of some updating. Paint was chipped and the environment had nothing of interest for people to engage with. There were no prompts or aids for people with dementia to assist them in locating their room or personalise their rooms. When we checked some of the mattresses and bedding we saw that some were soiled and there were malodours present. We found that three people had pillows that were very lumpy and duvets that were old and very thin. We spoke to manager about this and they agreed to complete a full audit of all the bed linen and replace this, where necessary.

Due to the lack of meaningful engagement for people living with dementia, poor care delivery and ineffective care plans we found that this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's complaints were responded to appropriately. We spoke with one person who told us "I have made complaints. They took my complaints seriously." A relative told us, "My [family member] made a complaint because they were attacked by one of the residents. This complaint was dealt with very well." There was a process in place for the recording and investigation of complaints. We reviewed the complaints log and saw that complaints were investigated and responded to in accordance with the complaints policy.

Inadequate

Is the service well-led?

Our findings

The management of the service lacked leadership and was not transparent or open. We found during our visit that people had been placed at risk of harm due to unsafe practices and ineffective systems that monitored people's health and safety. For example people who were on pressure relieving equipment had their mattresses set incorrectly. This issue had not been identified by the monitoring system in place. People had their liberty restricted unlawfully with regard to access to their cigarettes. This practice had not been appropriately assessed and monitored by the manager. We found that people's nutritional and dietary needs were not monitored which placed people at risk of harm from consuming food that was both inadequate and against their wishes.

We also found that the audits in place that monitored people's records in relation to three hourly turns, hourly call bell checks and fluid balance charts had failed to identify gaps in these records which placed people at risk of harm from pressure ulcers and from dehydration.

Feedback from staff did not always demonstrate that they were being given the appropriate training or supervision to carry out their role effectively. For example the most recent supervision records provided were dated March 2016. We spoke with four staff about supervision and three people told us that they had supervision every three to four months and one person told us "I have informal chats with the senior staff but I don't think I have ever sat down and had a face to face meeting. I thought this was mainly for when you did something wrong." Although we saw from records that staff had received safeguarding training, we witnessed two separate incidents which meant where we could not be assured that all staff had the knowledge and understanding of what constitutes abuse. For example we saw one staff member restraining a person in a chair and the practice witnessed by one staff member who stated they were going to restrict someone from having a cigarette if they didn't eat their meal. This meant that the standard of training provided had not ensured all staff were aware of practices that constitute abuse.

We found concerns in relation to the recruitment process in place as one staff member had been appointed as a junior nurse but had great difficulty in understanding our questions and required another staff member to translate what we were asking. We could not be assured that they were trained effectively as they could not understand English. We found that they had been fully inducted into administering medicines to people in April 2016 by the manager but during our visit on 30 September we found that they were unable to answer basic questions that related to the side effects of medicines they were administering to people and were unable to confirm the names of two people they had just given their medicines to.

The manager also told us they walked around the home on a daily basis; however they had not found some of the concerns we discovered during our visit. For example fluid and hourly monitoring checks that had not been completed. People who had been left for significant periods of time without any care or support and pressure relieving mattress settings that were incorrect.

The audit undertaken by the area manager on 30 August 2016 raised many of the issues we identified during our two day visit but these had not been actioned. For example the report stated that 'There is a need for a

more structured format for recording activities, no call bell risk assessments in place, there is a need to make the assessment format more person centred and written in the first person and that they were struggling with the English language and the training matrix had gaps.' We saw from the action plan that the timeline for implementing these outstanding issues was recorded as 'Immediate and 'On-going' but with no deadline dates recorded.

We spoke with staff about the management of the home. Staff gave us mixed feedback about the support they received from the senior staff. One person told us "I like working here as the staff are friendly and supportive, although I don't get to see the manager that much."

We were told by the manager that there were no formal staff meetings held but staff met on an informal basis as part of the daily handover sessions. We were also informed that relatives meeting were held periodically and the minutes seen from the most recent meeting held in September 2016 showed a variety of issues discussed, for example plans for the Christmas party, the updating of person centred care plans and areas of the environment that require attention. The meeting was attended by four relatives and the managers of the home. However there were no action plans devised from the meetings held for March, June and September 2016 to confirm that the outstanding issues raised had been addressed and actioned.

Governance systems were not robust. We found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Feedback was obtained through the completion of an annual survey. However the results of the most recent annual review were unavailable at the time of our visit. We also saw that there had been an independent review carried out in September 2016 where 11 people had responded to a questionnaire about the service. Although the home achieved an overall score of 92 % the findings of our visit did not reflect this rating.

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 Due to people not receiving the care and support that met their needs and people's preferences not being upheld, we found that this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Due to people's choices and preferences not being upheld and their nutritional needs not being met we found that this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Due to the ineffective systems in place to keep people safe this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Due to people's liberty and choices being

restricted we found that this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust. We found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not always recruited with the necessary communication skills to provide safe care and treatment to people. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.