Mrs P Kent

Kent Lodge Residential 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on the 13 and 17 February 2015 and was unannounced.

At the last inspection on 15 May 2014 we asked the provider to take action to make improvements as we found that the provider had failed to assess and manage risks in relation to people's health, welfare and safety. The provider had not taken action to regularly monitor the quality and safety of the service. There was a lack of training and supervision support provided for staff. We asked the provider to produce an action plan which would describe the action they would take to make improvements. The provider failed to send us any action plan.

We carried out this inspection to check if improvements had been made. We continued to have major concerns regarding the lack of action taken by the provider to safeguard people. Leadership of the service was found to be weak and inconsistent. Support and resources needed to run the service were not always available.

Summary of findings

Kent Lodge provides accommodation and personal care support for up to 30 older people who require support including people living with dementia. On the day of our inspection there were 23 people living at the service.

Prior to our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

This service does not have a manager registered with the Care Quality Commission (CQC) as is required by law. The current manager had been in post 12 months and had recently submitted their application to register with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's safety was compromised in a number of areas. This included the management of people's medicines and the recording and analyses of accidents and incidents.

Staffing levels were insufficient to meet the needs of people who used the service. The provider did not have a system in place to ensure continuous assessment of staffing levels and make changes when people's needs changed.

The provider did not operate a safe and effective recruitment system. People were put at risk because the provider did not take steps to carry out Disclosure and Barring (DBS), criminal records checks prior to staff starting their employment.

We were not assured that people's choices and rights were being respected. Staff had not received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The provider did not demonstrate any understanding of their roles and responsibilities in safeguarding people and taking steps to follow the principles of the MCA 2005. They were not fully meeting the requirements of the Deprivation of Liberty Safeguards.

People had not always been supported to access, when needed, the support of health care professionals. Staff had not recognised the onset of pressure ulcers and had not supported people to access care and treatment from health care professionals in a timely manner.

The service was not run in the best interests of people using it because their views and experiences were not sought enough. Improvements were needed in the ways that the service obtained people's views and used these to improve the service.

Staff did not demonstrate that they had the required knowledge to be able to safeguard people and report any safeguarding concerns to the relevant safeguarding authority.

People told us their privacy and dignity was respected and made positive comments about care staff. There was insufficient planning to support people's wishes and preferences regarding how they wanted to be cared for at the end of their life. There was also insufficient planning to promote and support people's individual leisure interests and hobbies. We were therefore not assured that the planning and delivery of care supported people's individual needs, wishes and preferences.

We found there to be a number of continued breaches. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were put at risk because staffing was not well managed. Cleanliness and hygiene standards had not been maintained.

People's medicines were not managed safely. We could not be sure that people had received their medicines as prescribed.

The provider did not operate a safe and effective recruitment system. People were put at risk because the provider did not take steps to carry out Disclosure and Barring (DBS), criminal records checks prior to staff starting their employment.

Is the service effective?

Inadequate

The service was not effective as people did not receive care that was based on best practice. Staff and the manager did not have the required knowledge and skills to protect people at risk of dehydration, malnutrition, pressure ulcers and health related conditions such as diabetes and epilepsy.

People were put at risk as they had not supported to access healthcare services in a timely manner when their health needs changed.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff interacted with people well but people who were quiet were given little attention. Staff did not always respond to people's needs and requests in a timely, compassionate and responsive manner.

Personal life history documents had not been completed and so staff did not know peoples history unless they took the time to get to know them. Care plans did not set out people's choice and preferences in how they wished to live their daily lives and for when they reached the end of their life.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. Care plans did not contain enough information about people's needs for staff to deliver responsive care.

The provider did not have a system for logging complaints, concerns and suggestions. People did not have opportunities to air their views regarding the quality of the care.

People did not have their individual needs, wishes and preferences assessed in relation to their interest and hobbies and how these could be supported and provided for.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. The management of the service lacked direction and positive leadership.

People were put at risk because there was a lack of systems for monitoring the quality and safety of the service.

Staff and health professionals expressed concerns about the management of the service.

The manager and the provider did not identify, assess and manage risks relating to the health, welfare and safety of people. There were no plans in place to guide staff in emergency situations. The provider had failed to identify areas of the service that were unsafe and failed to take action to protect people from the risks of harm.

Kent Lodge Residential 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 took place on 13 and 17 February 2015 and was unannounced.

The inspection team consisted of two Inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service. The Expert by Experience had experience of older people and people living with dementia.

We reviewed the previous inspection reports to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local safeguarding authority.

We spoke with 10 people who were able to verbally express their views about the service and four people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed

the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to six people's care. We spoke with eight members of staff, including the manager, care staff and the cook. We looked at records relating to the management of medicines, staff recruitment and training, and systems for monitoring the quality of the service. We also spoke with stakeholders, including two members of the local authority safeguarding team and three health care professionals.

Prior to our inspection we had received concerns about the service provided; these had been reported to and investigated by the local authority. The local authority had kept us updated with the support that they were providing to the service to assist them to improve the care and support provided to people. During our inspection we looked to see what action had been taken as a result of these concerns.

Inadequate

Is the service safe?

Our findings

At our previous inspection in May 2014 the provider was not meeting the requirements of the law as they did not protect people against the risks of receiving care or treatment that was inappropriate or unsafe. We found at this inspection that they had not taken action to improve. They had continued not to provide individual assessment of risks which would identify risks such as the moving and handling of people, risk of developing pressure sores and identification of risks as a result of dehydration and malnutrition. There were no plans in place to guide staff in the safe use of mobilising equipment for two people who could not mobilise independently without staff support to transfer.

One person's assessment of need was incomplete under sections eating and drinking, pressure care and mobility. Community nursing notes stated that this person had a red broken area on their sacrum and a repose cushion had been prescribed to prevent further deterioration. There was no risk assessment and plan of care in place to guide staff in the care and treatment in relation to pressure care. We asked the manager why these sections had not been completed; the manager said he did not know why. We visited this person in their room and found they were sitting on an ordinary cushion. Their repose cushion prescribed by community nurses was lying on top of a commode. We asked staff why the repose cushion was not in use. They told us they did not know why.

We saw staff on two occasions assisting people to mobilise into armchairs using electric hoist equipment. Although this was done safely and efficiently, the health, welfare and safety of people had been compromised as the same hoist sling was used for a number of people. No individual assessments of appropriate sized slings had been carried out. This meant that there was a risk of injury from ill-fitting hoist slings as well as a risk of cross infection from the same hoist sling being used for a number of people.

We asked health and social care professionals for their opinion of the service and were told that they had concerns about the lack of skills and knowledge staff had in caring for people at risk of acquiring pressure sores and the monitoring of people at risk of malnutrition. Community nursing staff told us that staff had not informed them in a timely manner of people who required health input to treat pressure sores.

People's care was not planned and delivered consistently. People who had been identified by district nursing staff as at risk of developing pressure sores did not have risk assessments with action plans in place which would guide staff in protecting the welfare and safety of people. Pressure relieving equipment provided by health professionals was not always delivered to the people it had been prescribed for. This meant that for one person they experienced deterioration in their skin integrity from a grade three to a grade four sore and as a result were admitted to hospital. This demonstrated that people were not protected against the risks of inappropriate or unsafe care and treatment.

One person, who could not move without help from staff, had been diagnosed with a pressure sore. They had not been repositioned every three hours as instructed by healthcare professional. Repositioning records had gaps of up to 26 hours. Staff told us that they could not be sure that people had been repositioned according to healthcare professional advice. This they told us was due to a lack of leadership and delegation of staff which led to confusion. Healthcare professionals told us that staff had limited understanding of how to identify people at risk of and care for people with pressure sores. Skin integrity risk assessments had been provided by community nurses to help staff identify people at risk. We found that these had been completed incorrectly for two people. Staff had assessed these people as at low risk of acquiring a pressure sore when they already had a grade one sore. We were therefore not assured that the planning and delivery of care met people's needs and protected their health, welfare and safety.

This meant that there was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had concerns about the numbers and suitability of staff. Staff told us that there were not enough staff to make sure that people were supported in a safe manner. They said that people sometimes had to wait a long time to be supported due to the lack of staff available. One senior carer told us, "We have to see to the laundry, cook the tea, clean the kitchen and give people their medicines. We cannot do all of it and have time to then support people with social activities. It's too much." This was also confirmed by other staff.

Inadequate

Is the service safe?

People's views about the service varied. Four people told us that they felt safe living in the service and a further three people told us that they did not. One person said, "I leave my door open all the time, even at night this helps me feel safe." Another said, "The carers are good but they are short staffed. When I ring my bell it depends on how busy they are and where you are in the queue as to when they will respond." Another said, "They normally come quickly when I ring my bell, or if they can't they pop in and ask if I wouldn't mind waiting for a few minutes as they are busy with someone else."

Prior to our inspection we received information of concern that night staff had been left to care for 24 people alone as the manager had failed to arrange cover for staff absences. This was evidenced from a review of staff rotas. We discussed this with the manager who confirmed what we had been told. They told us that they did not have time to access staff from an agency and had gone home leaving this staff member to work alone. Staff told us that there were seven people who required support from two staff at any one time when supporting with personal care and mobilising. We were therefore not assured that staffing was sufficient to meet the needs of people at all times.

Staff responses to people who required assistance varied. We observed some people who could not mobilise without staff support were left sitting in wheelchairs at a dining table for long periods of time after eating their meal. We observed staff in the afternoon to all take their break together which left people without access to staff. One person told us, "They all go for their break about 4pm you cannot find anyone if you need them."

Staff told us there was not enough staff to meet people's needs especially in the mornings. One staff member told us, "We are constantly asking for more staff but it has fallen on deaf ears. Even if it was someone to do the teas or the laundry or provide some activities for people that would help." Another said, "Several requests have gone in to management for extra staff in the morning, but nothing has come of it and we could certainly do with some extra hands."

The manager did not have a formal way of calculating people's dependency levels to assess how many staff were needed. Without this system they could not be assured that there were enough staff to meet people's assessed needs. The registered manager and staff told us that there were problems with staff absences with a lack of a system to obtain cover.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found significant problems with the cleanliness and hygiene of the service. We found the environment and equipment was not clean, hygienic or well maintained. For example, we saw that people's bedrooms and en-suite bathrooms were not properly cleaned. Bathrooms and toilets were found without hand cleaning gel and paper towels.

The laundry room contained one washing machine and no tumble dryer. We saw staff struggling to find places to dry people's laundry. Staff told us there were no drying facilities available and explained how they found this a struggle in the winter months. People's clothing was found drying on radiators throughout communal lounges and corridors.

We looked at six people's bedrooms and found that three commode chairs were rusty and two stained with brown matter on the seat and the legs of the commode. A check of mattresses and bedding found two beds with a stained mattress and divan base. Some parts of the service had a strong unpleasant odour. Carpets throughout the service were stained and not properly cleaned. These issues put people at the risk of acquiring or transferring infections.

Systems in place to monitor the regularity and quality of cleanliness in the main kitchen were found to be lacking. Kitchen staff signed daily cleaning schedules stating they had cleaned the fridge, cookers and flooring. However, when we checked these areas we found the fridge had spillages of food, milk and butter. Food had been left uncovered and without a date of opening. Cartons of milk previously stored in the freezer were left to thaw on top of a freezer but had been left too long and felt warm. Cookers were unclean and contained food residue. Cupboards and drawers had dust, crumbs and spillages of fluid both inside and outside. We were therefore not assured that audits and checks on cleanliness of the environment were being managed to maintain appropriate standards of cleanliness and hygiene. This meant that people had not been protected from the risk of harm.

Inadequate

Is the service safe?

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not operate a safe and effective recruitment system. People were put at risk because the provider did not take steps to carry out Disclosure and Barring (DBS), criminal records checks prior to staff starting their employment. We reviewed the recruitment records of three staff employed in the last 12 months by the current manager. We found that one member of staff had not had a DBS check carried out. DBS checks had not been applied for until the other two staff had started working at the service. One a month after they started work and the other the DBS application had been made on the day they started their employment.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not managed safely. We looked at information in medication administration records and care notes for six of the 23 people who lived at the service. A check of stock for one person prescribed anticoagulant. Warfarin, a medicine used to thin the blood indicated that this person had not received their medicine as prescribed. The number of tablets remaining did not balance with the records of receipt and administration of their medicines. There was no system in place which would enable effective monitoring of medication stocks and records of people's medicines. We were unable to account for some medicines in our audit because the amount in stock did not match the administration records. Where people had been prescribed medicines on a when required basis, for example for pain relief, or when they were prescribed in variable doses, for example one or two tablets, we found there was insufficient guidance for staff in care plans as to the circumstances when these medicines were to be used.

Staff and people told us they did not have access to pain relief medicines during the night time period when this was needed. Staff told us that night staff did not have access to medicines during the night time period and had not been trained to administer medicines. We discussed this with the manager who told us they had not considered that people would require medicines during the night. We were told by the manager that on occasion staff would administer medicines into a pot ready for later administration by night staff. We were concerned that their response had not recognised the needs of people to receive medicines for relief from pain as and when they needed and lacked understanding of recognised safe practice in the administration of people's medicines.

Administration records, for prescribed creams and lotions were not completed appropriately to show that people had been administered with their prescribed creams when needed. For example two people prescribed a barrier cream to reduce the likelihood of skin deterioration, there were several gaps where we could not be assured that people had received their medicines as prescribed. There was no guidance for staff in place to show where on the body prescribed creams should be applied and the reasons for their administration.

The managers audit system in place which would enable effective monitoring of people's medicines was ineffective in identifying medication errors. We found that monthly audit checks had not been consistently carried out. Where errors had been identified the manager told us this had not been investigated and resolved. The provider's audits had not picked up the issues we found at this inspection

This meant that there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not make suitable arrangements to equip staff with the skills and knowledge needed to safeguard people against the risk of abuse, neglect or acts of omissions which cause harm or place people at risk of harm. All staff we spoke with told us they had not received training in how to recognise abuse and did not have the required knowledge of steps they should take to report suspected abuse. One of the body maps completed by staff identified bruising under the arms, this was not recognised by staff as a potential safeguarding or an indicator or poor moving and handling practice. Staff did not demonstrate their understanding of their responsibilities to ensure that people were protected from abuse. The local authority had identified safeguarding concerns and were providing the service with support to improve the service. These safeguarding concerns had not been independently identified and reported by the management in the service. Incidents that affect the service and police investigations had not been reported to the Care Quality Commission (CQC) as is required.

Inadequate

Is the service safe?

Following recent safeguarding concerns the local safeguarding authority had visited the service and advised the manager to records body maps for everyone currently living in the service. Bruises and sores had been identified but no investigations had been carried out by the manager to find out how people had acquired these marks.

This meant that there had been a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager and the provider did not identify, assess and manage risks relating to the health, welfare and safety of people. There were no plans in place to guide staff in emergency situations, such as an outbreak of fire. Staff told us they had not received training in any fire evacuation procedures. The fire risk assessment had not been updated as required following a visit from the fire service since our last inspection where they identified the assessment of risk to be of poor quality.

The front door to the service was left unlocked and the building unsecure throughout the day. Although there was a book for people to sign in and out, we observed people coming into the building without staff oversight. The lack of appropriate measures in place to ensure the security of the premises had the potential to put people at risk

When we toured the building with the manager we saw that people had been put at risk as areas of the service such as the laundry and the sluice room had doors wedged open with bottles of chemicals. The doors to people's bedrooms were directly opposite the un locked sluice room where hazardous chemicals were easily accessible and displayed on open shelving. The manager told us they had not been aware of the risks identified and confirmed that no risk assessments had been carried out.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

At our last inspection we were concerned with regards to the provider's lack of action to train staff in a number of areas such as how to recognise and care for people at risk of pressure sores, people at risk of malnutrition and de-hydration as well as people at risk of abuse. At this inspection we found that staff were not provided with the training that they needed to effectively meet the needs of the people who used the service. So the provider had not taken the action required to protect people following the identification of concerns at the last inspection.

We tracked the personnel records of four staff who had been recruited within the last 12 months. Two of the staff did not have a background in care. None of the four staff had received any induction training programme which would have provided them with the skills and knowledge they needed to meet people's needs. Newly appointed staff confirmed they had not received any induction training to support them in their new role. When asked why staff had not been provided with induction training, the manager told us that he had "decided that as staff had experience of working within other care environments there was no need to provide them with any formal induction."

Staff told us they had not been provided with training opportunities in the last 12 months to refresh and update their skills and knowledge. They had not received individual supervision, appraisal and staff meetings where their individual training and development needs could be discussed. The manager confirmed that no training had been provided other than workbooks that had been issued to staff for them to read in their own time. Staff did not have the knowledge or skills to competently use the risk assessment tools such as Waterlow a pressure care screening tool and a Malnutrition Universal Screening Tool (MUST). When these had been used they were found to be incomplete and scoring of risk incorrectly calculated. People did not have their health and welfare needs met by competent, trained staff.

Many people using the service had been diagnosed with a dementia. The staff had limited knowledge about dementia care and they were unable to tell us about different types of dementia or how it progressed. It was evident that staff did not have effective dementia awareness which would support them to care and support people and meet their needs appropriately. Staff had not been provided with training in recognising the needs of people living with dementia and we saw that they were unable to engage with some people effectively. They did not recognise when people were showing signs of being disengaged, for example staring ahead with no interaction from staff. Because staff did not understand how dementia affected each individual person they were unable to approach their care in a way that supported them as much as possible.

This meant that there had been a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans did not identify whether or not people had the capacity to make decisions about their everyday lives. No assessment of people's mental capacity had been carried out. For example, where people had bed rails in place no assessment of people's capacity to consent to these had been carried out. Care plans did not guide staff on actions they should take if a person lacked capacity to make specific decisions or if guidance had been sought in order to arrange for people qualified to do so to make decisions in their best interests. There was no explanation in people's records as to why this consent had not been sought. Without this staff could not tell us that they were ensuring people's consent was being sought and respected.

Staff had not been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager lacked understanding of DoLS legislation and what action they should take if someone's freedom of movement was restricted.

This meant that there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had access to health care professionals such as GPs and district nurses but referrals were not always made promptly and their advice not always followed consistently We found a lack of information about how people's health care needs were being assessed and met. Care plans Were blank in some cases. Three people were identified by staff as having diabetes, however their care plan did not contain any information about diabetes, what type or what action should be taken if the person became unwell. This put people at risk of not having their care and treatment needs

met. We saw from a review of incident records that one person had been diagnosed with epilepsy. However, there was no information contained within their care plan which meant that staff had not been provided with information to guide them as to what action they should take in response to care for this person when experiencing a seizure

This meant that there was a breach of Regulation 9 of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's views about the food that they were provided with varied. One person said, "The food is fair to middling. What do you expect in a place like this? It varies from day to day." Another said, "I enjoy the food. There is a choice, and if there is nothing you like they will make you a sandwich."

We saw that people were offered choices of drinks throughout the day but did not have access to drinks to help themselves without seeking staff support to do so We did not see people were provided with snacks other than biscuits with a cup of tea in the morning.

We saw that where people required assistance to eat and drink, this was done at their own pace and in a calm way. However, some people did not eat their meal and this was just taken away, with little or no verbal encouragement to eat or alternatives offered.

We observed one person refusing their food on both days we visited. We noted that their lack of appetite had been discussed with their GP who had advised weekly weighs. However, this person had not been weighed weekly as advised and had not been weighed since their admission to the service three weeks prior to our visit.

Food and fluid charts had been implemented for some people who staff told us were at risk of not eating sufficient amounts to meet their needs. Food and fluid records did not always identify the amounts of food and drink consumed and therefore there was no analysis of whether people at risk were eating or drinking sufficient amounts to meet their needs. There was no detailed risk assessment in place to show how these risks were minimised Not everyone had been assessed using a malnutrition risk assessment tool. Where malnutrition records had been maintained these had not been completed accurately. Staff had not on any occasion sought support and guidance from a dietician. Staff told us they did not know they could access a dietician for advice.

We spoke with the chef who told us they had not received any training to provide them with the skills and knowledge they needed to provide for the nutritional needs of people including those with special dietary requirements. They demonstrated a lack of understanding in how to provide food fortified with additional calories where people had been identified as at risk of malnutrition.

Several staff expressed concern to us regarding the quality of the food provided to people. We looked at the stock of food and spoke with the chef. We saw that meals provided were in the main frozen, processed meals. The chef confirmed that fresh vegetables were only provided on a Sunday. Cakes and biscuits were a named, value brand.

This meant that there had been a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires improvement

Is the service caring?

Our findings

We received mixed feedback from people. People described their experience of the service as "very satisfied", "They are all respectful and kind", It's good here I have no complaints other than I do feel lonely and isolated at times as they do not have the time to spend with you or chat" and "they are very relaxed about visiting times and you please yourself with your daily routine."

We saw that some staff and people who lived at the service interacted well but people who were quiet were given little attention. One person who appeared distressed told us, "This is the worst place ever. They don't take any notice of you. They don't give you a tissue to wipe your mouth or let you have your glasses. I want my handbag and they have taken it away from me." We asked staff why this person did not have access to their handbag. Staff told us they did not have one. We asked staff to go and look in this person's room to check if this was the case. Staff returned with the person's handbag. When the bag had been returned the person told us, "They just don't understand that my bag has my life in it, why don't they realise that? Thank you."

One relative told us they had asked staff to organise a daily newspaper for their relative to be delivered every day, but as far as they were aware this had not happened.

People told us that staff respected their privacy and dignity. One person said, "The staff are discreet when helping me with my bath, I always feel my privacy and dignity are respected." We saw that staff respected people's privacy and dignity when they were supporting people with personal care.

Personal life history documents had not been completed and so staff did not know peoples history unless they took the time to get to know them. Staff told us they rarely had time to sit and talk with people. Care plans did not set out people's choice and preferences for when they reached the end of their life.

Inadequate

Is the service responsive?

Our findings

Care plans did not contain enough information about people's needs for staff to deliver responsive care. For example, there was a lack of information with regards to people's medical histories. One care plan stated that the person had been diagnosed with epilepsy but did not provide any further details, and others stated the person had been diagnosed with dementia but did not record the type of dementia and no guidance for staff in supporting people. Care plans did not include an assessment of risk and offer solutions or strategies for staff to follow. For example, There was no clear guidance as to how people should be supported to mobilise or what their hobbies, interests or aspirations were.

People told us they received opportunities to receive a bath once a week. However, one person told us they were not receiving their bath as the nearest bathroom to them did not have any heating. They told us staff they had advised they have a strip wash daily until the weather gets warmer. We looked at the bathroom heater with the manager and confirmed the wall fan heater was not working. The manager told us they had been unaware that the heater was not working.

There was no visible sign of any activities taking place. People's individual needs for social stimulation, community inclusion and access to group activities had not been assessed. We did however, observe one member of staff take one person out to the shops. The member of staff involved in this activity told us this was in their own time. People told us, "There are no activities." One relative told us, "I think they have some music entertainment from time to time but not much else." Care staff told us there was no planned programme of group activities but that they did provide quizzes and baking sessions when they had the time to do so. We observed one member of care staff telling a group of people that they would, "Do some baking this afternoon." However, we noted that this activity did not take place.

We saw that people received little individual or group stimulation, apart from those who had visitors. There was no visible sign of any social stimulation or group activities taking place. People told us, "There are no activities", "The church people come in and people pray but there is not much to do, staff are too busy." One relative told us, "I think they have some music entertainment from time to time but not much else."

This meant that there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they had not been provided with opportunities to share their views for example, in how the service was run, the planning of their care, planning menus and opportunities to have their hobbies and interests assessed and opportunities to be provided to pursue these. The manager confirmed to us that they did not provide people with opportunities such as residents meetings or care reviews as they chose to speak with people regularly when walking around the service. When asked how the views of people had influenced any planning for improvement of the service they told us this was something they had not considered. We were not assured that the provider had systems in place to routinely listen to people's experiences and concerns.

This meant that there had been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us that there were no restrictions on the times that people could have visitors. We saw that people's visitors came and went during our visit. This showed that people were supported to maintain relationships with the people who were important to them

and reduce their isolation.

The manager told us the service had not ever received any concerns or complaints from people and their relatives. We asked staff how people were informed about the complaints procedure. They told us there was information in the entrance hall which they would guide people to. People told us they did not have any complaints about how the service was run.

Inadequate

Is the service well-led?

Our findings

We identified concerns at our previous inspection 15 May 2014 in relation to the quality assurance processes within the home. The provider did not provide us with an action plan as we requested to ensure compliance with this and other breaches of Regulations which had been identified with regards to; care and welfare of people, management of risks, mental capacity assessment and a lack of staff training, supervision and support. We found improvements had not been made in all of these areas.

The manager and the provider did not have systems to identify, assess and manage risks to people who used the service and others. We asked the manager to show us any audits that had been carried out to assess the quality and safety of the service. The manager told us that no environmental risk assessments had been carried out. They also confirmed that no audits had been carried out that would identify medication errors, health and safety risks to individuals such as those at risk of malnutrition and pressure ulcers. The manager told us that the provider visited the service once weekly but they did not carry out any formal monitoring to regularly assess the quality and the safety of the service.

We asked to view the provider's complaints records. They told us that other than the provider's policy describing their system for handling complaints there was no system for logging concerns and complaints. The manager told us they had not ever received any concerns or complaints. We were not satisfied that the provider had an effective system in place for identifying, receiving, handling and responding to people's concerns and complaints.

The provider did not protect people against the risks of unsafe and inappropriate care. We asked the manager what system they had in place for the recording of accidents and incidents and how they would analyse these. They told us they recorded all incidents and accidents. However, we found that where people had experienced falls, bruising to their body and had developed pressure sores these had not always been recorded. Where incidents of falls had been recorded or bruising noted on body maps these records did not contain any evidence of any actions taken by the provider to investigate and guide staff to protect people from further incidents. This meant that themes and trends were not identified. People were put at risk of repeated incidents as actions were not identified or evidence of lessons learnt.

This meant that there had been a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service could not be assured that the provider took steps to report important events that affect their health, welfare and safety so that, where needed, investigations could take place and action taken. The manager had failed to notify us of a person who had been admitted to hospital with a grade 4 pressure ulcer and who later died. The manager confirmed that they had not sent a statutory notification of this incident to the Care Quality Commission (CQC) as is required by the law.

This meant that there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

This service was not well led. There was a lack of direction and leadership was weak. All of the staff we spoke with told us that they had concerns about the current management of the service. Comments included, "I cannot believe how this place has gone downhill", "We don't know what we are supposed to be doing, there is little delegation and certainly no training" and "There is no direction in this place the manager does not know what they are doing. The care plans are a mess and we have not had any training or staff meetings in the last year." Staff were not adequately supervised, trained and supported. Newly employed staff had not been supported by the manager with induction training. All staff we spoke with told us they had not received any formal supervision meetings to discuss their training and development needs. They also told us that no general staff meetings had taken place in the last 12 months and only two senior staff meetings.

The current manager had been in post for 12 months. They had only recently submitted their application to register with the Care Quality Commission.

The manager did not demonstrate good management and leadership. They did not understand their roles and responsibilities in supporting staff to understand and respond to key challenges, concerns and risks. For example, they did not have systems in place to highlight potential risks to staff that would compromise people's

Inadequate

Is the service well-led?

health, welfare and safety due to a lack of risk management processes. We asked the manager how they personally kept up to date with current best practice to ensure they were delivering and leading by example best practice. They told us they had not attended any training in the last 10 years.

The provider did not demonstrate Prior to our inspection, we asked the provider to complete a Provider Information Return (PIR). The provider failed to return a PIR as required. We were therefore unable to determine what if any plans the provider had for driving forward continuous improvement and safeguarding people's health and welfare.

People we spoke with told us they had never been for their views or feedback regarding the quality of the care provided. The manager told us they did not have any quality assurance systems in place. The provider lacked understanding of the principles of good quality assurance. We were not assured that best practice was recognised or developed to move the service forward and improve the quality and safety of care for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 12 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered provider did not safeguard the health, safety and welfare of service users to ensure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to support them with their care and treatment including administration of their medicines during the night time period. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate safe and effective recruitment procedures. They did no ensure that no person was employed without confirming they were of good character as they failed to carry out Disclosure and Barring Service checks prior to staff starting work at the service. Regulation 21 (a)(i)(ii) (b) Schedule 3

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 CQC (Registration) Regulations 2009 Financial position The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of making appropriate arrangements for the recording, handling and safe administration of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The registered person did not ensure that service users and others had been protected against the risks associated with unsafe and suitable premises. Regulation 15 (1) (b)(c)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not make suitable arrangements to equip staff with the skills and knowledge needed to safeguard people against the risk of abuse, neglect or acts of omissions which cause harm or place people at risk of harm. Regulation 11 (1) (a)(3)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not ensure that service users were enabled to make, or participate in making decisions relating to their care and treatment or to express their views as to what was important to them in relation to their care or treatment. Regulation 17 (1) (b)(2)(b)(c)(ii)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements inn place in order to ensure that staff received appropriate training, supervision and appraisal in order to obtain the skills and knowledge they required for the work they were to perform. Regulation 23 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People were not protected against the risks of receiving care and treatment without establishing whether or not they had capacity to consent. The staff and the manager had not been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Regulation 18 (1)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that service users were protected from the risks of inadequate nutrition and dehydration. Regulation 14 (1)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to protect people against the risk of receiving care or treatment that was inappropriate or unsafe by means of the carrying out of an assessment of needs; and the planning of care to ensure the welfare and safety of service users. Regulation 9 (1) (a) (b) (i)(ii)(iii)

The enforcement action we took:
We issued an Urgent Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not protect service users, and others who may be at risk, against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable them to regularly assess and monitor the quality of the service provided in carrying on the regulated activity. They also failed to identify, assess and manage risks relating to the health, welfare and safety of service users and other who may be at risk. Regulation 10 (1) (a) (b) (2)

The enforcement action we took:
We issued an Urgent Notice of Decision to vary the conditions of the provider's registration.