Purity Nursing Limited

The Priory Nursing and Residential Home

Inspection report

Spring Hill
Wellington
Telford
Shropshire
TF1 3NA

Tel: 01952242535

Date of inspection visit:
16 August 2018
21 August 2018
29 August 2018

Date of publication:
18 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 16, 21 and 29 August 2018. The first and third days of the inspection were unannounced.

The Priory Nursing and Residential Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home provides accommodation and support with nursing and personal care to a maximum of 37 people. The home provides a service to older people and younger adults. Accommodation is arranged over two floors with a shaft lift giving access to the first floor.

Our last inspection of the service took place in March 2018 where the overall rating was good.

This inspection was prompted by concerns shared with us by the local authority safeguarding team and the clinical commission group (CCG).

At the time of our inspection there was a registered manager in post however they had been on extended leave since July 2018. We have since received an application from the registered manager to cancel their registration with us. 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.

Risks were not always identified and there were no systems in place to mitigate risks to the health, safety and well-being of the people who lived at the home. People's medicines were not managed or stored in a safe way. People were not fully protected from the risk of harm or abuse. People were not protected by the provider's procedures for the prevention and control of infection. Environmental risks were not well managed or addressed in a timely manner. There were no systems in place to monitor accidents or make improvements when things went wrong. There were sufficient numbers of staff to meet people's physical needs. The provider's staff recruitment procedures helped to ensure staff were suitable to work with the people who lived at the home.

The provider's systems did not ensure staff had the skills, training, knowledge or experience to meet the needs of the people who lived at the home. People's rights were not respected. People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible. No reasonable adjustments had been made to support people who had a visual or hearing impairment. There were no effective procedures in place to monitor and meet people's healthcare needs. People were not supported to eat well in accordance with their tastes and preferences. There was a lack of signage to assist people to orientate themselves around the home. An assessment of people's needs was

carried out before they moved to the home.

Staff were kind to the people who lived at the home however people's dignity was not always respected. Staff did not have time to spend quality time with people. Staff did not have information about people's social history or interests. People's records were not securely stored and people's confidentiality was not always respected.

People were not supported to be involved in the planning or review of the care they received. Care plans had not always been updated to reflect changes in the support people received. People had limited opportunities for social stimulation. People could not be confident that any complaints about the care and treatment they received would be responded to. Information about how to raise concerns had not been produced in an accessible format for people who had a visual or cognitive impairment. People could not be confident that their wishes during their final days and following death were respected.

Ineffective leadership in the home had impacted on the people who lived at the home and the staff team. The provider's quality assurance systems had failed to identify the significant concerns in the service and had been ineffective in driving improvements. The ethos of honesty, learning from mistakes and admitting when things had gone wrong was lacking. The provider had not met their legal responsibilities to inform the Care Quality Commission of significant events which had occurred in the home.

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

People were not protected from the risk of harm or abuse.

Risks to people were not well managed and placed people at risk of receiving unsafe care and treatment.

There was no learning from accidents and incidents.

People's medicines were not managed and stored safely.

People were not protected from the risk associated with the control and spread of infection.

People lived in an environment which was not safe or well maintained.

Recruitment procedures helped to ensure staff were suitable to work at the home.

There were sufficient staff to meet people's physical needs.

Is the service effective?

Inadequate

The service was not effective

There were no effective systems in place to ensure staff had the skills, knowledge and experience to support the people who lived at the home.

People were supported by staff whose performance was not regularly monitored.

People's rights were not protected in accordance with the Mental Capacity Act 2005. Some people were being unlawfully restricted.

People were not provided with information in a format which met their needs.

People were not supported to maintain their health and well-being.

Meals provided did not consider people's needs and preferences. Systems to monitor people's intake were effective in identifying concerns.

Signage did not assist people to orientate themselves around the home.

People's needs were assessed before they moved to the home.

Is the service caring?

Inadequate

The service was not caring

People said staff were kind but people were not always treated with respect.

Routines were task led and people received little interaction from staff.

Staff did not always ensure people's right to confidentiality was respected.

People had their own bedroom which they could personalise.

Is the service responsive?

Inadequate

The service was not responsive

People's views were not considered when planning and reviewing the care they received.

Care plans had not been updated to reflect people's changing needs.

There were limited opportunities for social stimulation.

People did not feel confident that complaints would be taken seriously. The complaints procedure had not been produced in accessible formats for people.

People's preferences during their final days and following death were not always discussed or recorded.

Is the service well-led?

Inadequate

The service was not well-led

In the absence of the registered manager, there were no effective systems in place to ensure the home was well managed.

The staffing structure did not provide clear lines of responsibility and accountability.

People had not been kept informed about changes in the management of the home.

The provider's quality monitoring procedures were ineffective in identifying and addressing risks to people and areas for improvement.

People were not protected from an ethos of honesty, learning from mistakes or admitting when things went wrong.

The provider failed to notify the Care Quality Commission of significant events which occurred in the home.

The Priory Nursing and 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 comprehensive inspection took place on 16, 21 and 29 August 2018. The first and third day of the inspection was unannounced. We gave short notice of the second day as we needed to meet with the provider. The first and second day of the inspection was carried out by an adult social care inspector and inspection manager. The third day was carried out by two adult social care inspectors.

We brought forward our planned inspection because we received concerns from the local authority safeguarding team and the clinical commissioning group (CCG). We also received information about an incident which had a serious impact on a person who used the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks. The incident is currently being looked at by the police and we will review information following their investigation to consider what regulatory action we may take.

Following the second day of our inspection we wrote a letter of intent to the provider to seek reassurance on how they would mitigate the immediate concerns and risks to people. The response received did not initially alleviate concerns and we requested further information be sent. The provider has now provided an action plan on how they will address these concerns.

The provider was not requested to submit a provider information return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We looked at statutory notifications sent in by the service. A statutory notification is information about important events which the service is required to tell us about by

law. We looked at previous inspection reports and other information we held about the service before we visited. We considered information of concern received from the local authority and CCG. We used this information to help plan the inspection.

During our visits we spoke with nine people who lived at the home. Some of the people we met with were unable to tell us about their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 members of staff and looked at a sample of records relating to the running of the home and the care of individuals. These included the care records of 10 people who lived at the home. We also looked at records related to the management and administration of people's medicines, health and safety, quality assurance and staff recruitment.

Inadequate

Is the service safe?

Our findings

At our last inspection the service was rated good. At this inspection we found serious concerns over the safety of the service.

People were not fully protected from receiving unsafe or inappropriate care. For example, one person's care plan identified that they were at high risk of falls and required constant supervision when mobilising. Records showed the person had nine unwitnessed falls in the past three months. On the first day of our inspection we observed the person wandering in the corridor unsupervised and they were very unsteady on their feet. There was a sensor mat on the person's bedroom chair but this was not working. The care plan stated the person also had a sensor mat on their bed but this was not in place when we visited. On the third day of our inspection we found action had been taken to address these issues. We read the care plan for another person who had been assessed at being at high risk of falls. Records showed that between May 2018 and 22 August 2018 the person had seven unwitnessed falls. The risk assessment had been reviewed in August 2018 however the person's care plan had not been reviewed since April 2018. The care plan stated staff must be aware of the person's whereabouts and that the person must be provided with a pendant alarm. We did not see the person wearing a pendant alarm during our visit. This meant there were no effective measures in place to help to reduce the risk of further falls. We were informed by a visiting professional that the same person had recently managed to leave the home through a fire escape without the knowledge of staff. A risk assessment and care plan had not been developed to manage this known risk which meant there were no systems in place to reduce the risk of this happening again.

We could not be confident that all accidents and incidents which occurred in the home were appropriately recorded or regularly analysed to reduce the risk of reoccurrence. For example, one person had suffered three serious accidents however, staff were only able to provide us with the accident report for one of the accidents. The person's care plan did not contain information about the action taken to prevent the accident from happening again. This was also the case for people who had experienced a high number of falls.

Risks to people who were assessed as being at risk of developing pressure damage to their skin were not well managed. For example, care plans did not identify the type of mattress they required or the correct setting for airflow mattresses. On the third day of our inspection we saw individual charts had been implemented which detailed the person's weight, type of mattress and required setting. However, not all charts had been fully completed and daily checks had not always been carried out. This meant people could be placed at risk of damage to their skin.

We read the care plan for a person who was an insulin controlled diabetic. The person required weekly checks on their blood sugar levels. Whilst this was being carried out, there was no information about the acceptable ranges nor was there any information about the signs and symptoms which may indicate the person's sugar levels were too high or too low. There was no information for staff about the action to be taken in these situations. This could place the person at significant risk of harm. On the third day of our inspection we found the required information had been included for one person but not for the person we

had previously identified.

Care plans did not contain sufficient information to mitigate risks to people who required the use of a hoist to transfer. There was no information for staff about the size of the sling required. This meant a person would be at risk of harm or injury if an incorrect sling was used. This had been addressed on the third day of our inspection.

People were not protected by the management and storage of their prescribed medicines. The room and fridges storing medicines were well in excess of acceptable temperatures which meant there was a risk that medicines may not be effective. The recommended room temperature should not exceed 25 degrees centigrade however records showed that between June and August the temperature had been between 31 and 33 degrees centigrade. Fridge temperatures were recorded as being between 9 and 19 degrees centigrade which was more than the required range of 2 and 8 degrees centigrade. We found prescribed creams and thickening powders in the bedrooms of three people they had not been prescribed for. On the third day of our visit we found this still to be the case in one person's bedroom. Where people required their fluids to be thickened, staff stored their thickening powders in their bedrooms. These had not been stored securely which meant they could be accessed by the individual or other people who may wander into their bedroom. NHS England issued a patient safety alert about the safe storage of thickening powders following the death of a person in a care home after they had ingested the powder. We randomly checked medicines which required additional secured storage. The records for one person showed that two staff had signed to confirm the amount administered and the remaining balance as correct. However, although the amount administered was as per the prescription, the balance totals over three days were incorrect but this was not picked up. This error was not identified until another nurse carried out a stock check and even then, the remaining amount of the liquid medication was recorded as being 4.5mls more than should have been in the bottle.

People were not protected from the risks associated with the spread of infection. We found torn flooring in bedrooms and en-suite bathrooms, stained mattresses and bedding, ripped bedrail bumpers, catheters removed from sterile packaging and incontinence pads removed from their original packaging and left in people's en-suite bathrooms. We also found toilet frames with dirty and rusty legs and broken foot operated bins. In two en-suite bathrooms we found catheter bags full of urine on the floor. On the third day of our inspection some action had been taken to mitigate risks to people. Torn flooring had been temporarily made safe and quotes had been obtained to replace flooring. Open sterile items had been disposed of and ripped bedrails had been replaced.

The environment did not provide a safe and well-maintained environment for people. The carpets in the first-floor landing were worn and threadbare. In two bedrooms and an en-suite bathroom, wallpaper was peeling off the wall. The main drive and parking area was uneven and full of pot holes which could pose a risk if people wanted to go out. Following our inspection we were informed that there was an alternative entrance which could be used if required. On the third day of our inspection the heating was on and we saw exposed piping in the downstairs corridor and some bedrooms which were hot to touch. We immediately raised this with the deputy clinical manager who assured us they would take appropriate action to ensure people's safety. A maintenance person had been in post for one month prior to our inspection. They told us staff recorded any repairs in a maintenance book and records showed that the maintenance person had taken timely action to address the issues. However, we found issues which had not been identified or addressed. For example, a person who lived at the home told us they had not been able to open their bedroom window for several months. They said, "I reported this months ago but nothing has happened." We also noted that the person's call bell lead had exposed wires. When we discussed this with the maintenance person, they took action to address the issues straight away.

The above issues are a breach of Regulation 12 Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected from the risk of harm or abuse. Although the staff we spoke with said they would report any concerns, not all staff had received training about safeguarding adults from abuse and were unsure of how to report concerns to external bodies. A member of staff who had been in post for eight months said, "I haven't had safeguarding training yet and I wouldn't know how to report it. I would like to know as it's really important." Another member of staff who had worked at the home for four months told us, "I haven't had safeguarding training. I haven't witnessed anything but I wouldn't know who to go to."

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

The maintenance person carried out regular checks on the home's fire detection systems and emergency lighting. Systems had also been serviced by an external contractor in June 2018. A fire risk assessment was last carried out in February 2018. The home's passenger lift was serviced by an external contractor in May 2018.

Staff told us there were usually sufficient staff to meet people's needs. One member of staff said, "It's ok when we are fully staffed but if we're short it makes things difficult. It means we can't help residents when they want and can't sometimes we can't get residents up until later in the day." Another member of staff told us, "It's very busy but I've never seen anybody go without; it just means residents have to wait longer until we can get to them." The people we spoke with did not express concerns about the assistance they received. One person said, "If I ring my call bell the staff come and help me. I don't have to wait too long but you hear the bells ringing all day." Another person told us, "When I use my call bell sometimes I have to wait if the staff are busy, but they do come."

The provider's staff recruitment procedures helped to ensure staff were suitable to work with the people who lived at the home. Checks included seeking references from previous employers and carrying out checks with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with the people who used the service.

Inadequate

Is the service effective?

Our findings

At our last inspection the service was rated good. At this inspection we found that the service was not effective.

There were no effective procedures in place to ensure staff had the skills, knowledge and experience to support the people who used the service. A member of staff said, I've only had one-day induction where I was shown around the home. I had two shadow shifts but I haven't had any training yet." We observed one member of staff assisting a person to transfer using a hoist. The member of staff told us they had not yet had received training in moving and handling. We immediately brought this to the attention of the nurse in charge who gave their assurances that the staff member would not be involve in assisting people until they had received the required training. Following this inspection, the provider confirmed that the staff member had completed training in safe moving and handling. Another member of staff told us, "I've worked here for eight months and the only training I have had is moving and handling." There had been a high staff turnover in the last six months and vacancies were being covered by agency staff. On occasions registered nurses supplied by an agency had never worked at the home before and there were no systems in place to ensure the nurses had the skills or experience to meet the need of the people who lived at the home. Following our inspection, the provider told us they had implemented systems to ensure the agencies used supplied only nurses who had worked at the home before and had the skills to meet people's needs.

There were no systems in place to monitor the skills, competence and knowledge of staff or provide staff with an opportunity to discuss their role. All the staff we spoke with told us they had not received any one to one sessions with a senior member of staff. One member of staff said, "I haven't had a supervision for six months. I have no idea what is going on about training or refresher training." Another member of staff told us, "I have worked here for nine months and I have never had a supervision." This meant there were no systems to identify or address any poor practice or training requirements.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's legal rights were not protected because the provider had failed to ensure staff worked in accordance with The Mental Capacity Act 2005 (MCA). The 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. Some people had bedrails and sensor mats in place and we saw one person's bed had been lowered to the floor. When we checked people's care plans, there were no assessments of their capacity to consent to the use of the equipment and there was no evidence that decisions had been made in people's best interests. A person's communication care plan stated they were able to communicate their needs and make decisions however we saw that the person's representative had signed a "do not attempt resuscitation" consent form and we

were unable to see the rationale for this or whether the person's wishes had been considered.

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

We found some people were being unlawfully deprived of their liberty because the provider had failed to follow the principles of the MCA. We met with one person who said, "I am not allowed out of the home." When we asked why, the person told us, "They (staff) never give me a reason. I can move around myself and I don't understand why they will not allow me to go into town." The person's care plan did not contain an assessment of their capacity nor was their evidence the restriction had been legally authorised. People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). Where people required this level of protection the provider failed to ensure applications had been made to the appropriate authority and that staff had the knowledge and skills to recognise when and how to complete a DoLS application. On the first day of our inspection a registered nurse told us they had been informed by a visiting professional that they needed to complete an urgent DoLS application for a person who was being deprived of their liberty. The registered nurse told us they had never completed one before and didn't know what to do. In the care files we read we found some DoLS authorisations had expired and we were unable to see that new assessments of capacity and applications had been made.

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

Some people could tell us they were able to make choices about how they spent their day. One person said, "I decide what time I get up and what time I go to bed." Another person told us, it's my decision to stay in my bedroom. If I want to go to the lounge I can. I just ask." However, it was not clear that people with a cognitive impairment were given the same choices. For example, we met with a person who was being nursed in bed. When we asked them why they were in bed they replied, "I don't know." We found no rationale for this in their plan of care.

People were not provided with information in a format which met their needs. This meant they were not always provided with opportunities to make informed decisions or choices. For example, we met with one person who had a profound hearing impairment. Their care plan stated they used picture cards, sign language and lip read. We asked staff about the person's picture cards and they replied, "I don't know; maybe they are in the bedroom. I haven't seen them." We observed another member of staff asking the person to wipe their hands prior to lunch but the member of staff had turned away from the person. Staff told us and records confirmed they had not received any training in sign language. There had been no consideration for reasonable adjustments to ensure the person knew when the fire alarm sounded. Menus had been produced in a format which would be difficult for people with a visual impairment to understand. On the third day of our inspection we met with the newly appointed deputy clinical manager and discussed our concerns. They had not heard of the accessible information standards. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. By law all organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. The deputy clinical manager informed us they would look into this.

People were not always supported to maintain their health and well-being. It was difficult to locate documentation which detailed when a person was referred to a healthcare professional and we were unable

to see that staff had followed any advice given. For example, one person who had experienced a significant number of falls was seen by a healthcare professional in June 2018 who advised staff follow a recognised in-house falls prevention exercise programme and to continue with the use of sensors on their bed. The person's care plan showed no evidence that this had been carried out and when we discussed this with staff, they had no knowledge of the recommendations made. There were no movement sensors of the person's bed and the person continued to experience falls. Another person had been refusing their prescribed medication since July 2018. We saw a completed form which stated, "GP to be kept in the loop about refusal of medication." We were unable to see that the person's GP had been kept informed, however the person was seen by a visiting professional in August 2018 who advised liquid medications should be tried. Although this was implemented, the person continued to refuse their medicines and this resulted in a hospital admission the day before the second day of our inspection. It wasn't until the third day of our inspection and after concerns raised by visiting healthcare professionals that a request to the person's GP to consider whether it would be in the person's best interest to have their medicines administered covertly, was requested.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the meals offered varied. One person told us, "I get enough to eat and drink but the food's a bit rough sometimes and not very palatable. I eat in my room and it's not always hot when I get it." Another person said. "I think the food is alright." Another person told us, "The food is alright but the soup and sandwiches every teatime gets a bit boring." We observed the mealtime experience during our inspection. People were provided with plated meals from a hot trolley and we observed that staff poured gravy over the meals, including curry, without asking people. We asked staff about the meals they were serving on one of the days we visited and they were unable to determine between the choices of chicken and leak pie and chicken curry as there was no pastry on the pie. When puddings were being served we heard a staff member say, "There is no apple pie left so they will have to have ice-cream." People's diverse nutritional needs were not always considered or met. For example, we met with one person who was vegetarian. When staff brought them their meal we asked what they were having. The staff member told us, "Just the vegetables and potatoes." We asked if there were any meat free protein substitutes and the staff member said, "Not that I'm aware of. They [the person] has the meal without the meat."

Some people required their food and drink to be monitored as they had been assessed as being at high risk of malnutrition and dehydration. Whilst people's intake had been recorded, we were unable to see how concerns about people's intake were passed on to the nurse in charge. For example, the records for one person's daily fluid intake had not been totalled and there was no information about the acceptable intake. When we totalled the amount, this equated to only 300 millilitres in a 24-hour period. This had not been recorded in the person's daily records so we unable to determine how this information would be brought to the attention of the registered nurse on duty. Where people required regular monitoring of their weight, this was not always carried out. For example, one person's records showed they should be weighed monthly but they had not been weighed since February 2018. Another person's weight had not been recorded since they moved to the home in June 2018.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been no recent admissions to the home however the care plans we read contained assessments of people's needs before a placement at the home was offered.

The environment could be further improved to assist people with a visual or cognitive impairment to orientate themselves around the home. For example, there were long corridors leading to the two lounge areas however there was no signage which would assist people to locate bathrooms, the lounges or bedrooms. There were no orientation boards which would help people understand the day, date and season.

Inadequate

Is the service caring?

Our findings

At our last inspection the service was rated good. At this inspection we found that people were not always being treated with dignity and respect.

People told us staff were kind and caring. One person said, "The staff are nice and kind to me." Another person told us, "The staff are hardworking and kind." When we spoke with staff it was evident that they cared about the people who lived at the home. However, staff morale was low and staff told us recent changes and uncertainty in the management had left them feeling unsettled. One member of staff explained the impact this was having on the people they supported. They said, "The residents know something is not right." A relative wrote to us expressing their concerns that staff, "did not seem themselves and were stressed." They also said they had witnessed two staff shouting at each other in front of the people who lived at the home."

Routines were task led and were not centred on the preferences of the people who lived at the home. For example, we observed staff had supported some people to change into their nightclothes by 1500hrs. We asked a staff member about the rationale for this and they told us, "We start getting people into their nightclothes between half two and three and we put some residents to bed after tea. It helps ease the load for the night staff." We heard another member of staff approach a person and say, "Come on we need to get you into your pyjamas."

People's care plans contained the contact details of their next of kin but there was no information about people's preferences, social history, hobbies or interests. This information would help staff to ensure people received personalised care and support. We observed staff were busy and did not have time to sit and chat to people.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity was not always respected. Some people who had been assisted into their nightclothes during early afternoon had not been provided with dressing gowns and were wandering around the home. We observed one person sat in a chair in the lounge with their trousers undone for a period of two hours. Staff did not notice and even assisted the person to transfer into a wheelchair. We noticed another person who was sat in the lounge had spilt their drink on themselves when struggling to place the beaker on a table which was placed to the side of them. This was not noticed by staff and the person spilt another drink half an hour later. Again, this was not noticed or addressed. People were offered biscuits with their drinks however staff did not offer a plate but placed the biscuit directly on the table. When people were being assisted to dining tables for lunch we heard a member of staff say to another staff member, "Where shall we put her?" The person said, "I don't want to be put anywhere."

We observed a nurse providing staff with a handover however this was conducted in a corridor which meant conversations could be heard by visitors and people who lived at the home. People's care records were not

securely stored. We observed the room containing people's care plans was left open when staff vacated the room. This meant it could be accessed by visitors or people who lived at the home.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their own bedrooms which contained personal items that were important to them such as photographs and pictures. We observed staff knocked on bedroom doors before entering.

Inadequate

Is the service responsive?

Our findings

At our last inspection the service was rated good. At this inspection we found that the service was not responsive to people's needs.

People told us they were not consulted or involved in planning and reviewing the care and support they received. One person said, "I've never seen a care plan. Apparently, I was resident of the day yesterday. I didn't know this until a staff member offered me a shower I asked why and she said it's because you are resident of the day. This was a surprise to me but the rest of the day was just the same as every other." Another person told us, "I don't know anything about a care plan. I haven't had any discussions with staff."

People were not always provided with opportunities for social stimulation. We were informed that an activities co-ordinator was employed however, they were not present during the three days of our visit. A person who lived at the home said, "I think there are activities twice a week but it's a bit boring. I'm not into bingo." Another person told us, "I prefer to stay in my room so I don't know what activities there are." In one of the lounges the television was on however nobody appeared to be watching it. There was no staff presence in the lounge other when staff were assisting people. Other than the television, there was nothing to occupy people.

People could not be confident that their wishes during their final days and following death would be understood and followed by staff. When we were reading through a care plan with a person who lived at the home they were shocked to discover an end of life care plan was in place and this and their preferences had not been discussed with them. The person had a strong faith and received regular visits from a local pastor however, this had not been recorded in their plan of care.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans we read had not been regularly reviewed to ensure they reflected people's needs and preferences. For example, one person had experienced seizures and had required admission to the accident and emergency department at the local hospital. The person was discharged back to the home the same day however, four days later a plan of care had not been implemented and regular observations had not been carried out. Another person's care plan had not been reviewed since April 2018 and had not been updated to reflect a high number of falls. We read through another person's care plan with the person. They pointed out that the moving and handling assessment was incorrect and had not been updated following a physiotherapy assessment. It was recorded that the person required the use of a hoist when transferring from their bed to a chair however, the person told us they no longer used a hoist. They said, "The staff only know about this because I tell them."

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

A complaints procedure was displayed, however this not easy to locate as it was placed on a notice board with a lot of other information. The notice board was situated near the entrance to the home in a corridor which not all people would access. The complaints procedure has not been produced in easy to read format so may not be accessible to people who had a visual impairment. A person who lived at the home told us they had raised five formal complaints during their stay at the home but had only received a response to two.

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

Inadequate

Is the service well-led?

Our findings

At our last inspection the service was rated good. At this inspection we found the service was not well led.

Prior to our inspection concerns had been raised by the local authority quality team and commissioners about the lack of leadership and the quality and safety of care provided at The Priory. This had led to the local authority making regular visits to the home to monitor the safety of the people who lived there.

There was a registered manager in post however they had been on leave since July 2018 and we have received an application from them to cancel their registration. In the absence of the registered manager, the provider had failed to ensure that effective management systems were in place. This meant staff were left feeling unsupported and there were no systems in place to monitor the training, skills and competency of the staff. A member of staff said, "I've never had a supervision and there haven't been any staff meetings." Another member of staff told us, "We haven't had staff meetings and I have no idea what is going on and don't know what is happening about training or updates."

After the second day of our inspection we wrote to the provider detailing our immediate concerns about the lack of leadership and potential risks to the health and safety of the people who lived at the home. We informed the provider we were considering urgent enforcement action and required an action plan which provided assurances that action would be taken to mitigate any risks to people. The provider sent us their action plan as required and this provided assurances that measures had been put in place to address our immediate concerns. This included environmental risks, risks associated with the control and spread of infection, the storage and management of people's medicine, the management of people at risk of pressure damage to their skin and the management of people with diabetes.

On the third day of our inspection we met with the deputy clinical manager who had been in post for a week. They told us they would be providing management cover in the absence of the registered manager. They told us of their commitment to improving standards at the home and addressing the concerns raised at our inspection and concerns raised by the local authority and commissioners.

The staffing structure did not provide clear lines of accountability or responsibility. For example, prior to the appointment of the deputy clinical manager, a registered nurse had been given the responsibility of overseeing the management of the home however they were unable to effectively carry out this role as they had not been provided with appropriate training or supernumerary time. Staff were unaware of the management arrangements or who they should report to. One member of staff said, "It's never been as bad as it is now. There is no management or leadership. It feels really uneasy and unsettled." Another member of staff told us, "There's just no structure and you are not given any direction. I haven't got a clue who is in charge."

There was a culture of task-centred instead of person-centred care. Staff told us there were not always sufficient numbers of staff to enable them to spend quality time with people. The lack of effective leadership had resulted in a lack of direction for staff and had failed to ensure that people received a service which

promoted their well-being and met their individual needs and wishes. People's views about the quality of care they received had not been sought. People had not been involved in planning and reviewing the care they received. The provider had failed to inform people about the changes in the management of the home. A person who lived at the home said, "Something is going on here but I don't know what. I don't know who is in charge now and I know a lot of staff have left." The provider has since told us they have now had a meeting with people and their representatives.

The provider's quality assurance systems were not effective in monitoring or improving the quality of the service people received. Systems failed to identify the widespread shortfalls and concerns we found during our inspection. These included risks to the health, safety and well-being of the people who lived at the home. Some of the failings we found at this inspection had previously been identified and raised with the provider during visits by the local authority and commissioners however the provider had failed to take appropriate action to mitigate risks. These included care plans which did not reflect people's current needs, concerns about the lack of leadership and skills and training of staff and the storage and management of people's medicines.

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

The ethos of honesty, learning from mistakes and admitting when things had gone wrong had not been embedded. Staff did not feel confident in raising concerns or making suggestions for improvements. Three staff we met with told us they felt victimised after they used the whistleblowing policy to raise serious concerns about the care and treatment people received by staff. No action was taken to address the concerns until they were brought to the attention of the provider by the local authority safeguarding team. We heard that a person who lived at the home had experienced three serious accidents when being assisted with their moving and handling needs. The person told us, "Once I broke my wrist, another time the hoist fell on me and another time I fell off the seated weighing scales. I don't think it's been investigated and I've heard nothing back." This did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure that significant events which occurred in the home were reported to the appropriate agencies such as Care Quality Commission (CQC) and the local authority safeguarding team. The provider has a legal responsibility to inform the CQC of significant events which occur in the home.

This was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support which took into account their needs and preferences. People were not involved in decisions about their care and treatment. People had limited opportunity for social stimulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and privacy was not respected and people were not treated with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always sought in line with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and take reasonable measures to mitigate risks to the health, safety and well-being of people in relation to people's individual risks and risks associated with the premises, infection control and medicines.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to follow the principles of the Mental Capacity Act (2005) which meant people were being unlawfully deprived of their liberty. People were at risk of abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's preferences for nutrition were not considered. People's intake for food and drink was not effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's complaints procedure was ineffective in investigating and responding to concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to ensure that significant events which occurred in the home were reported to the appropriate agencies such as Care Quality Commission (CQC) and the local authority safeguarding team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to

perform

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the service was appropriately managed in the absence of the registered manager. The provider had failed to establish and operate effective systems and processes to ensure they were able to assess, monitor and improve the quality and safety of the services provided. The provider had failed to assess, monitor or mitigate risks relating to the health and safety of service users; failed to maintain securely an accurate and contemporaneous record in respect of each service user; including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; failed to seek or act on feedback from service users; and failed to evaluate and improve their practice in respect of processing of the information available to them.

The enforcement action we took:

We issued a warning notice