Medingate Limited

# Morningside Rest Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection was unannounced and took place on the 8 and 11 June 2018. At the last inspection we identified breaches of Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvements had been made and these breaches remained in place. We also identified additional breaches of Regulation 11 of the Health and Social Care Act and Regulation 9 of the Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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.

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

The care home is registered to accommodate up to 31 people in one adapted building. At the time of the inspection there were 17 people living at the service.
Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, safe, effective, caring, responsive and well led to at least good. At this inspection we found that improvements had been made in some areas, but not others. We also identified additional areas that required improvement.

There was a registered manager in post for part of the inspection. However, following a previous inspection we carried out in August 2017 we issued a Notice of Decision to cancel the registered manager's registration due to significant failings we had identified within the service. During this inspection our decision came into effect and the manager's registration was removed.

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.

The registered provider had taken steps to recruit a new manager however these had not been successful. There were no clear arrangements in place to ensure effective management of the service whilst a new manager was being recruited. We issued a requirement under Section 64 of the Health and Social Care Act that the registered provider give us information relating to this by the 13 July 2018. This information was received on the 19 July 2018.

Quality monitoring processes had not always identified issues within the service. The registered provider had employed an external consultant to support with monitoring the quality of the service; however the content of their findings had not been released by the registered provider to management within the service which meant that this information was redundant.

At the last inspection we identified issues around the safe use of portable radiators. At this inspection we found that this issue had been addressed. However, we identified other areas of concern in relation to people's safety.

We observed one person being pushed in a wheelchair without foot rests which caused the person to catch their foot and wince in pain. In another example the kitchen was left unlocked and unattended for a period of time. There were people in the service who were without the ability to assess risks for themselves and would be at risk if they accessed the kitchen without support.

Parts of the service were not always kept clean. For instance, some parts of the service had a strong odour. In the conservatory the fan had a thick layer of dust on the blades, chairs were dirty and there were cigarette butts piled up in and around a plant pot outside the conservatory's back door. These issues had not been identified and addressed.

People were not always supported to have maximum choice and control of their lives and the policies and systems in the service did not support best practice. For example, a mental capacity assessment had not been completed for one person who had been placed on a diet. In another example an application had been made to restrict one person who did not meet the criteria for restrictions under the Mental Capacity Act 2005.

Outcome based support was not always implemented and best practice guidance not always used. At the previous inspection we asked the previous registered manager to put a positive behavioural plan in place for one person. Whilst this had been done it was basic and did not fully support staff to provide effective support. Staff told us they did not always know how to support this person and had not received relevant training.

Care records did not always contain up-to-date information about the support people required. For example, updates had not been made to a person's care record following a fall, despite this having

highlighted significant issues with supporting this person after having fallen. In another example a person's care record gave specific information regarding the action that should be taken in respect of a person's continence needs. We reviewed monitoring charts which showed that this process had not been followed.

At the previous inspection we raised issues regarding the lack of adaptations to the premises for people living with dementia. At this inspection we did not find that any action had been taken to address this.

During both days of the inspection it was apparent that there was a lack of meaningful activities available to people. There was no activities co-ordinator in place to support with this. This placed people at risk of becoming bored or socially isolated.

Morale amongst staff was low and this had been picked up by people using the service. One person made comments which showed they had been made privy to information about the internal politics amongst staff. This showed a lack of professionalism because staff had failed to put appropriate boundaries in place between themselves and the people they supported.

Staff told us that they did not feel supported by management within the service or the registered provider. During the inspection a number of staff left the service as a result of feeling unsupported. This has been an ongoing issue which the registered provider has persistently failed to address.

People had received their medication as prescribed. At a previous inspection we placed a requirement on the registered provider's registration that a medication audit be carried out by a pharmacist on a monthly basis. We checked and found that this was being done.

Positive relationships had developed between people using the service and staff. We observed examples where staff supported people in a kind and gentle manner. Staff were respectful when supporting people to attend to their personal care needs.

Care records contained personalised information about people using the service. This helped staff get to know the people they were supporting and facilitated the development of positive relationships.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

We observed some practice that did not always promote people's safety and wellbeing.

Risk assessments had not always been updated following incidents.

Parts of the service needed to be cleaned to minimise odour.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People's rights and liberties were not always being protected in line with the Mental Capacity Act 2005.

Care was not always provided in line with best practice guidance to deliver positive outcomes.

People were supported to access health care professionals where needed.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not always protected from internal disputes within the staff team.

People's confidentiality was not always being protected.

Positive relationships had been developed between staff and people using the service.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care records did not always contain up-to-date, relevant information about people's needs.

There were limited or no activities available for people.

There was a complaints process in place which was available for people to access.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was no clear management structure within the service.

Staff told us they did not feel supported by management in the service, or the registered provider.

Quality monitoring systems were not always effective.

# Morningside Rest 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.

The inspection took place on the 8 and 11 June 2018, was unannounced on both days and was carried out by two adult social care inspectors.

Prior to the inspection we spoke with the local authority who shared information about concerns they had received in relation to the service. These focussed on the effective management of the service. We also checked the Health Watch website; however, they had not undertaken a recent visit to the service.

Due to technical problems, the registered provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection 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 four people who used the service and one person's relative. We spoke with seven members of staff including the previous registered manager. We looked at three people's care records and made observations on the interior and exterior of the premises. We looked at records relating to the day to day management of the service, such as audits and maintenance files.

Following the inspection we required the registered provider to give us information on the management structure within the service, a management rota for the service, evidence that the passenger lift was in the process of being fixed and a copy of an investigation being conducted into allegations of misconduct against an individual who worked at the service. We did this under Section 64 of the Health and Social Care Act 2008, which places a legal obligation on the registered provider to respond. The registered provider

made this information available to us.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because portable radiators were being used and posed a risk of scalding people. We also found that monitoring of accidents and incidents was not taking place. At this inspection we found that improvements had been made in relation to the use of portable radiators; however, there remained ongoing issues with monitoring accidents and incidents in a timely manner. We also identified further issues which meant there was an ongoing breach of Regulation 12.

During the inspection we asked for a copy of accidents and incident monitoring records. We later observed the acting manager part way through completing these for May 2018. The acting manager told us they were doing this to add further detail; however, we noted that parts of the form were blank. This showed this was in the process of being completed because it had not been done. This had been an ongoing issue within the service and needed to be kept up-to-date to ensure robust monitoring of incidents, to identify patterns and trends.

We reviewed accidents and incident records. In one instance we found that an appropriate risk assessment had not been put in place for meeting the needs of a person who was at risk of falls. In other examples we saw that risk assessments had been completed as required. This person required specialist equipment in the event of a fall. Records showed that a referral had been made to the occupational therapist; however, this was not explicit in stating the need for specialist equipment. Following the inspection, we raised our concerns in relation to this person with the local authority to ask for a review of this person's needs. We did this to ensure that the service was able to properly support this person.

We observed one person being pushed in their wheelchair without the appropriate food rests in place. This person caught their foot on the floor and winced in pain. We intervened and asked this member of staff to go and get the foot rests for the wheelchair and put these in place in order to prevent any further injuries.

On the first day of the inspection we observed an occasion where the kitchen was unoccupied whilst the door was unlocked. There were people within the service who were unable to assess risks to themselves and would be at risk if they entered this area. During the inspection we observed a separate occasion where a person tried to access the kitchen and was appropriately prevented from doing so by kitchen staff. This demonstrated the need to ensure the door was secured whilst the kitchen was unattended. After raising this issue with staff, the kitchen door remained secure for the remainder of the inspection.

There was a passenger lift in place which was not working at the time of the inspection. The registered provider informed us that this was in the process of being fixed, however they did not know when the works might be completed. A risk assessment had not been completed to reflect this change and ensure that those people on the first floor were able to use alternative means of accessing the ground floor in a safe manner. Following the inspection we received an update from the registered provider confirming that the lift had been fixed.

Some parts of the environment were clean, whilst others were not. In the dining area a number of chairs were stained, and in the lounge area there were marks to the backs of some of the chairs where people's heads had been resting. The fan in the conservatory had a thick layer of dust on the blades and just outside the conservatory there was a plant pot filled with cigarette butts. We identified three bedrooms and one corridor which had a very pungent smell. We raised this with the acting manager who told us that these areas would be thoroughly cleaned to get rid of the smell.

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff following appropriate infection control procedures. For example, they had access to disposable aprons and gloves which were used whilst supporting people with their personal care needs. Where required, soiled clothing was placed in a dissolvable bag and then placed in a designated area in the laundry room before being washed. We observed staff wearing aprons when accessing the kitchen which helped minimise the risk of cross contamination.

Whilst we have outlined some issues in relation to risk assessments, on other occasions we found that these were in place and being kept up-to-date as required. For example, where people were at risk of developing pressure ulcers this had been appropriately assessed. We spoke to a visiting professional who commented that in their experience people were receiving the correct support in relation to their pressure areas.

We reviewed the registered provider's safeguarding and whistleblowing policies and found these to be out of date. Neither policy provided contact details for the local authority or the CQC which meant these did not provide staff with all the relevant information needed if they needed to raise a concern. However, when we spoke with staff they demonstrated that they knew how to report any safeguarding concerns. There were no current safeguarding issues being investigated by the local authority at the time of the inspection. The registered acting manager informed us these policies were in the process of being updated.

During the last inspection in February 2018 we did not find any issues with recruitment. Since the last inspection no new members of staff had been employed at the service. Because of this we did not need to look further into recruitment practices.

There was a dependency tool in place which helped determine the number of staff required to be on duty. We identified that this had not accurately recorded that one person needed the assistance of two staff. The dependency tool was updated and reflected that there was sufficient staffing to meet people's needs.

Prior to the inspection we received concerns from a health professional regarding an instance where they had found inadequate staffing levels. Staff also told them that on occasion there would not be sufficient staff on the morning shift. We followed up on this during the inspection and observed that there were sufficient numbers of staff in post to meet people's needs. The registered provider was in the process of investigating these allegations at the time of the inspection.

Following a previous inspection we imposed a condition on the registered provider's registration which required them to have a medication audit carried out by a pharmacist on a monthly basis. We looked at records which showed this was being done. These audits showed there were no issues with the medication process.

Incident records showed that on occasions where medication records were not being appropriately signed by staff this had been raised with individual staff members. There had been one incident where a member of

the domestic team had found discarded medication in a person's room. This had been followed up with the staff member responsible.

A fire risk assessment was in place and follow up action had been taken to address any areas of improvement needed. There was a fire escape plan in place and evidence that drills had been carried out with staff. However, a night time drill had not been carried out to ensure that people could be safely evacuated with the reduced staffing levels over night. We also identified that the stair lifts on the main stairs may act to obstruct a safe evacuation; however, there were two alternative routes available which mitigated this risk. Following the inspection, we raised these concerns with the fire service so they could check that the service was safe.

Personal Emergency Evacuation Plans (PEEPs) were in place which outlined how staff should support people to leave the premises the event of an emergency.
Environmental checks were being carried out. For example, water temperatures were being monitored to ensure they were not too hot or too cold. A gas safety check had been completed and fire extinguishers and emergency lighting had been serviced and checked to ensure they were in working order.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in February 2018 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because adaptations had not been made to the environment to meet the needs of people living with dementia, and action had not been taken in response to feedback provided by people. In addition, we found that adequate support plans were not in place to support staff with managing behaviours that challenge. At this inspection we found that insufficient action had been taken to rectify these issues and the breach therefore remained in place.

Care plans were not always completed sufficiently to ensure that effective outcomes for people were identified and met. At the last inspection we discussed one person who needed a positive behavioural support plan to be put in place to help with managing their behaviours that challenge. At this inspection we found that the acting manager had made some effort to involve community based professionals, however this had been unsuccessful. In addition, a behavioural support plan had been put in place but this was basic, ineffective and was not being followed by staff. This plan stated that staff should not respond to episodes of verbal aggression. A visiting health professional told us that they had observed staff being respectful to this person, however they described staff acknowledging and engaging with the person's episodes of verbal aggression. This showed the care plan regarding this person's behaviour was not being followed.

We spoke with staff who stated they did not always know how to support this person. Training around managing behaviours that challenge had not been provided to staff to support them in their role. Action had not been taken in a timely manner since our last inspection in February 2018 to ensure staff had the skills and knowledge necessary to support this person.

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

At the last inspection we also identified that only minimal adaptations had been made to the environment to meet the needs of people living with dementia. At this inspection we found the environment to be the same and was failing to promote people's orientation around the building. Consideration had not been given to the placement of objects of interest about the service to help people orientate themselves, or the use of specific colour schemes and enhanced lighting. This is because people living with dementia can experience changes to their visual perception which alterations to the environment can help compensate for.

At the last inspection in February 2018 people told us that they wanted more variety during their tea time meal. During this inspection we observed that no changes had been made to the tea time options. This showed that people's feedback in relation to food was not being acted upon. However, people commented that they enjoyed the food that was available and told us they were able to ask for seconds if they wanted.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found examples where appropriate processes had not been followed. In one example we observed a person had been put on a weight-loss diet. It was not clear whether this person had the mental capacity to agree to this and no assessment had taken place in relation to this. This person's daily notes also showed that they could be resistive to care interventions, however a capacity assessment and best interest decision had not been put in place.

We looked at a DoLS application for another person, restricting their ability to leave the service without support. In this example the application stated, "[Name] does understand the risks if they were to go out alone and has never tried to leave…[however], they would not be free to leave the home on their own if they ever attempted to." A mental capacity assessment around this person's ability to make this decision had not been completed. It would be an unlawful restriction if staff tried to prevent a person with capacity from leaving the service. This demonstrated a lack of understanding around mental capacity law.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed that staff had been provided with training in other areas such as safeguarding, infection control, fire safety and health and safety. There was an induction process in place which followed the standards required by the Care Certificate. The Care Certificate is a national set of minimum standards that care staff are expected to meet.

We looked at supervision records which showed that these had been completed. Supervision allows staff to discuss any training and development needs they may have and also allows management to raise any performance related issues with staff.

Kitchen staff maintained a list of those people with specific dietary needs. This included people who required soft options or people with diabetes. During meal times we observed appropriate food options being made available to people.

People had been supported to access health and social care professionals as required. During the inspection we observed a health professional visiting the service to provide support to people. People's care records showed that they had been visited by their GP and other health professionals. This helped ensure people's wellbeing was being maintained.

Requires Improvement

# Is the service caring?

## Our findings

People's comments regarding staff were very positive. They told us they liked staff and felt well supported by them. Their comments included, "Staff demonstrate kindness, consideration and respect", "I have received care and compassion from all staff" and "Staff are nice, very good". We spoke with one person's relative who also commented positively on staff. Whilst the comments we received regarding staff were positive we identified areas where improvements needed to be made.

People's confidentiality was not always protected. At the last inspection we raised concerns about people's private correspondence being stored in pigeon holes in communal areas. At this inspection we found the pigeon holes had been moved to a different communal area, but remained in place. We also identified some occasions where offices containing people's personal information were left unlocked and unattended.

This is an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Morale throughout the staff team was low. Staff told us there was a divide amongst staff which created a negative atmosphere within the service. Low morale and the division between staff was evident during the day-to-day operation of the service. For example, one member of staff swore and became frustrated whilst undertaking a task in the lounge area. This was in front of people who lived at the service. Following the inspection, the acting manager confirmed with the local authority that a number of staff had left the service. This was a direct consequence of low morale and a failure by the registered provider to take effective action to address this, despite this having been an ongoing issue.

Whilst we observed examples that demonstrated positive relationships had developed between people and staff, at times this was impacted upon by a negative culture within the service. For example, we spoke with one person living at the home who was able to give us a detailed account of the divide amongst staff because staff had included them in their discussions about this. In another example we spoke with a member of staff who made reference to people participating in the negative dynamic amongst staff, stating, "The divide includes residents too". This showed a lack of professionalism because staff had failed to maintain professional boundaries between themselves and the people they supported.

On other occasions we observed positive interactions between people and staff. In one example a member of staff was discreet in supporting a person to attend to their personal care. In another example a member of staff approached a person sensitively, using distraction techniques to keep them calm and settled.

People's privacy was protected. Personal care was delivered in people's bedrooms or in bathrooms where staff would ensure the door was locked and blinds/ curtains closed. People who wished to spend time in their bedrooms did so with the doors open or closed as they preferred.

At the time of the inspection there was no one who was in receipt of support from the local advocacy service. However, management were aware of those situations where an advocate may be needed. An

advocate acts as an independent source of support to people who need support making decisions about their care needs. This helps ensure that people receive the support they need with making decisions about their care.

People's religious needs had been recorded in their care records, however those people we spoke with told us that they were non-practicing and did not need support in relation to this.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in February 2018 we identified some issues with regards to the accuracy of some people's care records and the provision of activities for people. During this inspection we found these to be ongoing issues.

Care records were not always updated with developments that had occurred. For example, one person sustained a fall in June 2018 during which it was highlighted that they required specialist equipment to help them get up in the event of a fall. However, their mobility care plan and moving and handling risk assessment had not been updated since May 2018. This meant that guidance for staff would was not clear on how to support this person in the event of a fall.

Another person's care records stated that they needed support to maintain a routine with their continence and gave specific instruction around involving health professionals if this routine was not maintained. We looked at daily monitoring charts which showed this person's routine had not been maintained; however, there was no record of consultation with health professionals around this. We also spoke to this person who did not show any signs of distress or of being unwell. We asked that action be taken to follow this up.

During the two days of the inspection we observed that there were no activities available for people using the service. We observed people spending time sat in the lounge area with the television playing, however no one appeared to be interested in this. One person commented, "There are not many activities available." We were informed that the activities co-ordinator had been unavailable for approximately six to seven weeks. This meant that there was nothing in place to ensure people had access to physical and mental stimulation.

Information was not available to people in an alternative format should they need this, for example the use of pictorial care plans for people who had lost the ability to read. There is a requirement placed on the registered provider to ensure alternatives are available so that people's information is accessible to them.

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

Other care records contained a clear level of detail regarding people's physical, mental and personal care needs. These also included an outline of people's likes, dislikes, preferred daily routine and life history. For example, one care record outlined a person's place of birth, important relationships and work history. Another outlined a person's favourite and least favourite foods. This helped staff get to know the people they were supporting and facilitated the development of positive relationships.

There was a complaints procedure in place for people to follow. This contained all the relevant information people needed to make a formal complaint and was on display at the entrance to the premises. One person's relative told us they would feel comfortable making a complaint and that they felt action would be taken in response to any concerns they had.

At the time of the inspection there was no one in the service who was at the end stages of their life. However, where people had chosen not to be resuscitated in the event of a cardiac or respiratory arrest this information was displayed prominently at the front of their care record. This helped to ensure that people's advance decisions about their end of life care were respected.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in February 2018 we identified breaches of Regulations 6 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not appointed a nominated individual to act as a point of contact with the CQC. We also identified ongoing issues in relation to embedding quality in the day-to-day running of the service. Following our last inspection, the registered provider appointed a nominated individual which meant they were no longer in breach of Regulation 6. However, during this inspection we identified ongoing issues with quality monitoring processes within the service.

Following our inspection in August 2017 we took enforcement action to cancel the registered manager's position due to failings within the service. During this inspection this enforcement action came into effect which meant that the registered manager was no longer registered with the CQC. This meant there was no manager in place within the service. Interviews had taken place and one candidate had been selected for the position, however during the inspection this individual left. Following the inspection, we asked the registered provider for clarity regarding the interim management structure however, this information was not forthcoming. We therefore issued a requirement under Section 64 of the Health and Social Care Act 2008 that the registered provider give us this information by the 13 July 2018. This registered provider failed to respond to this in the timeframe required; however we received an update on this on the 19 July 2018.

Over the past 12 months a number of whistleblowing concerns had been received by the CQC and the local authority regarding the service. Whistleblowing is where staff can raise concerns without fear of any reprisals. One member of staff told us that the previous manager had spent time trying to determine who the whistleblower was. This is an issue we raised during our inspection in August 2017 as it obstructed staff from feeling able to report on poor practice. This demonstrated a lack of professionalism within the service because it showed that the emphasis was not on trying to resolve the whistleblowing concerns, but identify those staff who were raising the concerns. This also showed that the registered provider had failed to take effective action in enabling staff to feel safe when raising any concerns.

Low staff morale had been an ongoing issue within the service which the registered provider had persistently failed to address. During the inspection a number of staff resigned from their posts, telling us this was because they did not feel supported by either management in the service, or the registered provider. Following the inspection, we asked the registered provider to give us a plan for making improvements with regards to staff morale; however, this was not received.

Audit systems were in place to monitor the service. For example, health and safety audits were being completed which included checks on water temperatures, fire escapes and infection control. Care records were also being checked for accuracy. However; we found that accidents and incidents audits had not been completed for May 2018, and we identified some areas of the service which had a strong odour which had not been identified or addressed by audit systems. In care records we identified examples where information was not always up-to-date and relevant plans and risk assessments had not been put into place. In one office we also found a number charts relating to the monitoring of people's care needs. Many

of these did not include people's names which meant these could not be used to track people's care.

The registered provider had contracted an external consultant to carry out quality monitoring at the service. During the inspection we asked the acting manager to provide us with copies of these, however we were informed that whilst these had been sent to the registered provider, a copy had not been forwarded to management in the service for "The past two months". This meant that the information from this quality monitoring process could not be used to make improvements.

Policies and procedures were in place, however these had not been kept up-to-date. For example, the record keeping policy had last been updated in March 2017 and did not include information on new regulations implemented by the General Data Protection Regulation (GDPR). The safeguarding and whistleblowing policies also failed to include relevant information about the CQC and local authority. During the inspection we were informed that these were being updated.

The registered provider had a disciplinary procedure in place, however this did not include any time scales within which any investigations into misconduct should take place. We were made aware of one allegation of misconduct which had been identified in March 2018, however after three months it was unclear where the investigation was up to. Minimal information had been provided to the individual accused of the misconduct which contradicted the registered provider's own policy, which stated, "You will always be given as much information as possible regarding the allegations of misconduct". We issued a requirement that the registered provider give us this information relating to the allegations and outcome of the investigation by the 13 July 2018.

Records showed that a recent staff meeting had not been held with staff. Staff meetings should be used to share important information about the service.

These are ongoing breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the service had been sought during service user meetings. During these people had discussed different ideas for activities. We were informed that whilst an activities co-ordinator was not in post to put these suggestions into effect, this post was in the process of being recruited to.

The registered provider is required by law to notify the CQC of specific events that occur within the service. This had not been done. During the inspection we found that the passenger lift was not functioning, however we had not been notified of this. We requested that the registered provider give us a date by which this would be fixed, however information was not forthcoming. We therefore issued a requirement that the registered provider give us this information by the 13 July 2018.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The CQC had not been informed of all significant events that occurred within the service, as required by law. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registered provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's care was not always being provided in a person centred manner. |

**The enforcement action we took:**

We issued a notice of decision to cancel the registered provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People's rights and liberties were not being protected in line with the requirements of the Mental Capacity Act 2005. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registered provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care was not always being provided in a way that maintained people's safety. |

**The enforcement action we took:**

We issued a notice of decision to cancel the registered provider.

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality monitoring systems were ineffective at producing positive change and embedding quality within the service. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registered provider.