Four Seasons 2000 Limited

Hemsworth Park

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Our unannounced inspection took place on 31 January 2018 and 16 February 2018.

At our last inspection we rated the service as 'requires improvement' and identified five breaches of regulation. These were in relation to;

Safe Care and Treatment. This was a repeated breach. We found information in care plans and associated documentation was not always accurate or up to date, and we saw a lack of guidance for staff to show how risks could be minimised. We observed a number of incidents which showed risk was not always managed robustly.

Dignity and respect: This was a repeated breach. We found there was an on-going lack of support for service users who did not speak English. This had a negative impact on their experience of care and support at the service.

Need for Consent: We found consent was not recorded in line with the requirements of the Mental Capacity Act 2005. Staff routinely signed consent documentation rather than the person using the service or their representative.

Good Governance: We found governance systems were in place but had failed to identify some issues which we saw at inspection. Insufficient action had been taken to ensure breaches of regulation identified at our previous inspection were rectified.

Staffing: We found our observations and some feedback from people and staff identified staffing levels were not always adequate to meet people's care and support needs in an effective way. We also saw staff did not always receive supervision in a manner which supported them to remain
effective in their roles.

Following the last inspection, we met with the provider to confirm what they would do and by when to improve the key questions 'safe', 'effective', 'responsive', 'caring' and 'well-led' to at least good.

At this inspection we found improvements only in terms of the support for people whose first language was not English. The remaining breaches were not resolved and the provider was still not meeting these regulations.

Hemsworth Park 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 service is arranged into four units, for nursing (Creighton), people living with dementia (Vale View), Younger People's Rehabilitation (Bailey) and Residential (Lake View). The service can accommodate up to 93 people. At the time of our second day of

inspection there were 81 people using the service.

There was a registered manager in post. 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.

Staff were recruited safely, however we found they were not always deployed in sufficient numbers to provide safe and timely care. They could not always minimise risks appropriately as they did not always have access to up to date or detailed information in care plans. Care plans were not always updated in response to changes in people's needs. We observed a number of occasions where people were not assisted with appropriate moving and handling support.

Medicines were not always managed safely, and we saw a number of occasions where people were without medicines because re-ordering systems had not been robust. Secure recording and ordering of controlled medicines was not always in place.

Although staff said they understood how to report concerns about potential abuse, we found systems in place to manage this were not sufficiently strong. Several incidents were reported to the safeguarding teams at our request during the inspection. Staff had access to personal protective equipment (PPE) but we found some areas of the home to be malodorous and not always clean.

Care of wounds and pressure areas was not always safe or effective, and controls put in place after the first day of our inspection had not improved the monitoring of this sufficiently. We concluded there was a lack of strong clinical oversight of the nursing unit in particular.

Staff had access to training, however individual support and performance review was still weak. The registered manager responded by putting new plans in place between the first and second days of our inspection.

The approach to assessing and documenting people's capacity to make decisions was still not always effective. People were not always appropriately involved in decisions about their care. Conditions placed on people's Deprivation of Liberty Safeguards (DoLS) were not well managed, and we found evidence the provider was not always meeting these.

People gave mixed, though mostly negative feedback about the meals served to them. We observed some people had very poor support in this area of their care, and records were not kept in an appropriate way. We found there were differences in the food available to people depending on their needs and which unit they lived in.

Staff did not routinely engage in conversation with people, and we observed very poor approach to care and interaction, particularly on the dementia and nursing units. There were a number of times when staff were not respectful or caring in their language and actions. People's opportunities to shower or bathe were infrequent or non-existent, and we saw personal care was not always given.

Some improvement had been made to the experience of people whose first language was not English, some people told us they had been supported with their faith, and we were told information could be made available in accessible formats where needed. We found that there were inconsistencies in people's experience of and access to care, and preferences were not always respected.

There were no records of complaints or concerns. The registered manager told us there had been no complaints, however this was not true. We had asked for them to record feedback from a family member as a complaint and record and manage it as such. They had not done this. Other people told us about complaints and concerns they had raised.

People living at Hemsworth Park had infrequent opportunity to engage in meaningful activities and spent much of their days with little to no stimulus.

Feedback about leadership and management in the home was mixed although mainly negative. We found evidence of insufficiently robust leadership in the home and at provider level. Audit activity had been conducted and reviewed, however had failed to identify the shortfalls in care and quality identified in our inspection.

We identified nine breaches of regulation connected with safe care and treatment, safeguarding, staffing, consent, nutrition and hydration, dignity and respect, acting on complaints, person centred care and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not safely managed. People often went without medicines which had been allowed to go out of stock, including those for significant pain relief.

The approach to risk assessment and management was inconsistent. Some care plans lacked guidance to show how risks could be minimised. The management of safeguarding concerns was not always effective.

Staff were recruited safely, however evidence showed they were not deployed in sufficient numbers.

Is the service effective?

Inadequate

The service was not effective.

Systems for assessing and documenting people's consent were not robust. Conditions placed on DoLS authorisations were not always adhered to.

Care, especially related to wounds, was not always effective. We saw some serious worsening of wounds was not well managed.

People's mealtime experiences were often poor. Management of nutrition and hydration concerns was not robust.

Is the service caring?

Inadequate

The service was not caring.

Some staff lacked respect for people's privacy and dignity.

People had few opportunities to bathe or shower, and support for people's continence needs was not always provided.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always reflect people's up to date needs. There was a lack of planning for end of life care to ensure people's wishes and needs would be met at this time.

People lacked stimulus as the provision of activities was poor.

Complaints were not well managed. There were no records showing any complaints or concerns had been raised, which was not the case

Is the service well-led?

Inadequate

The service was not well-led.

Governance systems such as audits and checks had not identified the issues we identified during the last inspection, and had not driven improvement in the service overall.

We received very mixed feedback about leadership at home and provider level.

Hemsworth Park

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 over two days, both of which were unannounced. We visited the service on 31 January 2018 and 16 February 2018.

On the first day the inspection team consisted of four adult social care inspectors, a specialist advisor for governance and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both had experience of supporting people with dementia, and one was able to speak with two services users in their own language. On the second day the team was four adult social care inspectors and a specialist advisor in medicines.

Before our inspection we reviewed all information we held about the service. This included past inspection reports, registration information and notifications which the provider is required to send to us. We also contacted a range of other bodies such as the local authority commissioning and safeguarding teams, the fire and rescue service, the clinical commissioning group (CCG) and Healthwatch, a consumer champion that gathers information about people's experience of using health and social care services in England.

Before the inspection we received a provider information return (PIR) from the service. This is a document which asks for information about what the service does well and any improvements they plan to make.

During the inspection we spoke with the registered manager and their mentor, two regional managers, a resident experience manager with responsibility for medicines and the deputy manager. We also spoke with two nurses,18 members of care staff, 2 members of domestic staff, 21 people who used the service, seven visiting relatives, a member of the catering staff and two visiting health professionals. We spent time making observations in all areas of the home, including people's own rooms with their permission. We looked at documentation including 18 care records, medicines administration and stock records and other information relating to the running of the home such as servicing certificates, training records, staff files and

minutes of meetings. 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.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2017 we rated this key question as 'requires improvement'. We found a repeat breach of regulations relating to safe care and treatment as we found risks associated with care and treatment were not always well managed, and observed a significant incident where moving and handling practice was not safe. We also identified a continuing breach of regulations relating to the numbers of staff on duty. At this inspection we found concerns relating to the care of wounds, risk assessments and medicines management, and identified a third consecutive breach of regulations relating to safe care and treatment. We also concluded the provider remained in breach of regulations relating to staffing for a third consecutive inspection, and identified a further breach of regulations relating to safeguarding concerns.

Although people told us they received their medicines on time, we found medicines were not being managed safely at Hemsworth Park. We saw evidence of a number of occasions where people went without medication, including for end of life pain relief and for complex medical conditions, because ordering was not always timely or well managed. This meant there was a high likelihood of people being left in pain or experiencing a change in symptoms of conditions such as those connected with Epilepsy and Parkinson's disease.

We saw one person was receiving medicines hidden in their drinks, which is also known as covert medication. This was not highlighted on their medicines administration records (MARs) and we saw there was a lack of instructions available as to how and when this was to be given. We looked at the person's care plan and saw a best interests decision had been made to give the person their medicine in this way, however there was no evidence to show which GP or pharmacist had been consulted or their advice. There was a general statement saying, 'Professional Bodies and family were involved in making this decision.

Some medicines require additional secure storage and record keeping because of the nature of the drugs they contain. These are also known as controlled drugs. We saw these records were not always appropriately completed. For example, we saw one entry for a controlled drug had been duplicated in the records, and contained no information as to the method this medicine should be given, for example orally or by injection.

We found medicines for someone who had passed away some weeks before our inspection were still on the premises, and an accumulation or waste or surplus medicines which should have been disposed of in a controlled way. We found one fridge used to store medicines at controlled temperatures had no thermometer to enable staff to check for correct operation. We also found one medicines room lacked appropriate ventilation to maintain a temperature appropriate for the safe storage of medicines.

There was an inconsistent approach to the assessment and documentation of risks associated with people's care and treatment. For example, some risk assessments were given scores but there was no explanation of what this meant. In other care plans we saw risk assessments were in place but were poorly completed with missing or inconsistent information. We saw information around the level of risk for one person was confusing. A handover sheet stated they were at risk of choking, and a risk assessment stated they were

'medium risk'. However, when we reviewed their care plan there was no information about how the risk or how it was managed; we saw the person eating fish in batter and chips. The unit manager told us a speech and language therapist (SALT) had carried out an assessment and said the person could eat a normal diet. When we asked to see evidence of this they were unable to locate the SALT assessment. We asked for a copy to be requested and added to the person's care plan.

Another care record stated the person was 'type 2 diabetic' but there was no information in the care plan about how this should be managed other than 'requires a diet without sugar as [person]'s blood sugar may become too high' but no other information to guide staff as to how to identify concerns or support the person properly.

Management of risk was also inconsistent. For example, we saw one person using a wheelchair that had previously belonged to someone who had passed away. This meant the equipment may not have been suitable or safe for the person to use, as there was no evidence of any related assessment in their care plan. On the Vale View unit we observed housekeeping staff mop the corridor floor, leaving it wet. Although warning signs were put out to alert people to the hazard, this was not an effective measure for people living with dementia, who may not have understood the relevance of the signs. We observed one person walking down the corridor when no staff were present. We saw they moved the warning signs.

People who needed support when mobilising, for example from a chair to a standing position, did not always receive safe assistance from staff. For example, we observed one incident where a person was assisted to a standing position by two members of staff who did not use equipment such as a stand aid or hoist. We looked at the person's care plan which stated they should always be transferred using a hoist as they were unable to weight bear. We saw people assisted from wheelchairs when the staff had not first applied the brakes and the person had moved to the edge of the seat, meaning the transfer was not safe. We spoke with the person who we had been told was responsible for moving and handling. They told us they did not feel confident in this role despite having had additional training. They said the registered manager had arranged for them to have additional support from a more experienced member of staff.

We concluded this evidence showed the provider remained in breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incident reports were added to an electronic system, and this information was used to assess whether there were any trends that needed to be addressed.

Staff we spoke with told us they understood how to recognise and report concerns about potential abuse, however we found people lacked some protection at Hemsworth Park because there was not a robust approach to recognising and reporting potential safeguarding incidents. For example, in one person's care plan we saw a health professional had recorded staff were to refer deterioration in the person's skin care as a safeguarding, however there was no evidence this had been done. A staff member said they had reported this to the registered manager, however the referral was not sent until we requested it during our inspection. On the second day of our inspection the registered manager told us they had attended a meeting with a local safeguarding team which had increased their knowledge of what should be reported to them, and what alerts should be sent to bodies such as the safeguarding authority and Care Quality Commission. We identified a number of concerns during the inspection which we had to ask the registered manager to report as safeguarding incidents. We found the registered manager did not keep a log of incidents which would have assisted them in identifying emerging trends and themes, or demonstrate a lessons learnt culture where actions taken in relation to one specific incident were used to prevent further occurrences. For example, we had to ask for reporting of pressure sores and medicines errors that we identified during the

inspection.

We concluded the provider was in breach of Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who used the service and their relatives said they felt they were safe at Hemsworth Park, however feedback was varied. Some people told us they did not feel safe, and said this was due to the levels of staffing in the service. Comments included, "Sometimes it's chaos here - they get short staffed," "When I call from help - they come and apologise and say they won't be long - but they take a long time," "This place is not run properly - there are not enough staff," and "There has definitely been a cut in staff since I came to live here." Some people gave examples of how staffing levels had an impact on their experience of care, for example one person said staff were not always able to respond to their continence needs in a timely way, which left them feeling frustrated.

Staff also told us they did not feel they were deployed in sufficient numbers. Staff we spoke with said they had challenged the staffing levels but had been told by the management team = they were correct. They gave examples of how they were unable to meet people's needs safely, for example not being able to support people to shower or bathe regularly, and staff regularly having to cover other units during their shift, meaning their unit did not have sufficient staff. Staff said the numbers of staff present did not always match the rotas, told us they were moved from one unit to another and did not always know what people's needs were, and frequently were unable to take breaks during twelve hour shifts because they were needed to assist people. One member of staff told us, "I could cry when I go home as I can't give the care they should have. It's not right."

We saw there were often extended periods of time when staff were not present in communal areas, particularly on the Vale View unit. We saw one person who was at high risk of falls was not adequately protected because staff were not always present to observe when the person began to move. We observed people calling out who were not heard by staff as they were not present.

The registered manager used a system to determine staffing levels based on the needs of the people who used the service. At our last inspection our observations and what people who used the service told us evidenced our concerns there were not enough staff on duty, and the provider told us they would review the dependency output to ensure it was correct, and added some additional staff to the rota. At this inspection we again observed staff did not have or make time to talk to people, people told us they often felt staff were not present in sufficient numbers and staff gave examples to show us why they felt the staffing levels were too low. We discussed this with the registered manager, who said they planned their rotas according to the dependency calculations.

We concluded based on this evidence the provider remained in breach of regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence staff were recruited safely. The provider had appropriate systems in place including requesting employment references and making criminal checks to ensure people were not barred from working with vulnerable people. Records of interviews were kept, meaning the provider could evidence people's suitability for their roles.

Our checks showed equipment and installations such as those for gas and electricity mains were regularly checked and serviced. Staff had access to appropriate protective equipment (PPE) and we found soap dispensers, hand sanitisers and paper towels were well stocked. On the Vale View unit we found malodours

on the first day of our inspection, which were still present on the second day. New carpet was fitted and some furnishings were replaced during our inspection, however we saw faeces in one bathroom which was not cleaned effectively, and noted other areas including people's rooms where malodours were present.

Inadequate

Is the service effective?

Our findings

At our last inspection we rated this key question as 'requires improvement.' Staff were not receiving adequate support to remain effective in their roles, and we identified a continuing breach of regulations in relation to this. We also identified a breach of regulations in relation to consent. At this inspection we found the provider had not taken timely action to improve staff support, and remained in breach of this regulation for a third consecutive inspection. We also found the provider remained in breach of regulations relating to consent.

People using the nursing unit did not always receive safe care and treatment for pressure wounds. We spoke with a relative who told us they had raised concerns about a pressure ulcer which had begun to deteriorate, leaving the person crying out in pain. When we checked the person's care records on the first day of our inspection, we saw information which stated the pressure wound was healed in January 2018, however a subsequent review nine days later by nursing staff contradicted this conclusion and showed it was significantly worse. We raised concerns with the registered manager, and on the second day of our inspection they told us they had reviewed the treatment of wounds and pressure care. Although we saw evidence this was the case, we found further examples of ineffective record keeping. One person's care plan referred to the presence of a single pressure ulcer; however a recent photograph showed two broken skin areas. This meant the assessments for pressure care had remained ineffective.

This evidence contributed to the continued breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives did not express any concerns about the competence of staff to meet their needs. We saw there was a training programme in place for staff, with a mix of face to face and computer based learning. Then registered manager showed us a planner (matrix) which was used to monitor and plan training. We reviewed these records and saw most training was up to date, however there were some gaps. For example, 43 staff did not have up to date training in fire alarm testing, the frequency for which was 6 monthly for day staff and four monthly for night staff. Similarly 35 staff did not have a record to show their fire training had been kept up to date. Observations of staff practice, for example in relation to dementia care, moving and handling and wound care indicated training was not always effective.

Although it was an issue raised at our last inspection, staff had still lacked support to remain effective in their roles. Supervision meetings were used as a means to pass information to staff, or as a means of addressing poor performance. There was a lack of opportunity for staff to discuss their individual performance, training needs or development opportunities. This finding was unchanged from our previous inspection. On the second day of our visit the registered manager told us they had conducted some supervisions which did include reflection on individual performance, and we saw there was a plan in place to ensure all staff received regular and effective supervision for the rest of the year.

We concluded this evidence contributed to the repeat breach of regulation 18 (Staffing) 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 did not always find evidence people were consulted about and consented to their care. We saw records were not always fully completed. For example, in two care plans we saw details recorded about whether people consented to photography, but there was no signature of the people or their representatives. We saw another person had bedrails in place, however their care plan did not refer to these or show how the person's consent had been sought or obtained. On one unit we saw a person had been kept in bed for a number of weeks due to concerns about their safety in a wheelchair. The records showed the decision had been made by a member of staff, with no input from the person or their representative. We saw the person was regularly agitated, however there was no evidence anything had been done to address the concerns about their wheelchair, for example checking to see if further adaptations such as a lap belt could be used.

Some other care plans we looked at also lacked evidence of assessment of people's capacity to make decisions. For example, one care plan lacked this documentation, although we saw references to the person having 'confusion' and 'Alzheimer's'. Another person's clothing had been stored away from their room, however there was no documentation to show how or why this decision had been made, and how the person's consent had been obtained.

Some staff were observed to be gaining verbal consent from people. For example, we saw staff asking what they wanted to eat and drink, and if they could support them with personal care.

We saw the provider was recognising where applications for DoLS were needed, however some DoLS had been authorised with conditions the provider had to fulfil, and we found a low level of awareness of these conditions. For example, on one unit a member of staff told us there were no DoLS with conditions in place, however this was not the case. On another unit a staff member told us, "I leave all that (MCA and DoLS) to the seniors. I don't understand it." The senior on that unit told us they did not know who had conditions on their DoLS and said they had asked the registered manager for more training in this area.

On another unit we found staff were able to speak more confidently about MCA and DoLS, and we saw examples of appropriate capacity and best interests documents in people's care plans.

The registered manager told us there was a copy of any DoLS authorisation in the person's care plan, but we found this was also not always the case, meaning staff did not always have access to this information. There was no management overview of who had a DoLS and what any conditions were, and no mechanism in place to enable the provider to check they were meeting the conditions. We found conditions were not always being met. For example, the provider had been asked to provide sensory equipment for one person, and liaise with other health professionals to devise meaningful activities for another person. We could not find evidence the provider had acted on these conditions.

We concluded the provider was in breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people often spent much of their day either seated in one position or in bed. For example, on one unit we saw two people seated in their wheelchairs in the dining room at 9am. They remained like this until late afternoon with little interaction from staff. We saw they were asleep in their wheelchairs with food left in front of them. This had gone cold. We expressed concern to staff that the people had not been repositioned or assisted with continence care for several hours. Staff offered support to people at 3pm.

Most people told us they did not always enjoy the food served at Hemsworth Park, although some people gave some more positive examples. Comments included "The food is not the best of the best. It is edible. You get spaghetti on toast for your tea. It is cheap and nasty stuff," "The meals are not so good, although, I do like the lasagne. The meals can be cold as one of the hotplates is broken. The tea bags are the cheapest they can buy," and "The food is awful here." One person told us they felt they were served "Kiddy meals", which they told us included spaghetti hoops or beans on toast and jelly and cream. The person said the portions were small. Another person said there was a lack of variety in the sandwiches that were regularly served.

We observed there was no heated food trolley on the nursing unit on the first day of our inspection. The cook told us it had been reported as broken the week before. When we returned 16 days later it was still broken. When we raised this with a member of the management team they called another home which was closing and asked for a food trolley to be brought to Hemsworth Park.

Staff we spoke with also gave mainly negative feedback about the food. One member of staff told us, "The pureed food at lunchtime today looked appetising and smelt nice but it's not always like that. We don't get the selection the other units get in terms of cakes and snacks." When we expressed concern to the staff member about this difference between units they told us, "Nutritionally they get what they need on here. It's okay for them." They also told us one person from their unit ate in another unit because they had better choice there. They were only able to do this because they did not require assistance to mobilise. This meant people did not experience equal treatment in respect of the meals provided at Hemsworth Park.

Some people's experience of mealtimes was poor. On the Vale View unit we saw housekeeping staff were more mindful of people's nutritional needs than care staff. For example, we observed care staff serve a meal to someone reclined in bed by placing the plate on the person's chest. This left them unable to eat effectively. We saw a member of the housekeeping staff noticed what the care staff had done; they went to find a table which fitted over the person's bed, relocated the plate and gave the person encouragement to eat. Another person received their meal whilst seated in a chair in their room. Although care staff placed the food on the table in front of the person, they did not ask if they could remove the soiled continence pad the person was holding at the time. The table had food debris from the person's breakfast which was not cleared away, and the member of staff failed to notice the person's feet were in a puddle of liquid underneath their chair. We observed the person was unsettled and not eating until a member of the housekeeping staff noticed them and removed the soiled pad before encouraging the person to eat.

When we arrived on the second day of our inspection some people in the lounge on the Vale View unit told us they were hungry and thirsty. We did not see evidence they had been offered anything to eat or drink since they had got up. One was calling out, "Breakfast please, oh please. When? When?" Another person called out, "Come on, a drink, a cup of tea, anything." We saw staff walk past people asking for food and drinks. They used phrases such as, "Two minutes," "It won't be long," and "It's coming soon." One person repeatedly stretched out their arms and made grasping gestures as they called out. We asked staff if anyone

had been given a drink and they told us this would have been done by the night staff. When we checked, the records showed no one had received food or drink since the previous evening, however this included water given with medication. When we raised this with the registered manager they told us they would ask staff to give priority to giving people a drink when they woke up.

Our observation of breakfast on the Vale View unit showed people had a poor experience. Staff called 'Breakfast time' at 9.08am, and people began to gather in the dining room, however no breakfast was served to people until 9.30am. We saw one person reaching for empty cups and jugs to try and find a drink. They then attempted to eat a napkin and remarked, "This toast is very thin." When we alerted staff to this they told us, "Toast is coming." When we asked why there had been a long gap between people coming to the dining room and breakfast being served one member of staff told us, "We have been getting people up."

People who needed an adapted diet did not always receive food presented to them in an appetising or appropriate way. For example, on one unit staff told us they were given bread and cheese and expected to use a microwave to produce cheese on toast. We checked this feedback with a member of the catering staff who confirmed this was the case, as they had no means of making cheese on toast for everyone and keeping it hot. Cheese on toast had been served as a main meal option. On another unit we saw pureed food was routinely served with no consideration to its appearance, meaning it was not always appetising for people. Staff on the nursing unit told us there was no appropriate soft option for people who needed such a diet, and said they were given a pureed diet instead.

On another unit we saw one person needed a textured diet. Staff said the only breakfast option for them was tomatoes, and we saw they also cut up toast to mix with this. This meant the person did not always have full choice of what they could eat.

Records to show how people's nutrition and hydration were being managed were not always well completed. For example, there was no evidence to show how this monitoring was used to ensure people had sufficient to eat and drink. There were no target amounts for staff to refer to and often intake was not totalled or recorded in a meaningful way. For example, recording '1/4 plate eaten' instead of accurate records of what the person had actually eaten. Records were not always made at the time people ate. We saw a member of staff completing food intake records for everyone on one unit at 2.37pm, when lunch had been served at 12.30pm. When we asked them how they made accurate records they told us, "I have a good memory. I stare at each plate for two minutes before I scrape it and then I've remembered." This practice meant there was a risk people's food intake records were not based on their actual consumption.

We concluded this evidenced the provider was in breach of Regulation 14 Meeting Nutritional and Hydration Needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records relating to people's care were not always made correctly. A visitor told us they had expressed concerns about staff not supporting their relative with their pressure care effectively. They said they had spent time with the person and staff had not come into their room, however they had seen records completed which stated the person had been repositioned during their visit. We were also told the person had been admitted to hospital where staff had identified they were dehydrated. The person's relative said they had seen entries on fluid charts which showed the person had been given drinks when their relative was able to say no staff had been in the room.

The unit for people living with dementia was not well adapted to this need, for example directional signage to help people move around the unit, although the registered manager told us about improvements that were planned. People were served white food (porridge) on white crockery, which can make it difficult for

people living with dementia to identify their meal. When we raised this with the registered manager they told us coloured crockery was available and they would ensure it was used.

Inadequate

Is the service caring?

Our findings

At our last inspection we rated this key question as 'requires improvement'. We found there was a lack of support for people who did not speak English, and identified a breach of regulations associated with this. We also found there was a lack of planning in place for people's end of life care. At this inspection we found some support for people who did not speak English had improved. A member of the inspection team could speak to people in their own language, and they told us they did not have any concerns. We concluded the provider had taken sufficient action in relation to this aspect of the care they provided. However, we found evidence of a lack of dignity and respect and concluded the provider remained in breach of this regulation overall.

We asked people and their relatives about whether the staff were caring and received mixed feedback. Comments included, "It has its ups and downs. The staff are not bad. They do their best," "Some staff are better than others – I don't think it's as good as it was five years ago. Most of them will just do the job – whilst others will go that bit extra. If you asked some of the staff what was wrong with [name of person] they would not know," "The staff are very nice – easy to talk to and they are all very pleasant," and "Some staff are all right, some are not."

It was clear from our formal observations recorded during our short observational format of inspection (SOFI) on the Vale View unit that staff interactions were mainly neutral and at times poor. People were observed in mainly negative mood states. Although staff were often caring in their approach when directly supporting people, they were not always mindful of people's privacy and dignity. We observed a lack of interaction between staff and people who used the service, and noted repeated instances of staff speaking about people indiscreetly or inappropriately in front of others. For example, when one person asked a member of staff for assistance to use the toilet the staff member said loudly, "He needs a pee." On another occasion a staff member announced, "[Name of person] is constipated." Although they tried to give reassurance to the person, they had spoken without regard for the person's feelings or privacy. Staff regularly spoke about people's needs to each other without discretion in communal areas. For example, comments we heard included, "I'll do [name of person], shall we leave [name of person] to be toileted in a bit?", "They're all toileted, I'm off for my break," and "Some of the walkers are in the living room." One member of staff described a person's support needs to us and said, "There is one man on here who reckons to be blind."

We found staff did not often chat with people unless they were providing assistance, and this conversation was usually task based. We saw staff serving meals to people whilst chatting and laughing amongst themselves and not directing any conversation at people who used the service. Some interactions we observed were not caring. For example, one person asked a member of staff, "Am I going home?" and the member of staff said, "No, you're stopping here," then walked away. We saw the person looked sad after this exchange. Another person was offered a plate with biscuits on and they tried to take the plate. The member of staff said, "Not the plate" and pulled it away.

On the Lake View unit we observed friendly and polite interactions. Two visiting health professionals told us

they had not witnessed any poor interactions, and had received some positive feedback from people about the service. One health professional told us they thought things had been "getting better." Our observations showed people's experience of care was not equal in all units of the home.

In records of feedback received from relatives we saw one person had said, 'Only issues we have had are the attitude of some of the older members of staff, they show lack of compassion and come across as impatient, the younger members of staff seem to have more time and explain what they are doing to try to put our relative at ease.'

There was a poor approach to assistance with personal care such as assistance with bathing, showering and continence throughout the home. For example, on the Vale View Unit we found records showed that in the first 16 days of February 2018 only two people had had either a shower or bath, on one occasion each. The remainder of people had not had this opportunity. On another unit we saw 15 of 20 residents had bathed or showered in the first 16 days of the month, however this was only once per person. On a third unit we found a bathroom hoist was not working, meaning some people could not use this room to bathe. We saw they had to pass the main entrance to access the bathroom on another unit, however as there were no changing facilities they had to dress and undress in their rooms before and after bathing. Staff we spoke with said this had been the situation for over a year. Records showed people on this unit were not having regular opportunities to shower or bathe. One person's records showed they had not had a bath or shower for over seven weeks. We heard staff talking about the records as we were looking at them. We heard one of them say, "Oh no, [the inspector] will find loads."

A person we spoke with told us they had not been supported to shave. They said, "There's no point. It's too much trouble (for staff)." A member of staff told us they "Hadn't had a chance to get [person] in the bath or shower yet." The person had been in the home for over a week. When we asked why they had not had a bath or shower the member of staff shrugged their shoulders. On one unit we observed people's nail care was not routinely attended to.

We did not see people who required assistance being supported to use the toilet. One person's relative told us they had expressed concerns about this, however were not aware that anything had been done as a result. People remained in bed or in seats for long periods of time.

We concluded the provider was in breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some evidence of consideration of equality and diversity issues. The registered manager told us they would be able to ask the provider for information and documentation in alternative formats, for example in large print. They told us no one using the service at the time of our inspection needed such documentation.

Staff we spoke with in one unit told us the service had improved the way they met people's cultural and religious needs. They told us one person whose first language was not English had received better support. They had a support worker who visited them weekly and communicated in the person's first language. We saw pictorial cards with Polish and English definitions. The unit manager also discussed a recent health assessment which included attendance by an interpreter which ensured the person understood the advice given.

Another person had been supported to engage in a religious celebration. One member of staff told us, "We did this really well. Everyone helped so it worked for [Name of person] which is what matters."

Inadequate

Is the service responsive?

Our findings

At our last inspection we rated this key question as 'requires improvement.' We did not identify any breaches of regulation, however found care plans were not always updated effectively following reviews. At this inspection we found care was still not always responsive to people's needs, and identified breaches of regulations relating to complaints and person-centred care.

People we spoke with told us they would know how to make a complaint. Comments included, "I would speak to the manager if I had a complaint," "I would speak with the head nurse," "I would not hesitate to make a complaint - I have done - I am free to speak my mind," and "I have complained about many things - they don't like me complaining."

When we asked to look at records relating to complaints the registered manager told us there had been none. However, we had evidence this was not the case. For example, in June 2017 we had been contacted by a person wishing to raise concerns. In our correspondence with the registered manager at that time we asked,' Please can you arrange to have a formal meeting with [name of person] and any family members/advocates [person] wishes to have present, and to follow your complaints procedure in recording and responding to this.' There were no records kept of these conversations and no evidence the registered manager had recorded the complaint. We also spoke with people during our inspection who told us they had raised serious concerns about the quality of care with the registered manager, but there was no evidence of any recording of or response to these matters. When we asked the registered manager if they were aware of any concerns people may have expressed they told us they did not document these, but said they had been asked for an additional pillow for one person, and had acted on this immediately.

We concluded the provider was in breach of Regulation 16 Receiving and Acting on Complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of feedbacks from relatives showed there had been some negative comments about activities in the home. For example, one person had said, 'Generally happy with the care, provision of stimulation for dementia sufferers appears to be difficult.' Another person had said, 'Feel staff could interact more with the residents.'

We asked people about the activities in the home. Comments included, "Sometimes they have activities in a morning sometimes in an afternoon. They play bingo and have various entertainers," "There is nothing ever going on," "[staff member] does do bingo occasionally. Sometimes they have singers come," "Yes there are activities. Some people go out," "None of the activities suit me - I am not offered any one to one time," and "I look forward to going out - I have been bowling this morning - it was real fun."

Staff gave mixed feedback about activities. A member of staff on one unit told us, "There's no activities. They don't come on this unit or take them out. We have raised it." Another member of staff told us the activity staff had said they were not taking out 'anyone that needs toileting.' On another unit several staff expressed concerns about activities. They told us there were limited opportunities for people to engage in meaningful

or person-centred activity in the home or in the community. They told us, "Care staff don't get chance to do activities and the activity workers only really come on a Tuesday to get the shopping list. People just sit there in the lounge." When we looked at records of activities they confirmed the feedback we received from staff. For example, one person's journal stated in September 2017 they had 'joined in with a quiz'. The only other entries were requests to join a quiz on 14 November, bingo on 15 November 2017 and a shopping trip on 17 January 2018.

During our inspection we saw people lacked opportunity to engage in meaningful activities. For example, we did not see any activities provided for people on the nursing unit on either day of our inspection, and records in people's care plans evidenced this was often the case. For example, one care plan we looked at contained no evidence they had participated in activities, and in another the only activities recorded were chatting to staff and watching television.

On the first day saw a lack of understanding of how to effectively engage people living with dementia. We saw a member of the activities staff ask in the lounge of the Vale View unit if anyone wanted to play bingo, however they did not approach people individually or give people time to consider what they had said before leaving the lounge. No one took up the offer of the activity. There were no other activities taking place. Staff brought three newspapers and gave them to three specific people without any discussion about who wanted to look at them.
The activities planner on the wall showed 'reminiscing with pictures/photos' and on a chalk board it stated 'This week, baking and a quiz', however we did not see these taking place.

On the residential unit we observed people spent a morning sitting in the lounge with only the television for stimulation. We did not see people watching this. When we asked staff about the lack of activity they told us the activity staff had taken a group of people bowling so they were not available. We did see people playing bingo in the afternoon, however.

Care was not always responsive to people's needs, which was a concern identified at our last inspection. For example, during the first day of our inspection we raised concerns with the registered manager about pressure care. On the second day of our inspection they told us they had reviewed the treatment of wounds and pressure care. Although we saw evidence this was the case, we found further examples of ineffective record keeping. One person's care plan referred to the presence of a single pressure ulcer, however a recent photograph showed two broken skin areas.

On one unit staff we spoke with told us a person regularly routinely refused personal care, and would push staff. They said the person needed three staff to assist them at times. When we looked at the person's behavioural care plan we found it did not reflect the person's needs sufficiently. The care plan stated the person could become, 'non-compliant', but did not contain information about how this presented, how often or how staff could assist the person. The care plan also stated the person would raise their fist, but not lash out. The care plan had last been reviewed in October 2017 and had not been updated to include the information that the person would push staff. We asked to see records of instances where the person had experienced behaviours that challenged them or others, and were told these had not been kept because this happened several times a day. Making such records could have helped with the identification of any triggers or successful de-escalation methods and ensure care planning was responsive to changes in people's individual needs.

We looked at care records for another person who experienced behaviours that challenged them and others and found there was a similar lack of recording to ensure care documentation and provision was responsive to changes in need.

Another person's clothing had been removed from their room and we saw it was being stored in a bathroom cupboard. Staff we spoke with told us clothing had been moved because the person mixed clean clothing with items that were soiled or wet. The person's personal hygiene and continence care plans did not refer to the issues described by staff.

We an inconsistent level of information in care plans about people's preferences for their care and support, and found these preferences were not always respected. For example, in one care plan we saw the person preferred showers to baths, and required prompting and encouragement to maintain their personal hygiene. Their care records showed they had only had one shower in seven weeks. These records showed they had been offered a bath rather than a shower every day in January and on the first 13 days of February.

We concluded the provider was in breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2017 we rated this key question as 'inadequate'. We found governance systems had failed to identify the evidence seen at our inspection, and had already rated the service as requiring improvement overall on two previous inspections. This meant the provider was failing to take action required to improve the quality of the service. At this inspection we found the provider remained in breach of four regulations connected with safe care, staffing, consent and governance. One breach connected with dignity and respect had been resolved, however we found evidence of a new breach of this regulation. We identified four new breaches of regulations relating to complaints, safeguarding, nutrition and hydration and person centred care. This meant the provider was still failing to take robust action to improve the quality of the service and people's experience of care, and we have again rated this key question as 'inadequate'.

There was a registered manager in post when we inspected the service. They had previously been the deputy manager and had covered the home manager role during a period when there was a high turnover of registered managers. They were supported by a deputy manager, although they had resigned and were due to leave the service the day after the inspection concluded. The registered manager also had support from a mentor who was a registered manager at another of the provider's services, an administrator and a lead member of staff in each of the four units.

When we asked, people and their relatives gave mainly negative feedback about the running of the home and their overall satisfaction. Comments included, "Overall, I would recommend this home to people, although it could be managed better," "I don't know the manager. No I would not recommend the home to people and I don't think the home is well run, "The management team are new - let's see how it goes," "The manager is smashing - he is so friendly," "I have no confidence in the manager," and "Overall, no I would not recommend the home to people – I am not saying it is bad – I would not want people to be disappointed. It's not like it used to be."

Staff we spoke with gave feedback about the registered manager and provider. Comments included, "[Name of registered manager] is supportive but nothing gets done. He listens, but that's it," and "[Name of registered manager] has found his feet. He listens." Several staff said they did not have a positive experience of leadership at a senior level, and told us they felt the regional manager was not approachable and was not always willing to speak with staff. One member of staff characterised the provider's approach as, "Paperwork as a priority and care as secondary."

Leadership in the home was not always strong. For example, we saw staff on one unit lacked direction and the person in charge did not always know where staff were. When staff argued openly the person in charge of the unit did not challenge this. We saw staff moved from one unit to another without any clear sense of direction or awareness of people's needs. One member of staff told us, "We are always being asked to cover. I feel like a spare part. I don't know any of the residents; I wouldn't know what to do if anything happened." Another member of staff said, "I was just rota'd on here (the unit). I need to get my hours in so they put me on here."

Concerns identified with the nursing unit in particular showed there had not been robust clinical oversight of the care provided. One member of staff said there were different cultures between days and night staff. "Night staff expect people to be in bed and if anyone is in the lounge when they come on we get that 'look'. Night staff are supposed to get people up but they don't, day staff have it all to do."

Although some areas for improvement identified in our last report had been addressed, others had not, and we found further breaches of regulations. The provider remained in breach of some regulations for the third consecutive inspection, meaning leadership in the home and oversight from senior managers had not been sufficiently robust.

The systems to monitor, measure and improve quality in the service were not effective. Audits were carried out both by the registered manager and regional manager, and we saw these were kept up to date with action plans to address any issues found, however we found evidence of nine breaches of regulation which the audit systems had failed to identify and correct. For example, we found evidence of a poor approach to the management and supply of people's medicines despite medicines audits taking place. When we presented this finding we were told a new medicines audit was, "In development", however we saw a lack of recognition that urgent action was needed to prevent the same failures continuing or arising again. During feedback at the end of the inspection we asked for immediate action to review the audit systems in place at Hemsworth Park to ensure they were robustly monitoring and improving all aspects of the care provided in the service.

Although we saw minutes of meetings held to engage people and their relatives in the running of the service, people we spoke with did not have first hand experiences to discuss with us. One person said, "We have not been asked our views and opinions since [name of person] has been here." Another person told us, "I am not sure if I have filled in any questionnaires about the service."

We saw minutes of the meetings were produced, along with a 'you said, we did' poster which drew attention to actions that would be taken as a result of feedback about activities. People had asked for more trips out and more arts and crafts activities, but the 'we did' section mainly highlighted what plans would be put in place in the future rather than evidencing these requests had been met.

We saw there were minutes of staff meetings taking place, but staff we spoke with told us they had few opportunities to attend and did not feel they were always listened to.

We concluded the evidence related to governance and the overall failure to improve the quality of the service meant the provider remained in breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.