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Malmesbury House

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 20 September 2016 and was unannounced.

Malmesbury House provides accommodation and personal care for up to 19 older people. There were 13 people living at the service at the time of our inspection, all of whom were living with dementia.

There was a registered manager in post at the time of our inspection who had been registered since 9 December 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were not adequately protected from the risk of fire. The provider had not implemented the actions required in the fire risk assessment they had commissioned to maintain appropriate standards of fire safety. Fire drills had not been carried out as often as they should and some staff had not attended fire training to enable them to adequately evacuate people from the home.

People were not protected from avoidable risks and there was no evidence of learning from accidents and incidents. People were not adequately protected against the risk of infection because standards of infection prevention and control were poor.

People were not adequately protected by the provider's recruitment procedures. The provider had not made all necessary checks on staff to ensure they were suitable and eligible to work at the service. People were not adequately protected against the risk of abuse because staff had not been made aware of their responsibilities to report concerns.

People's medicines were not managed safely. There were no protocols in place to guide staff about the administration of 'as required' medicines.

The provider did not support staff to gain the skills they needed to provide people's care effectively. Staff had not received all the training required for their role and this had an effect on the care people received. Staff did not receive feedback about their performance or have opportunities to discuss their training and development needs.

People's care was not always provided in line with the Mental Capacity Act 2005. There was a lack of understanding of the Act and its principles at all levels and we found that decisions had been made on behalf of people without their mental capacity being established.

People were not cared for in a clean and properly maintained environment. There was a pervasive smell of urine and mattresses and bedding were old and stained. Pest control treatment to eradicate bed bugs was ongoing. The carpets in many areas were threadbare, the curtains stained and items of furniture were

missing handles.

People were not always supported to maintain their dignity. Some people were dressed in stained and dirty clothes. Other people were visibly unkempt and had not been supported to maintain their personal hygiene. There was no guidance for staff about how to support people who refused personal care to maintain their appearance and personal hygiene. Staff had positive interactions with people but spent periods of time together when they could have been engaging with people.

People's needs were not always accurately assessed before they moved in to the service. This had resulted in some people being unnecessarily restricted due to a lack of appropriate equipment and staff training. Care plans did not always record people's individual needs, which put them at risk of receiving inappropriate care and treatment.

People did not have access to meaningful activities. There was a lack of appropriate activities to keep people occupied and engaged and there were no opportunities to go out.

The service was not well led. None of the registered providers were involved in monitoring the service. Concerns identified that had been identified by the registered manager's audits had not been addressed. People were not given opportunities to have their say about the service. Concerns that had been raised were not addressed by the registered manager or the provider. People's care records contained inconsistent information and were not stored securely.

The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency. People's healthcare needs were monitored and they had access to treatment when they needed it. Care records demonstrated that people saw healthcare professionals when they needed to.

People told us they liked the staff at the service. They said staff were kind and friendly. Relatives told us staff knew their family members well and had positive relationships with them. They said they could visit at any time and that their family members could have privacy when they wanted it.
People told us the registered manager was approachable and available if they wished to speak with them. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve

•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

At our last comprehensive inspection under previous legislation on 3 January 2014, we found the provider was compliant with all the regulations assessed. We carried out a responsive inspection on 26 February 2014

due to information of concern and found that some areas of the service were not adequately maintained. We made a requirement action about this.

We carried out a follow up inspection on 26 September 2014 and found the provider had taken action to become compliant with the regulations. Safety measures had been implemented and issues relating to electrical safety addressed.

This was the first comprehensive inspection of the service under the Health and Social Care Act 2008.

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.

Standard of fire safety were inadequate.

Standard of hygiene and infection control were inadequate.

People were not protected from avoidable risks.

Concerns were not notified to the local safeguarding authority when people were at risk.

People were not protected by the provider's recruitment procedures.

People's medicines were not managed safely.

There were plans in place to ensure that people's care would not be interrupted in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported to gain the skills they needed through training, supervision and appraisal.

People's care was not always provided in line with the Mental Capacity Act 2005.

People did not always have access to a reasonable standard of food and their dietary needs were not always known by staff.

People were not cared for in a clean and properly maintained environment.

People's healthcare needs were monitored and they had access to treatment when they needed it.

Is the service caring?

Inadequate

The service was not caring.

People were not supported to maintain their dignity.

Staff spent time together when they could have been engaging with people

People told us staff were kind and friendly. Relatives told us their family members had developed positive relationships with staff.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

People did not have opportunities to take part in meaningful activities.

People's needs were not appropriately assessed before they moved to the service.

There were appropriate procedures for managing complaints but concerns raised were not always addressed.

Is the service well-led?

Inadequate

The service was not well- led.

There was insufficient oversight and monitoring of the service by the registered provider.

Where concerns had been identified through the registered manager's audits, these had not been addressed.

Issues related to the attitudes, values and behaviours of staff had not been addressed.

Care records were inconsistent and were not stored securely.

People told us the registered manager was approachable and available if they wished to speak with them.

Malmesbury House

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 was 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 20 September 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider had returned a Provider Information Return (PIR) in July 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR before our inspection to ensure we addressed any areas of concern.

Before the inspection we received information of concern from an organisation whose representative had visited the service the previous week. The concerns related to poor hygiene, persistent odours and a poorly maintained environment. We followed up these concerns during our inspection.

During the inspection we spoke with seven people and three relatives. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff. We spoke with seven staff, including the registered manager, care, catering and domestic staff.

We looked at the care records of three people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at five staff recruitment files and records relating to staff supervision, appraisal and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

After the inspection we spoke with a healthcare professional who visited the service.

Inadequate

Is the service safe?

Our findings

People were not adequately protected from the risk of fire. The provider had commissioned a fire risk assessment by a fire safety consultant, which had been carried out in September 2015, but had not implemented the actions the risk assessment identified as necessary to maintain appropriate standards of fire safety. The actions required by the fire risk assessment included installing additional fire detection in communal parts of the building, installing additional emergency lighting on a fire escape route, developing an emergency pack for staff, carrying out fire drills at least twice a year, providing fire training for all staff and providing additional training for staff with specific roles during an evacuation. None of these measures had been implemented by the provider or registered manager. The registered manager told us, "I haven't had time to look at the fire risk assessment."

Bedroom doors were fire resistant but three of the doors did not close properly, which meant they would not be effective in the event of a fire. Following the inspection, we shared our concerns about fire safety with the Fire and Rescue Service. The Fire and Rescue Service visited the service on 3 October 2016 to follow up these concerns and gave us feedback about their findings.
The Fire Safety Inspecting Officer advised us that the provider was not maintaining adequate standards of fire safety at the service. The Fire Safety Inspecting Officer said the fire risk assessment carried out in September 2015 was comprehensive but the provider had not carried out the recommendations made in the risk assessment to protect people from the risk of fire. The Fire Safety Inspecting Officer's report was awaited at the time of writing this report.

The provider's PIR stated that, of 15 staff employed, eight had received training in fire safety. The training record showed that two of the four staff who worked nights had not attended fire training since 2011. This was not in accordance with the provider's policy, which stated that staff should attend regular refresher training in this area. The remaining two night staff had no record of attending fire training. Two staff, who had worked at the service since 2014, had recorded in their one-to-one supervision sessions that they were unsure of fire procedures. One of the staff we spoke with had no knowledge of fire procedures. The member of staff told us they had not received any fire training since starting work at the service and did not know where the fire exits or fire assembly point were. They told us that, in the event of a fire, "The manager will give me instructions." The last recorded fire drill took place on 15 September 2015.

People were not protected from avoidable risks. Window restrictors that had been installed to protect people from the risk of falling were broken in some bedrooms. Staff told us these had been broken for some time but no attempt had been made to reduce the risk to people by repairing the window restrictors. Where accidents and incidents had been recorded, there was no evidence of learning or improvement from these events. For example one person had three unobserved falls recorded in the previous nine months but on each occasion, the 'actions taken' section of the accident reports recorded only, "Remind her to use call bell." This meant that no effective control measures were put in place following incidents to prevent a recurrence

People were not adequately protected against the risk of infection. Nine bedrooms had been treated for bed

bugs since April 2016. One person's care records showed that they had suffered a number of bites from bed bugs. Treatment to eradicate bedbugs was still ongoing in some rooms, including the lounge, at the time of our inspection. The service did not have a sluice and the small laundry room was not equipped to clean soiled bedding adequately. There was insufficient space to provide a soiled area for dirty items, hand washing facilities, a disinfector for reusable items and a clean storage area, well separated from the soiled area. The food serving trolley and the trays used for people's meals were being stored in the laundry room. Most of the bathrooms in the service contained neither soap nor hand towels. This meant the provider was failing to adhere to current guidance on the prevention and control of infections in care homes issued by the Department of Health (DH).

Staff were not given sufficient guidance regarding infection prevention and control. The cleaner had not had any infection control training since starting work at the service. The cleaner was unaware of basic infection control measures. They were unaware that different coloured mops that should be used for different parts of the service and told us they used one mop for all hard floors. The PIR returned by the provider stated that only seven of the 15 staff employed had received training in the prevention and control of infection.

People's medicines were not managed safely. Several people had medicines prescribed to be used 'as required'. Information about why, when and how these medicines should be administered to the individual person was not available to staff. There were no protocols in place to guide staff about when to administer these medicines or to identify, for example, whether people were able to verbally ask for their medicine when they needed it.

The registered manager carried out monthly medicines audits but where shortfalls were identified, there was no evidence that the management of medicines improved. Every monthly medicines audit from January 2016 to August 2016 stated, "few gaps." There was no action plan drawn up to address this issue and the same concern was noted in the following month's audit. The registered manager told us that all staff responsible for medicines administration were required to attend regular refresher training in this area. However the training record showed that medicines training for staff had expired in June 2016 and refresher training should have taken place by that date.

The provider was failing to ensure that the premises were safe, to do all that is reasonably practicable to mitigate risks, to adequately protect people from the risk of infection or to manage medicines safely, which was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not adequately protected by the provider's recruitment procedures. The provider had not made all necessary checks on staff who were not UK nationals. There was no evidence that the provider had established the right to work status of one member of staff employed from outside the UK. The UK residence permit of another member of staff employed from outside the UK had expired. The registered manager acknowledged that the provider had not obtained all necessary evidence that staff had the right to remain and work in the UK.

The provider had not obtained satisfactory evidence of good conduct in previous employment for all staff. One member of staff had not provided details of referees on their application form. We asked the registered manager where the one reference on file for this member of staff had been obtained from and were told the member of staff had brought it with them to interview, claiming it was from a neighbour. The registered manager agreed that this process had not been sufficiently thorough and told us they had, "taken a chance" as recruitment was proving difficult. There were gaps in employment history for several staff that had not been explored by the provider.

The provider was failing to operate safe recruitment procedures, which was a breach of Regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not adequately protected against the risk of abuse because staff had not been made aware of their responsibilities to report concerns. The provider had a legal duty to report any incidents of potential abuse to the local safeguarding authority. There was evidence that a notifiable incident had not been appropriately reported or investigated. Body maps completed for one person recorded unexplained bruising. This incident had not been reported to the local safeguarding team or to CQC and no investigation of the incident had taken place to establish the cause of the bruising. Following our inspection, we shared our concerns about the provider's failure to report notifiable incidents with the local authority.

Staff were not regularly trained in safeguarding. The provider's PIR stated that seven of 19 staff employed had attended safeguarding training. The registered manager told us that staff were required to attend safeguarding training every three years. However the training record showed that safeguarding training for staff had expired in June 2016 and refresher training should have taken place by that date.

Some of the staff we spoke with had an appropriate understanding of their responsibilities in relation to reporting abuse. They were able to describe the signs of potential abuse and the action they would take if they suspected abuse. However other staff told us they had not attended training in safeguarding and were unable to describe the process to be followed should they have concerns about potential abuse. Two staff told us they had not attended safeguarding training since they started work at the service and another member of staff said, "I'm not 100% sure if I've done safeguarding training." This presented a risk that staff would not recognise the signs of abuse or know how to report any concerns they had about people's care.

The provider was failing to operate effective systems to prevent the abuse of service users, which was a breach of Regulation 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and appropriately. There were no gaps or errors on the medicines administration records we checked during our inspection. The registered manager told us that none of the people living at the service administered their own medicines. We observed that the member of staff administering medicines during our inspection did so safely. The member of staff talked to people as they gave them their medicines to ensure each person was informed about what they were taking. The member of staff was able to describe people's personal preferences about how they took their medicines.

There were sufficient staff deployed to meet people's care needs in a timely way. Relatives told us staff were always available and that staff attended promptly when their family members needed them. One relative said, "There's always enough staff around. They're here very quickly if she needs anything." Another relative told us, "I never worry about her being on her own; I know the staff are never far away."

The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. Health and safety checks had been carried out to ensure that the gas, electrical and water supplies were safe for use.

We observed that staff used soluble bags for soiled linen to avoid the risk of contamination. Staff wore gloves and aprons when carrying out this task and disposed of these appropriately when they had finished.

Inadequate

Is the service effective?

Our findings

Staff did not always have the skills, knowledge and experience they needed to provide people's care effectively. The provider did not support staff to gain the skills they needed through training, supervision and appraisal.

The provider's PIR and the service training record both demonstrated that staff did not receive all the training required for their role and there was evidence that this had an effect on the care people received. The PIR stated that none of the staff team had attended first aid training. The registered manager confirmed this and that there was no qualified first aider on duty at the time of our inspection. This meant people would not receive effective care if they had an accident that required first aid.

All the people at the service were living with dementia but the PIR stated that only five of 19 staff employed had received training in dementia care. One member of staff told us, "I have asked for dementia training several times but I still haven't had it. I need it because they've all got dementia and I want to understand it, how to go about it." We observed that staff did not have the skills they needed to support people living with dementia effectively because they had not been appropriately trained. For example staff did not have the skills they needed to support people who refused care to maintain their appearance and personal hygiene.

Staff had not received regular supervision and appraisal, which meant that they did not receive feedback about their performance or have opportunities to discuss their training and development needs. The provider had recorded this as a concern and actions including, "Appraisals to be completed, organise staff training, seniors to complete supervision" had been included on the service improvement plan shown to us by the registered manager. However these actions had not been completed and no date by which they should be completed had been recorded on the improvement plan.

The provider was failing to provide appropriate support for staff through training, supervision and appraisal, which was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did not receive effective care due to a lack of staff training and appropriate equipment. Two people who had been admitted to the service needed to be transferred by hoist when mobilising. There was no hoist at the service and staff had not had training to use hoists, which meant these people were confined to bed. A healthcare professional told us, "Staff weren't trained to deal with them and they didn't have the equipment they needed. They didn't have hoists for people who needed them. They had to be nursed in bed. The manager agreed with us that they shouldn't have been there." The registered manager told us that these people had moved to nursing homes. However during their time at this service, their needs had not been met.

The provider was failing to provide appropriate care that met people's needs, which was a breach of Regulation 9 (1) 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 application 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 that decisions had been made on behalf of people without their mental capacity being established or assessed. For example one person was being given their medicines covertly. There was evidence of pharmacy guidance and a best interest decision to support this but no evidence that the person's capacity had been assessed at any time. This meant that the person had not been supported according to the principles of the MCA. We asked the registered manager why people's capacity had not been assessed when decisions about them were being made. The registered manager said they had been told by the previous service manager that they should not do this and, as a result, had not carried out mental capacity assessments when decisions that affected people's care were being made.

There was a lack of understanding of the Act and its principles. The registered manager told us that none of the staff team had attended training in the MCA or DoLS to enable them to understand the Act's purpose and how they should apply it in their work. As a result, some people were restricted without their consent or legal authorisation. The registered manager told us, "There are restrictions on people. There is a key pad system, people are not free to go out on their own." The registered manager said applications for DoLS authorisations had been submitted for people who were subject to restrictions in their care. However the registered manager was not able to demonstrate that mental capacity assessments had been carried out as there were no records, which meant there was no evidence that people lacked the capacity to make decisions for themselves.

The provider was failing to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice, which was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they usually liked the food provided at the service. One person said, "It's pretty good, on the whole." Relatives told us their family members enjoyed the food. One relative said, "It's a varied menu, it looks good." Another relative told us, "It's not too bad but it could be better. It's a bit like school dinners." At lunchtime, staff supported people to eat their meals where they chose. Some people chose to eat in the dining area whilst others chose to remain in the lounge. Everyone was able to eat independently without the support of staff.

Staff offered people a choice of meals, showing them both options to ensure they could make an informed choice. People told us the cook was willing to make them an alternative if they did not like what was on the menu. Relatives said their family members always had enough to eat and access to snacks and drinks throughout the day.

Although people enjoyed what they ate, the food on the day of our inspection was not presented as well as it should have been. The cook told us that lunch was served at 12.30pm and that people would have a choice of beef burgers or smoked haddock. We observed that the beef burgers and smoked haddock had already been cooked at 11am. The beef burgers and smoked haddock were then placed in an oven until lunch was

served. This meant that both meal options were over cooked by the time they were served.

People were not cared for in a clean and properly maintained environment. There was a strong smell of urine in many parts of the service, particularly in and around the bedrooms of people who suffered with incontinence. The registered manager told us the affected areas were cleaned regularly but the carpets were so old that the odour could not be removed by cleaning.

Mattresses and bedding in some bedrooms were old, stained and smelled strongly of urine. We found dirt and rust around some toilets. The carpets in many areas, including several bedrooms, were threadbare. The curtains in many bedrooms were stained and many items of furniture were missing their handles. The manager's monthly audits described the carpets in some parts of the service as "rotten." The audits also recorded that curtains were stained and that several bedrooms smelled of urine.

A healthcare professional told us, "It's an old building and it's not ideal. It's dismal and dreary and there is a smell. Some of the carpets are very threadbare." A member of staff said, "Honestly, I think the carpet and furniture are not clean; it's not comfortable and it smells. I think it needs some action." The registered manager agreed that the environment in which people were living was unacceptably poor. The registered manager said, "This home needs an upgrade. We have a good cleaner but the material is so old you can't clean it properly. Everything needs to be changed."

The provider was failing to ensure people were cared for in a clean and properly maintained environment, which was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were monitored and they had access to treatment when they needed it. People told us staff supported them to see a GP if they were unwell. One person said, "They'll always get the doctor out if need be." Relatives told us staff monitored their family members' health and supported them to obtain treatment if necessary. One relative said, "They monitor her health and they always let me know about any healthcare problems. She hasn't lost weight or had falls and she sees the doctor when she needs to." Another relative told us, "She can always see the GP if she's not well."

Care records showed that staff weighed people regularly as part of healthcare monitoring. The records we checked did not identify anyone who had experienced significant weight loss. The registered manager told us a referral would be made to an appropriate healthcare professional if a person's weight changed significantly. Care records demonstrated that people saw healthcare professionals when they needed to, such as the GP, dentist or district nurse.

Relatives told us that staff always gained their family members' consent before providing any aspect of care. Our observations confirmed this. We saw staff explain to people what was about to happen before they provided their care and maintain communication while supporting them to ensure they were comfortable. Staff understood the importance of gaining people's consent to their care. One member of staff told us, "We would never just do something to someone without asking them." Another member of staff said, "We always check they are happy to receive care before we give it."

Inadequate

Is the service caring?

Our findings

People told us they liked the staff at the service. They said staff were kind and friendly. Relatives told us staff were caring. One relative said of their family member, "She seems to get the care she needs. The staff are good and seem caring." Another relative told us, "The staff are good, they do their best." A healthcare professional told us, "The staff try their best. They are caring. The carers are kind, we have no concerns there."

Although people liked the staff who cared for them, people were not always supported to maintain their dignity, which meant their overall experience of care was inadequate. We observed that some people were unkempt, wearing stained and dirty clothes. Some people had visibly greasy hair and long, dirty fingernails. One person smelled of urine. Staff told us that these people often refused personal care and that their appearance was a result of this. There was no evidence that the best way to address this issue had been considered. There were no guidelines in place for staff about how to support these people to maintain their appearance and personal hygiene.

Although staff were friendly in their interactions with people, we observed that staff spent long periods of time together when they could have been engaging with people. For example, during the afternoon the three care staff on duty sat together in the dining area for 30 minutes while ten people sat in the lounge area with no engagement or interaction with anyone. We observed that this happened on several occasions during the day. This, along with the poor state of the care service and the unpleasant odours, meant there was a lack of compassion in the way people's care was provided.

The provider was failing to ensure people were treated with dignity and respect, which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with their friends and families and had developed positive relationships with staff. Relatives told us that most staff knew their family members well and had developed friendships with them. One relative said, "Some of the staff are like family friends now. They are kind and caring." Relatives told us they could visit their family members at any time and they were made welcome by staff when they visited. The atmosphere in the communal areas of the service was relaxed and when staff did speak to people they did so in a friendly manner.

Relatives told us staff encouraged their family members to maintain their independence. They said their family members were encouraged to mobilise independently and to do what they could for themselves. Relatives told us that staff respected the choices and decisions their family members made. They said they were consulted about their family members' care plans and that their contributions were listened to.

Relatives told us their family members could have privacy when they wanted it and their private information was kept confidential. People had access to information about their care and the provider had produced information about the service. The provider had a confidentiality policy, which detailed how people's private and confidential information would be managed.

Requires Improvement

Is the service responsive?

Our findings

Relatives reported there was little to stimulate or engage people. One relative told us, "They could do with more stimulation. I usually see people sitting round watching TV but Mum doesn't complain." Another relative said, "Mum only goes out if we take her. There used to be trips but they seem to have stopped." A healthcare professional told us, "There's nothing going on, there's no stimulation; people are just sitting there." This was confirmed by our observations. We observed that people sat in the lounge for long periods with no stimulation other than the television, which remained on the same channel all day. The registered manager told us an activity would take place at 3.00pm on the day of our inspection but no activity took place.

People did not have access to meaningful activities. There was no activities co-ordinator employed and there was a lack of appropriate activities to keep people occupied and engaged. People told us there was little to do during the day. One person told us, "There's not much to do." Another person said, "There's nothing to do except watch the telly." People told us there were no opportunities to go out. One person told us, "I don't go out because I can't walk but I'd like to see the shops."

The provider had admitted some people in the past whose needs could not be met at the service. The registered manager told us they had carried out pre-admission assessments for some people but, in other cases, had relied upon the assessment provided by the placing local authority. The registered manager said they sometimes carried out assessments after people had moved into the service as they did not have time to visit them for an assessment beforehand. We found that one person currently living at the service had no pre-admission assessment.

The registered manager agreed that they had admitted people in the past whose needs could not be met. They said this was due to the person's needs being different in reality to those recorded by the placing authority. The registered manager told us that some people had needed to be moved to nursing homes as they had been inappropriately admitted. The registered manager said of one person who was admitted on the basis of the placing authority assessment, "I would not have accepted her if I had done my own assessment. I've learned my lesson."

Each person had a care plan but these did not always record their individual needs, which meant people were at risk of receiving inappropriate care. The registered manager told us nobody had any special dietary needs. However we found that one person was using a particular medicine which meant they should avoid certain foods and fluids. There was no evidence that the person had been given any of these foods and fluids but there was no guidance in place for catering staff about the foods and fluids they should avoid. The cook told us another person needed their food "mashed", but there was no evidence that this decision had been recorded or reached following an appropriate assessment.

The provider was failing to carry out an assessment of people's needs and preferences or to provide appropriate care that met people's needs and preferences, which was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies complainants could contact if they were not satisfied with the provider's response. The last entry on the service complaints log was made in October 2014. The registered manager told us there had been no formal complaints since that date.

Inadequate

Is the service well-led?

Our findings

People did not benefit from a well led service. There was insufficient management oversight of the service to ensure that people received the care they were entitled to. None of the registered providers were involved in monitoring the service to ensure appropriate standards were being maintained. A representative of the provider visited the service regularly but did not record their findings or address the concerns identified in the registered manager's audits. The registered manager told us they could not fulfil all aspects of their role as they had no administration support or deputy manager to share some of the responsibilities.

The registered manager carried out monthly audits but where concerns were identified, action had not been taken to address them. For example, each manager's monthly audit from January 2016 to August 2016 recorded concerns including "rotten" carpets, "stained curtains" and bedrooms that "smell of urine." None of these issues had been addressed by the time of our inspection. The registered manager told us the registered provider did not make a budget available to maintain and improve the service. The registered manager said, "There is not an allocated budget, we just try to address what comes up. I don't know what the budget is but it's not enough; the home needs updating from scratch."

The PIR submitted by the registered manager in July 2016 reported that there were shortfalls in staff training in areas including fire safety, first aid, safeguarding, infection control, dementia care and MCA/DoLS. These shortfalls remained at the time of our inspection. The registered manager provided us with a list of areas that had been identified by them as needing improvement. This list was not dated but included providing staff with supervision, completing staff appraisals, organising staff training and developing a redecoration plan. None of these issues had been addressed by the time of our inspection.

We met with the registered manager and the provider's representative the day after the inspection to reiterate our concerns. The provider's representative agreed that the provider did not have adequate oversight of the service and that this had affected the care people received. The provider's representative told us, "I take responsibility for the issues that have been found. They shouldn't have happened. If we have a care home, we are legally responsible for the care of the residents. It shouldn't be down to CQC to find these things."

People were not consulted about the running of the service or given opportunities to contribute their views. Only one residents meeting had taken place in the previous 12 months and there was no system through which people could contribute their feedback. Concerns raised by people who lived at the service and their relatives were not addressed by the registered manager or the provider. For example one person had registered a concern about the bed bugs in their bedroom at a residents' meeting and a relative had complained verbally about bed bugs in their family member's bedroom. Bed bugs had not been eradicated at the time of our visit, although pest control treatment was ongoing. Another relative told us they had raised concerns about their family member's care with the registered manager on a number of occasions but the registered manager had not used this feedback as an opportunity to improve their family member's care or the state of their bedroom.

The culture within the service did not promote effective communication amongst the staff team. Staff told us they did not meet as a team to share information or raise any concerns they had. One member of staff said, "We haven't had a team meeting for a long time" and another member of staff told us they had worked at the service for 18 months but had not attended a team meeting in that time. The staff meeting file contained evidence of one staff meeting, held in April 2016.

Where issues arose with the attitudes, values and behaviours of staff, these were not effectively addressed. The minutes of the team meeting held in April 2016 indicated that some staff were displaying poor attitudes in their work, including being disrespectful to colleagues and the registered manager. The registered manager acknowledged that some staff continued to display poor attitudes in their work and told us that some staff had not demonstrated a willingness to modify their behaviour, despite the registered manager's efforts. The registered manager told us they did not feel supported by the registered providers in addressing the concerns about the attitudes and behaviours of some staff.

People's care records contained inconsistent information, which put people at risk of receiving inappropriate care. For example one person's care plan stated, "I can manage my own personal care" but recorded elsewhere that the person was incontinent of urine and wore pads that needed to be changed by staff. There was no guidance for staff about how often they should change this person's pads. It was clear that this person's continence was not being managed effectively because their bed and bedroom smelled strongly of urine. Confidential information was not stored appropriately. People's care plans were kept in an open cupboard in the dining area, which meant they were accessible to anyone in the communal areas of the service.

The provider was failing to effectively assess, monitor and improve the quality and safety of the service or to maintain securely accurate and complete records in respect of each person, which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the registered manager was approachable and available if they wished to speak with them. Relatives said the registered manager was willing to meet with them if they wished to discuss their family members' care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to carry out an assessment of the needs and preferences of all the service users admitted to the service. The registered provider had failed to design care with a view to achieving service users' preferences and ensuring all their needs are met.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure service users were treated with dignity and respect.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure that care was only provided with the consent of the relevant person.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to do all that is reasonably practicable to mitigate risks to people. The registered provider had failed to ensure that

the premises were safe to use for their intended purpose.
The registered provider had failed to ensure that medicines were managed safely and properly.
The registered provider had failed to adequately protect people from the risk of infections.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to operate effective systems and processes to prevent abuse of service users.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure that the premises were clean, properly maintained and suitable for the purpose for which they were being used.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to operate effective recruitment procedures.

The enforcement action we took:

NoP cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure that staff received appropriate training, supervision and appraisal to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

NoP cancel registration