Mr & Mrs A S Benepal

Shalden Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on 1 and 5 December 2016.

Shalden Grange provides accommodation, care and support for up to 35 people. At the time of this inspection there were 32 people living in the home.

The home has 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.

This inspection was brought forward from the planned date because we received information of concern and safeguarding alerts from the local authority. At our last inspection in September 2016, we found shortfalls in a number of areas and the service was rated Requires Improvement. We found breaches relating to the way people received care and treatment, that people's consent was not always properly obtained and people were not always treated with dignity and respect, the management and administration of medicines, the management of risks to people, premises and equipment that was not safe to use, the recruitment, training and supervision of staff, the service did not act in accordance with the Mental Capacity Act 2005, quality monitoring systems were not effective and record keeping required improvement.

At this inspection we found that very little improvement had been made.

The first day of this inspection was unannounced. The registered manager was not in the home upon our arrival and was unable to come to the home when staff contacted them. The second day of the inspection was arranged with notice but the registered manager was still unable to attend the inspection or provide the records we requested. The registered provider was present but did not have knowledge of the management arrangements for the home or the work of the registered manager. We found that there was no system in place for the management of the service when the registered manager was absent.

People were not kept safe because systems relating to fire safety were not effective. Staff did not know how to keep people safe in the event of an emergency such as a fire.

The premises and equipment were not always properly maintained. We identified some issues that posed risks to people such as exposed hot water pipes which could burn people. Systems for the identification and management of risks were not effective.

People may not have always received their medicines as prescribed and systems to manage medicines were not safe. Not all staff that handled medicine had their competency checked to do this before being allowed to administer medicine to people.

Staff had not been safely recruited which meant that the registered provider could not be certain that people were of good character and had the necessary qualifications, competence, skills and experience necessary for the work to be performed by them. Staff also did not receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

People were not always protected from abuse. Staff had not been trained to recognise and understand signs that a person may be being abused or neglected and the action they should take if they suspected this.

People's rights were not always protected because staff did not understand or adhere to the Mental Capacity Act 2005. Some people were being deprived of their liberty and had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. Some people's conditions in relation to their authorisations were not being met and other people may have been deprived of their liberty unlawfully.

Care plans lacked detailed information and there was little guidance for staff about people's support needs and how to meet them. This meant that staff may not know enough about people as individuals to be able to provide personalised care. Some people's health care needs were not met to ensure that they kept well. A small number of people were not always treated with respect and their dignity was not maintained.

The systems in place for assessing and monitoring the quality and safety of the service were still not effective. Systems for the day to day running of the home in compliance with legislation were also not effective. For example, the registered provider had not notified us of all of the significant events that had happened at the home. This was a repeated breach of the regulations. We were also not notified about allegations of abuse at the home, the investigation or learning and outcomes.

Record keeping had not improved. There were still shortfalls in the accuracy of records kept.

There were continued shortfalls in the governance of the home and the home was not well-led. The management of the home had continued to be reactive rather than proactive in relation to assessing the quality of the service and taking action to mitigate risk.

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.

Systems to prevent and manage fire were not effective or properly maintained.

Premises and equipment had not been properly maintained and equipment suitable to meet people's needs had not always been provided.

People were not always protected against the risks associated with the unsafe management and use of medicines.

People were not protected because appropriate checks had not been completed before staff started working in the home.

People were not always protected from the risk of harm and abuse. Staff had not been trained to recognise and report any concerns.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training, supervision and support they required to deliver care according to people's needs.

People's rights were not protected because staff did not understand or adhere to the Mental Capacity Act 2005.

People were not always supported to consult a health professional when they requested this or when their condition required this.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respect people's dignity and could not always communicate effectively with people.

There were some positive interactions between staff and the

people they were supporting. Observations showed that some staff had a good rapport with people.

Is the service responsive?

Inadequate

The service was not responsive to people.

People had not always had their needs assessed before they moved to the home. People were at risk of their needs remaining unmet because assessments were not robust and care plans lacked information and detail. This meant that staff may not have the required information to fully support people. Some care plans had been updated and improved.

The service had a complaints policy but had not established an effective system for identifying, receiving, recording, handling and responding to complaints.

Is the service well-led?

Inadequate

The home was not well-led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

The culture at the home was reactive rather than proactive.

Not all records were made available. There were errors and omissions in the records that were seen.

Shalden Grange

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 5 December 2016. Two inspectors were present at both days of the inspection.

Before the inspection we reviewed the information we held about the service; this included any events or incidents they are required to notify us about. We also contacted the local authority safeguarding and commissioning teams to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion as the inspection was brought forward in response to the concerns received. The PIR 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 spoke with and met six people who were living in the home.

We also spoke with six staff, as well as one of the registered providers. The registered manager was not available. We looked at five people's care and medicine records in depth and sampled a further 11 people's care and medicine records. We saw records about how the service was managed. This included five staff recruitment records and staff rotas. Other records that related to the management of the service such as staff training records and equipment servicing records were not made available.

Inadequate

Is the service safe?

Our findings

Some people were living with dementia and were unable to tell us whether they felt safe. We observed people responding positively with smiles when staff approached them. This showed people felt relaxed with staff. Some people who were able to, told us they felt comfortable at the home. However, we identified areas of concern that impacted on people's safety.

At our inspection in September 2016 serious shortfalls in the systems to prevent and control fire, the servicing and maintenance of the building and equipment, access for people with disabilities, lack of suitable bathing and showering facilities, the provision of hot water in some parts of the home, infection prevention and control, assessment and management of risks to people including the risk of malnutrition, dehydration and skin breakdown were found. There were also concerns about the management of medicines, unsafe recruitment, training and supervision of staff and ineffective systems to protect people from abuse.

At this inspection we spent time with the staff who were responsible for medicines administration and found that very little action had been taken by the registered provider and registered manager to ensure that medicines were managed safely. This meant that people had continued to be put at risk.

During the inspection in September 2016, there were no care plans for PRN medicines (as and when needed) and no information to guide staff about when to administer them if the person for whom they were prescribed was unable to request them. Some people had been prescribed PRN medicines such as for pain relief or sedative medicines to be used when they were upset or unsettled. One person was prescribed a medicine that could be used twice a day when required. The medicines administration record (MAR) showed that this had been given to the person twice every day for over one month. There were no records to evidence why this medicine had been given and staff had not known why this had been given. At this inspection we found that there were still no care plans for six people who had been prescribed PRN medicines. The person mentioned above was still receiving their PRN medicine twice a day, every day and there was no evidence that a health professional had been consulted.

At the last inspection, some medicines had been prescribed to be given in variable quantities. There had been no care plans for this and no information to guide staff about how much they should administer or the maximum quantity that should be given over a 24 hour period. MAR charts also did not always record the quantity that had been administered. This meant there was a risk that people could be given too much of the medicine or a dose that was not effective. For example many of the medicines prescribed in a variable quantity were for pain relief and this meant they may not have had their pain managed appropriately. At this inspection we found that no improvements had been made.

Also at the last inspection some people had been prescribed medicines which must be taken at specific times to meet their health needs. There had been no recognition of this in care plans and where the required times varied from the general times that medicines were administered to other people in the home, this was not clearly highlighted on the MAR. At this inspection we found that no improvements had been

made.

At the last inspection a health specialist had reviewed a person's medicine for a specific health condition and had changed the doses of their medicines. The MAR chart at the inspection in September 2016 did not reflect the changes made by the specialist and the person was therefore not receiving the correct doses of two medicines. At this inspection we checked the MAR for December 2016 and found that some changes had been made. However, the letter dated 1.1.16 directed that the medicine should be administered five times a day but the MAR directed that it should be taken four times a day. None of the staff or the registered provider were able to find any further information about the administration of this medicine. The registered manager later provided a letter, dated 5.7.16, that confirmed the information on the MAR was correct. This had been held by the registered manager and not been kept with the person's other information or made available to staff in the home. At this inspection we found another person who had been prescribed a medicine to be given three times a day but the MAR showed that this was being administered once a day.

During the September 2016 inspection we highlighted that handwritten additions to the MAR did not always include the full information on the prescription label that should have been transcribed onto the MAR. Entries had not always been signed and there was no second signature to confirm that the entry had been checked and was correct. This meant that a system to check for possible errors was not in place. At this inspection we found that no improvements had been made. In addition, one person had been admitted to the home and the medicines they had brought with them had not been checked, counted or properly recorded to ensure that staff were administering the medicines correctly.

At the last inspection we found that the service used two types of MAR; one for general items that were kept in locked medicines trollies and one for topical items, such as prescribed creams, that was kept in people's bedrooms. There were multiple occasions where the records had not been completed, particularly for topical items, and it was not possible to establish whether people had received these medicines. At this inspection we found that no improvements had been made.

Not all medicines were stored safely. Twelve bedrooms were checked during this inspection. Nine rooms contained prescribed creams and three rooms contained other prescribed medicines that were not securely stored.

Some medicines needed to be stored in a refrigerator. Checks to ensure that the refrigerator was operating at the correct temperature for the medicines had not been carried out.

Senior staff were responsible for the administration of medicines to people. Two of the five senior staff were newly recruited to the home. One of the new staff members had given the provider evidence of previous medicines administration training but the certificate for this training had expired. There was no evidence that their competency to administer medicines had been checked. The other new member of staff confirmed that their competency had not been assessed.

Only 10 of the 32 (MAR) contained a photograph of the person to assist staff with identifying that they were giving the medicine to the correct person. Two of the photographs had been taken a long while ago as neither person was recognisable from their photograph due to considerable weight loss. This meant that new staff may not be able to correctly identify who they should administer medicines to. On 5 December 2016, we observed one of the new staff looking for a person. They confirmed that they were finding it difficult to administer medicines because they had not yet got to know people and said that, if other staff were not available they had had to ask other people living in the home, who people were.

In addition, analysis of MAR for two people showed that there had been two days where the service had run out of some of their prescribed medicines so they had not received this. This meant that stock control and ordering systems were not effective.

Two medicines that had a specific time within which they must be used after they had been opened. No date of opening was recorded. This meant it was not possible to establish whether the medicine was still safe to be administered. There were creams and eye drops on the medicine trolley that staff confirmed were administered to people but there was no entry on a MAR to document this.

We visited one person at 3pm on the first day of the inspection. There were some tablets in a pot on the table next to the person. When asked, the person told us that they did not know what they were for or why they were there. We checked the MAR and found that the record had been signed to confirm that the person had taken these medicines at lunch time.

This was a repeated breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

In September 2016 we found that the premises and equipment were not always safe to use and was not used in a safe way. Suitable equipment to meet people's needs had not always been provided. Bath and shower facilities did not meet the needs of the people living in the home, hot water was not always available in all areas of the home, equipment had not been properly maintained and serviced, ceilings and walls were damaged either from water leaks or general wear and tear, furniture was old and damaged or worn, wardrobes were not fixed to the wall and first floor windows that had not had openings limited to prevent people from falling from them. Fire prevention and fighting systems had not been properly checked and tested. At this inspection we found that no improvements had been made. This meant that some people had continued to be unable to receive a bath or shower and action had not been taken to protect people from possible harm caused by poorly maintained buildings and equipment.

Dorset and Wiltshire Fire and Rescue Service visited Shalden Grange on 20 September 2016 and issued an enforcement notice under the Regulatory Reform (Fire Safety) Order 2005:Article 50 requiring urgent works to improve fire safety in the home. This included repairs, improvements and maintenance of the fire detection systems, fire prevention systems, assessment and management of risk and training for staff to tackle small fires, call for assistance and evacuate people safely were required. A completion date for the works was set of 1 January 2017.

During our inspection in September 2016, staff did not know what actions they should take in the event of a fire or other emergency and the registered manager was advised to ensure that staff were trained as soon as possible to ensure the people living in the home were kept safe. At this inspection we found that no action had been taken to train the staff. Staff told us that, if the alarm was activated, they would evacuate people from the building. However, none of them were aware of who would call the fire service, the need to establish where the fire was or of the fire service guidance which meant people could be moved to a different area of the building and kept warm and safe before taking a decision to move people outside.

Records of weekly and monthly tests and checks of the fire alarm, emergency lights, fire doors and closures and fire fighting equipment to ensure that they were working correctly were not available.

During this inspection we found additional areas of the building and items of equipment which were not safe or adequately maintained or were not being used in a safe way.

An electrical wall socket was broken but was still in use. The person who was living in this room was very frail. Staff confirmed the person could not use a call bell and could not mobilise without the support of two staff. Had a fire started due to the condition of the socket or adaptor they would not have been able to evacuate from the room or call staff for assistance. None of the portable electrical items including televisions, lamps, portable heaters and radios that were in people's bedrooms, that we saw had evidence on them that they had been checked as recommended within Health and Safety Executive guidance that was highlighted to the Registered Manager in September 2016. There was no system in place to complete visual checks for damage or faults on electrical equipment to help control electrical risks.

Twelve wash hand basins were checked. Two had no hot water. Three had hot water that was too hot and could have scalded people. Both taps on two wash hand basins were coloured blue so had to be run to establish which were hot and cold. None of the wash hand basins had a plug which meant people could not fill the basin if they wished to do so.

A number of bedrooms had very hot pipes running around the edge of the room at floor level. The pipes could have caused burns to people if they were to fall against them. This area of risk had not been identified and therefore no action to mitigate the risk and protect people from harm had been taken.

Cracked wall tiles and a broken curtain pole in an ensuite facility that had been highlighted as a hazard at the previous inspection and again during an infection prevention and control audit undertaken by the local Clinical Commissioning Group (CCG) in October 2016, had still not been attended to.

Wardrobes had not been fixed to walls. Some were on uneven floors that made them unstable. There was a risk that a wardrobe could be accidentally pulled over and injure someone. One person had an unstable bed frame that moved and wobbled when it was sat upon.

There was a large crack, over one metre long, to a sash window in a bedroom. The toilet seat in one ensuite facility was broken and lying on the floor. The toilet roll holder in an ensuite facility was broken. There were broken toilets, old fridges, a broken commode seat and other rubbish piled up in the back garden.

Prior to this inspection, CQC was notified that some people in the home had been diagnosed with an infection that meant that everyone living in the home and staff should be treated simultaneously regardless of whether they had symptoms of the infection. Some of the people and staff we spoke with were not aware of the outbreak. Those who were aware, including some staff, described the treatment that had been given. Their descriptions made us concerned that the treatment had not been applied in accordance with published guidelines. Daily records for seven people, for the period we were informed the treatment had taken place, had no information recorded that treatment had been provided. There were no notices in the home to inform visitors of the infection and the registered provider was not able to confirm that families and visitors had been notified. Staff told us that three people had declined treatment but we could not see that any measures had been put in place to protect them, confirm whether they were infected or prevent re-infection of others if they were infected. We could therefore not be sure that people had received the correct treatment.

This was a repeated breach of Regulation 12(2)(d)(e) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that the premises and equipment is safe to use and was used in a safe way, suitable equipment to meet people's needs had not always been provided and steps had not been taken to assess the risk of, prevent, detect and control the spread of infections.

At the last inspection some people had been assessed as being at risk of malnutrition or dehydration. Staff were keeping records of the amount people ate and drank over each 24 hour period. However, there was no guidance or information in a care plan to instruct them what were acceptable levels of food and fluid intake and what to do if people did not eat or drink enough. This meant that effective measures to mitigate the identified risk had not been put in place. At this inspection we found that no improvements had been made. We checked the fluid charts for three people and found that all of them were drinking very little but there was no evidence that any action had been taken to encourage them to drink by offering different drinks or additional prompting from staff and health professionals had not been consulted.

At this inspection we found that three people had rails fitted to their beds. No risk assessments had been completed to ensure that this was the most suitable and safest course of action to be taken. Once fitted, there were no assessments to check that they had been fitted correctly and there was no evidence that the rails were checked regularly to ensure that they remained safe to use.

Two people had experienced a number of falls over the preceding months. No falls risk assessments had been completed and there was no evidence that any action had been taken to reduce or mitigate the risk.

These shortfalls were a repeated breach of Regulation 12(2)(a) and 12 (2)(b) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

At the last inspection we found that appropriate checks such as obtaining references, checking qualifications, experience and employment history and a criminal record check had not been completed for all staff. At this inspection the provider had recruited new staff since our last inspection. There were six new staff on the rota for the weeks of our visits. Examination of records showed another seven new names of people who had worked and made entries in the records since the previous inspection but no records were made available for these people to show whether appropriate checks had been carried out.

Checks to ensure that staff were of suitable character and able to meet the requirements of the role for which they were employed had not been completed. Of the six new staff shown on the rota during the inspection, there were records that the provider had checked the identity of three members of staff and had obtained a copy of a recent photograph.

Little evidence of people's character and previous work had been obtained. There was only one reference or testimonial for three of the new staff and none for the remaining three staff.

The registered provider told us that the registered manager had not been available when some of the new staff had been recruited and they had completed the recruitment process. They had carried out a criminal records and list of people barred from working with adults and children update check with the Disclosure and Barring Service (DBS) for one member of staff. For another new member of staff, they had a DBS check which was carried out in February 2016 by another care home provider but had not undertaken an assessment to evaluate any possible risks and take action to manage any risks that were identified.

No checks had been completed for the remaining four new staff. A record of employment history had only been obtained for one member of staff. No assessments had been carried out to identify and manage any risks arising from allowing people to work without checks. This meant the registered provider had, again, allowed staff to work in the home without first ensuring that they were fit to do so.

This was a repeated breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 because people were not protected against the risks associated with the unsafe recruitment of staff.

At this inspection we identified three people who were at risk of harm and neglect and made safeguarding alerts to the local authority.

Providers are required to notify us of any allegations of abuse at the home. The local authority had made us aware of allegations of abuse that had been investigated by them. However, we did not receive any notifications about allegations of abuse from the registered provider or registered manager.

At the last inspection we found that staff had not been provided with appropriate training to enable them to recognise abuse and raise concerns. Training records for existing staff members were not available at this inspection. None of the recently recruited staff had received training in this area as part of their induction training. We spoke with other staff who had worked in the home since before the previous inspection and they told us that they had not completed any training since that time.

Information, the outcomes and learning about safeguarding investigations had not been shared with staff. This meant staff may not have been fully aware of the actions needed to minimise the risks and improve the care and support to people.

These shortfalls were a repeated breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not been provided with appropriate training to enable them to recognise abuse and raise concerns.

Inadequate

Is the service effective?

Our findings

During the inspection in September 2016 we found that staff had not received adequate induction, training and supervision to ensure that they could deliver care and support to people safely and appropriately.

After the first day of this inspection we contacted the Registered Manager and advised them we would complete the inspection on 5 December 2017. We requested that all staff training and supervision records were available. These records were not provided. The registered provider told us that they were aware of some training that had been booked but this had been cancelled as they were too busy and could not release staff from their duties to attend training.

Staff should receive induction training at the start of their employment. At the last inspection the registered manager told us that all staff received in house induction to familiarise them with the people living there, the premises and working practices. There was no evidence that any staff employed at the service had completed the Care Certificate or the previous qualification, the Common Induction Certificate. This is the nationally recognised care industry induction training which sets the minimum standards of knowledge and competence that staff should achieve on completion of the course.

At this inspection, five of the six new employees were care staff without experience, or evidence of qualifications and experience, and should have commenced work on the Care Certificate. All new employees should have received a basic induction to the home. Records showed that only two staff had completed the same in house induction that was available at the last inspection. None of the staff we spoke with had commenced work on the Care Certificate and the registered provider was not able to provide any evidence that staff were enrolled on the training.

Staff should receive regular training in essential topics. At the last inspection, records showed some staff had received training in some, but not all, essential training topics as recommended by Skills for Care. Only 10 of the 19 directly employed staff at the last inspection had completed any training and this was not in all of the recommended topics.

Skills for Care is a national organisation that sets the standards and the minimum learning and development areas adult social care workers should be competent in before they can safely work unsupervised and the frequency they should undertake refresher training in these areas

Skills for Care recommend that training in safeguarding adults, fire awareness, emergency first aid and basic life support, medicines awareness and moving and handling are updated every 12 months.

At this inspection 10 staff of the 21 staff on the rota, according to the records seen at the last inspection, had completed some essential training or refresher training. Some courses had been completed with a trainer and a date was recorded. Staff had completed training in safeguarding adults, MCA and DoLS, infection prevention and control, emergency first aid training and moving and handling during the period October to December 2015. This meant that staff training in these areas was due or overdue. The registered provider

was not able to tell us about any training that had been planned for staff.
Records stated that staff had passed training in dementia care, fire awareness, health and safety, medication awareness and food safety but no dates had been recorded. The registered manager had been advised, at our last inspection, to keep records with dates of training, the content and how long the course was valid for but this was not made available at this inspection.

Therefore there were 11 staff, including the five new staff newly recruited staff, working in the home for whom there was no evidence that they had received essential training or competency assessments to ensure they could adequately perform their role.

The minimum learning and development areas adult social care workers should be competent in, as set by Skills for Care also include dignity, equality and diversity, fluids and nutrition, person centred care, communication, recording and reporting and positive behaviour support. There was no evidence that staff had received training in any of these areas.

At the last inspection some of the people in the home had health needs such as Parkinson's disease and diabetes. No specific training had been given to staff in any of these areas.

None of the staff we spoke with could tell us about any training they had completed since the last inspection.

This meant that staff may not always be able to deliver care and support to people safely and appropriately.

This was a repeated breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with appropriate induction, regular training and supervision.

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 make decisions for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when required. 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.

At the last inspection we found that that there was not always a sufficient understanding of the processes to assess capacity, make decisions in people's best interests where necessary and to accept that people have the right to make unwise decisions. For example, some people had bed rails fitted to their beds. This meant that people may not be able to get out of bed without assistance. The potential restriction to the person's freedom had not been assessed in accordance with the MCA.

At this inspection we found that no improvements had been made. We asked a senior member of staff how the decision to treat people with an infection, discussed in the safe section of this report, was made for those people who lacked the capacity to decide for themselves. They told us that they had given them the treatment because it was needed and did not understand that we were asking questions relating to the MCA and making best interest decisions. Some care plans stated that people may have capacity to make day to day decisions but would need support to make more important decisions. There was no recorded assessment of how this decision had been reached or who was involved in making the decision.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the home was not meeting the requirements of the Deprivation

of Liberty Safeguards.

At the last inspection, the registered manager confirmed that they were aware of the safeguards and had previously made applications. They confirmed that one person was living in the home with an authorisation from the managing authority to deprive them of their liberty. Discussions with staff and health professionals highlighted that there were other people living in the home who may have been deprived of their liberty. The registered manager had not submitted applications to the managing authority to enable full assessments to be carried out.

Prior to this inspection we contacted the local authority responsible for the supervision of DoLS. They confirmed that two people were living in the home with an authorisation to deprive them of their liberty and that there were specific conditions linked to these authorisations that must be met. Both of these people were living in the home during our previous inspection with authorised DoLS but we were not made aware of these people by the registered manager. In addition, the person the registered manager believed did have an authorised DoLS did not have one. There was no information in the care plans for the two people with authorised DoLS that this was the case and no reference to the conditions that the home must comply with for these people. This means that we cannot be confident that the provider and their staff are aware of their duties and responsibilities under the deprivation of liberty safeguards and that people's human rights are respected. Some people may have been illegally deprived of their liberty.

This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

Staff checked people's weights every month. Some people had lost weight but there was no evidence that support had been requested from health professionals such as GP's or dieticians. In some instances staff were recording people's food and fluid intake because they were aware that people had lost weight. These records showed that people were eating and drinking very little but the registered provider and staff were not able to tell us about any action that was being taken, such as providing fortified foods and drinks (such as full fat cream, full fat milk, or full fat cheese added to their meals) or additional snacks to increase their weight and improve their health.

The main meal of the day was served at lunchtime and the evening meal was a lighter meal such as snacks including sandwiches, beans on toast, and salads. The lunchtime meal consisted of three courses, the first of which was a homemade soup. Everyone was served their soup in a plastic insulated mug and no choices were offered. Staff told us that alternatives were available to the main meal if people requested this. However, the people that we spoke with told us that they did not know until they went to the dining room what the meal was going to be and most people were not certain that they could request something different. Lunch service started from 11:20 in the morning. The registered provider told us that this was because some people had an early breakfast and other people needed support at mealtimes so they started meals earlier to ensure staff were available to help them as necessary. Staff supported people to eat and drink in a relaxed way and at their own pace.

Some records contained information about food people liked or disliked. The registered provider and cook were also aware of some people's preferences. However, there was no system in place to ensure that those staff who could not access computer records would be aware of people's preferences if either the registered provider or cook were not available.

During the previous inspection we found assessments had identified that some people were at risk of

developing pressure sores. Records showed specialist air mattresses had been provided to help prevent sores developing but there was no procedure in place to ensure that the equipment was at the correct setting according to the person's individual health needs or diagnosis. Also, people who were at risk but unable to reposition themselves without support, were being repositioned by staff every two hours. There was no individualised information available about how the frequency of repositioning had been decided. For some people this would have affected the quality of their sleep and well-being. Repositioning records did not always reflect that people had received the support that was specified in their care plan. Four people had developed pressure sores since the inspection in September 2016 and community nursing staff were visiting people to dress wounds.

Staff told us that people's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. We spoke with one GP who said that they used to see the same member of staff who always had a good understanding of people's needs but that, since they had left, staff did not always understand people's needs and they were concerned that instructions which they gave to staff may not always be acted upon. Records included little information about visits from healthcare professionals and it was not always possible to determine that relevant people had been contacted for advice or what instructions had been given to the staff to ensure people's needs were met. For example, one person told us that they felt unwell and wanted to see a doctor. We told the registered provider this and they stated that the person had only recently seen a GP so did not need to see one again. We were told that the person often requested a GP when one was not necessary. The person's requests were not respected. No one was able to tell us when the person had seen the GP or verify what the GP had said because appropriate records had not been maintained. We were concerned that this person may have healthcare needs that the home was not responding to and made a safeguarding alert to the local authority. Another person had previously suffered seizures and was prescribed medication to prevent seizures. The provider told us that the servicer user had not experienced any seizures for many years. Records showed that the service user had recently started to experience seizures again. There was no information about the action taken to support the service user either during the event or after it and neither the provider nor the staff could confirm whether medical help and advice had been sought

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not respond to the needs of the service user and take action to ensure that they received safe care and treatment.

Requires Improvement

Is the service caring?

Our findings

People said that staff were kind and caring but some also said they often felt they had to wait a long time to receive the support they required. One person also said that some of the night staff could be rough sometimes and said "[person's name] is not nice to me".

Some staff were not able to effectively communicate with people because of their limited English language skills. One member of staff told us that it was often difficult to direct staff to provide the support people required because they found that there was a language barrier. A relative told us that they felt that their mother could not understand the staff or make herself understood by the staff. Staff that we spoke with were able to understand and respond to our questions with some rephrasing.

The registered provider had a good knowledge of the people living in the home, their support needs, family, friends and life history. However, very little of this was written down or accessible to staff. This information may have helped staff to understand people, establish rapport, or find interests or activities for people to follow or do.

At our inspection in September 2016 not all of the staff were caring in their approach to people. During this inspection we saw that some staff had developed a rapport with people and understood their needs. However, other staff were still more focussed on the completion of tasks rather than providing support to people in a way that was personalised to each person, their preferences and needs. For example, we were told, and observed, that one person responded better to some staff than to others. Staff told us they had been instructed that whichever member of staff was available was to attend to the person and there should not be any alteration to staff routines to accommodate this person's needs.

Analysis of staff rotas for the period of 30 October to 21 November 2016 showed that there were eight nights where both staff on duty were male. This meant that people did not have a choice about the gender of the staff who could support them with their needs including personal care on these occasions.

This was a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not treated with respect and dignity at all times while they are receiving care and treatment.

Inadequate

Is the service responsive?

Our findings

At our inspection in September 2016 we found that people's care needs were not always fully assessed, planned for and met. For example, people with conditions such as diabetes, dementia and Parkinson's disease did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur.

At this inspection we found that some of the care plans we had highlighted at the previous inspection had been reviewed and updated. The registered manager had developed a detailed plan for one person about the support they required to manage their diabetes. This was only available on the computer and most staff did not have access to this information. We asked staff about the support the person needed and they were not able to tell us the information that was in the care plan. For example, staff carried out blood sugar tests with the person and recorded the result. They were not able to tell us what the acceptable range for a blood sugar level should be or the signs and symptoms the person may exhibit if they were experiencing hypo or hyper glycaemia.

In addition, one person had recently been admitted to the home. There was no assessment information available for the person and only very brief care plans which, having met the person and spoken with staff, did not cover all of the person's needs or how to meet them.

This meant that the provider and registered manager had not taken action following the last inspection to ensure that people's needs were fully assessed and planned for and that and staff still did not have all of the information they needed to be able to provide the right care and support to people.

Some, but not all, people had life histories and information recorded on the computer about what was and had been important to them. Most staff were not aware of this information and only senior staff could access the computer. Staff did not understand the importance of people's preferences and past experiences in planning and delivering care to meet their emotional and well-being needs.

At the last inspection, people's care plans were reviewed once a month. At this inspection we found that the staff member responsible for this was no longer employed at the service. Most people's care plans had not been reviewed since the beginning of September 2016. Those reviews that had been carried out did not consistently identify whether the care plans were accurate, whether people's needs had changed or whether staff were delivering the care included in the care plan. For example, staff were monitoring the fluid intake for three people to check for possible dehydration. Staff had consistently recorded a very poor intake of fluids but this had not been flagged as a cause for concern either through the daily recording process or at the monthly review. Three people had lost significant amounts of weight each month for a number of months consecutively. Again, this had not been recognised as a possible cause for concern and there was no evidence that a GP or dietician had been consulted.

At the last inspection we highlighted that there was little or no information about people's wishes for end of life care and no information about whether people had a Do Not Attempt Resuscitation (DNACPR) orders in

place. This means that people have chosen not to receive cardio pulmonary resuscitation (CPR) if their heart stops beating. Prior to this inspection we received information that staff had found one person unresponsive and called 999. Paramedics had arrived and performed CPR on the person because staff had been unable to tell them if a DNACPR was in place. It was later confirmed that the person had made a decision not to receive CPR. This meant that the person's preference and decisions regarding their care and treatment had not been properly recognised and acted upon.

We asked staff which people living at Shalden Grange had DNACPR's in place. Only some of the senior staff were aware of this information and there was still no information, following the above incident, for staff to access to ensure that they were following people's wishes.

Another person had a contracted hand and had been provided with a palm protector. There was no information about how the person's hand should be cared for or how, when and for how long they should wear the protector. The person did not have their palm protector on at any point during the inspection when we saw them. This meant the person's care needs had not been planned for and delivered.

Two people were cared for in bed in their bedrooms. There was little or no stimulation for them. They were not able to reposition themselves, had nothing to look at, no music to listen to or anything to touch or hold. Staff had wedged the bedroom door open with a small table for one person but this was a fire door and would not have been able to close properly in the event of a fire.

Some people did not have call bells within reach. We were told that this was because they were unable to use them. There was no system in place to ensure that people were checked more frequently.

This was a repeated breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their personal, social and emotional care and welfare needs.

Some people spent most of the day in the lounge. There was a large screen television that was left on but very few other forms of occupation were available such as books or magazines and newspapers or large games, puzzles and items to touch or hold. During the afternoon of the first day of the inspection, six people played bingo in the dining room. We spoke with other people in the home and asked why they had not joined in. Two people said they had not been aware that it was taking place and one person said they did not care for group activities or games. There was a programme of activities on the notice board which showed group activities were organised on five afternoons each week.

At our inspection in September 2016 we found that an effective system for identifying, receiving, recording, handling and responding to complaints had not been established. During this inspection, the registered provider was unable to tell us what action had been taken to address these shortfalls or whether any complaints had been received since the last inspection. We checked a folder that was marked "Complaints" and found the same information that had been present at the last inspection and no additional information or updates.

This was a repeated breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because an effective system for identifying, receiving, recording, handling and responding to complaints had not been established.

Inadequate

Is the service well-led?

Our findings

During our inspection in September 2016 we found that arrangements to monitor the quality and safety of the service provided were not effective. At that inspection we found breaches in ten regulations. Audits and management processes had not identified any of the issues found at that inspection.

Following our inspection in September 2016 there was correspondence with the registered manager regarding the shortfalls we had found and the actions that must be taken to ensure that people received good care and treatment and all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were complied with.

At this inspection, only one of the breaches that were found during the September 2016 inspection had been addressed. All of the other breaches have been repeated.

The first day of this inspection was unannounced. The registered manager was not in the home upon our arrival and was unable to come to the home when staff contacted them. The second day of the inspection was arranged with notice but the registered manager was still unable to attend the inspection or provide the records we requested because they were on holiday. The registered provider was present but did not have knowledge of the management arrangements for the home or the work of the registered manager. We found that there was no system in place for the management of the service when the registered manager was absent.

The registered provider gave us access to some files and records in the office. This included the quality assurance and audit files. There were no new audits in the folder for any of the areas that had previously been checked which included care plans, response to call bells and temperatures of hot water and infection prevention and control. There was also no evidence that work had been undertaken to respond to the requirements of the previous inspection report.

At the last inspection we highlighted that the infection control audits undertaken in February and June 2016 and monitoring of the premises undertaken in June 2016, carried out by the registered manager, did not identify the risks posed by broken and damaged furniture and fittings such the areas surrounding wash hand basins. It also had not identified the issues with the water system and that foot operated waste bins should be provided. Following our inspection in September 2016, the local Clinical Commissioning Group (CCG) carried out an infection prevention and control care home assessment on 21 October 2016. They also found the items we had raised and a number of other issues. At this inspection, there was no evidence that action had been taken either in response to our inspection report or the report from the CCG.

During our inspection in September 2016, a number of different records were examined. These included care plans, daily records, medicines and staff records. Many of these records were not fully completed, dated, timed or signed. In addition, some records were illegible. Records also lacked detail and current information. At this inspection we found that no improvements had been made and in addition, a number of records were not available because the registered manager was not storing them at the service. This

meant that we could not be certain that records were being created, amended, stored and destroyed in accordance with current legislation and guidance.

The culture of the service has, again, been found to be reactive rather than proactive in ensuring that a good standard of care and accommodation is provided for the people living in the home. It is concerning that, following our inspection in September 2016, very little action has been taken to ensure people are kept safe and provided with good care from staff who have been trained to work to current standards and good practice guidance. For example, at the last inspection we highlighted that people were not cared for in a person centred way and that they were not always treated with dignity and respect. There was no evidence that staff skills had been analysed and additional training provided for areas where improvement was required. These are areas of staff training that are recognised by Skills for Care, as essential training for staff, but this training had not been provided.

The registered manager had not complied with relevant legislation relating to the Deprivation of Liberty Safeguards, safeguarding adults and CQC legislation.

Following this inspection we wrote to the registered provider to request an action plan setting out how they would address the immediate and urgent concerns from our visit. The action plan that was provided did not address all of the areas raised and some of the timescales that were in the action plan did not reflect the serious nature of the concerns raised. We wrote to the registered provider again setting out our concerns about their unsatisfactory response. They then submitted a comprehensive action plan which indicated that our concerns would be addressed. The registered manager later advised CQC that they had not seen the original letter, which was sent by email, until 24 hours before the deadline to respond. They had therefore had very little time to prepare a satisfactory response.

Since our inspection, the registered provider and registered manager have accepted support from the local authority to make people safe and improve standards of care. They have also made regular reports to CQC about the progress being made to address the shortfalls highlighted at this inspection.

The registered provider also confirmed that they would not admit any further people to the home until action to address the shortfalls had been taken.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

At the last inspection we advised the provider that we had not received any notifications from the home since 7 December 2015. The registered manager stated that none of the events that should be reported had taken place. We had found that at least one person had passed away and two people were living in the home with an authorised condition to deprive them of their liberty. The regulations set out that CQC must be notified of these incidents. At this inspection we had still not received any notifications although we were aware that some reportable events had occurred.

This was a repeated breach of Regulation 18 (2)(a)(b) (e)(4)(4A)(a)(b) of the Care Quality Commission (Registration) Regulations 2009 because the registered manager had not notified us of all incidents.

From 1 April 2015 providers have to display the home's rating. This was not displayed during the inspection in September 2016, nor was it displayed on the first day of this inspection. We raised this with the registered

provider on the first day of the inspection and found that the rating had been displayed when we returned on the second day of the inspection.