Idun Management Services Limited

Whitchurch Care Home

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

Summary of findings

Overall summary

Whitchurch Care Home provides accommodation and nursing care for up to 50 older people. At the time of the inspection there were 25 people in residence. Each person had their own en-suite bedroom. The home was spread over two floors with a lounge on each floor and a main dining room on the ground floor.

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

The inspection took place on the 17 and 24 January 2019 and both days were unannounced. The last inspection of the service took place in October 2017 and the service was rated Good.

At the time of this inspection the service was in a whole service safeguarding process and the provider had put in place a self imposed embargo on admissions. This meant the local authority safeguarding team were monitoring and working with the service to ensure people were protected from abuse and their rights safeguarded. A recent incident where a person had suffered a significant injury was being looked into by the statutory agencies.

At this inspection we found nine breaches of regulations. These include areas relating to safe care and treatment, safeguarding, treating people with dignity and respect, person centred care, staffing, complaints, statutory notifications and good governance. We will be asking the provider to send us a report of the improvements they will make.

The overall rating for the service is 'Inadequate' it will therefore be placed into special measures. The commission is now considering the appropriate regulatory response to resolve the problems we found.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were widespread and systemic failings identified during the inspection. The quality and safety monitoring systems used by the provider were not fully effective. They did not ensure that there were the right resources in place to ensure the quality of service provision and mitigate risks to people.

The provider had failed to make appropriate statutory notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

The provider had failed to report and take prompt action as required regarding adverse safeguarding

incidents appropriately.

There were not enough skilled and competent staff to meet peoples' needs. The staff team was unstable. The resulting high usage of agency staff had caused a lack of leadership for staff and confusion about who was responsible for people's wellbeing and care needs.

Staff had not received regular meaningful supervision; the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views. Staff training did not meet staff or peoples' needs. Staff recruitment procedures were not always followed appropriately.

Care plans were not consistently person centred. The guidance within peoples' risk assessments were not always followed by staff and records used to monitor peoples' health were not always completed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment.

People had access to healthcare professionals however we were not assured that staff always identified when referrals were required. People did not always receive their prescribed medicines as required.

We received some positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised.

The provider had a complaints procedure however not all complaints had been recorded as such or investigated following the procedure.

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.

There was a failure to safeguard people. Abusive incidents and allegations of abuse were not always reported appropriately.

There were not enough skilled and competent staff to meet peoples' needs safely.

Guidance within people's risk assessments were not always followed by staff.

People did not always receive their medicines as required.

Is the service effective?

Inadequate

The service was not effective.

Staff supervision and training was not effective in ensuring staff were supported, suitably skilled and competent in their roles.

Records relating to peoples' care and treatment were not fully completed to protect people from the risks of unsafe care.

Risks relating to people's hydration needs were not managed effectively.

DoLS applications had been made for all people that required them.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had failed to ensure that there were sufficient resources in place to enable the staff team to provide a caring service.

We received a positive response from some people about staff, however we observed occasions where peoples' care and dignity were compromised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently personalised and did not always contain unique individual information and references to people's daily lives.

Sufficient action had not been taken to ensure people's care and monitoring records were fully completed or analysed to prevent deterioration in their health.

People were supported to use healthcare services; however we were not assured that appropriate referrals were raised when there were concerns.

People did not always receive adequate mental and physical stimulation or person centred activities.

There were systems in place to respond to complaints however not all complaints had been recorded as such.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to ensure that the service could sustain improvement.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

Statutory notifications had not been made to the Commission for notifiable incidents.

Whitchurch Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification of a serious incident. This inspection did not examine the circumstances of this incident but did examine associated risks.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

This inspection took place on 17 and 24 January 2019 and was unannounced. The inspection was carried out over the course of two days by five inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Three inspectors attended the first day and two on the second.

Prior to the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke with eight people, the manager and other senior management staff, five relatives and eight members of staff. We tracked the care and support provided to people and reviewed six care plans relating to this. We examined eight people's medicines records. We looked at records relating to the management of the home, such as the staffing rota, policies, recruitment records, training records, meeting minutes and audit reports. We also made observations of the care that people received.

Inadequate

Is the service safe?

Our findings

People were not always protected from avoidable harm or abuse because staff did not always report incidents when they occurred and senior staff did not report them to the local safeguarding authority. The service had a policy and procedure regarding the safeguarding of people and guidance was available for staff to follow. Some of the staff said they had received training on safeguarding people from abuse and others said they were unsure. All of the staff we spoke with knew how to report incidents and any concerns. However examples of where incidents had not been reported included; one person had complained that their skin sores had been caused by being left lying on a wet towel for an extended period of time during personal care. We found note of this incident in supervision records. It had not been reported as a complaint or a safeguarding incident. The manager stated the skin sores could not have occurred due to neglect of care as the staff member providing care said they had left the person on the wet towel for a matter of minutes and the person's memory was confused by their dementia.

There was nothing to indicate if the incident had been reported formally, or if the person was satisfied and understood the staff response. The manager confirmed the incident had not been reported to the local safeguarding authority or notified to the commission. This meant that the local safeguarding authority was unable to conduct an independent investigation into the incident and the commission were unable to maintain their oversight of the service as required.

During the inspection we identified a number of incidents that should have been reported to the local authority.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing arrangements were not planned effectively; 19 out of 26 people using the service required at least two members of staff to assist them with their personal care or to assist them to mobilise or change their position. There were five care staff members on duty during the day and two nurses until 2pm after which there was one nurse. There were four care staff and 2 nurses at night. This level of staffing allowed the very basic personal care needs of people using the service to be met. As mentioned in the Caring section of this report the majority of people did not receive a bath or shower in the 4 weeks before the inspection. We also observed that care staff spent very little time with people unless they were carrying out a task.

The kitchen on the ground floor of the home was being refurbished and the adjacent main dining room was out of use. The service's lift was out of use preventing most people from being able to move between the floors. Without the lift people could not join in some activities and therefore required additional attention. Care staff were further stretched at mealtimes as they had to carry plated food up the stairs. This made them especially busy as a number of people needed support to eat. On the first day of inspection we saw that lunch took one and a half hours to be served to all people starting at 12:30 and ending at 14:00. On the second day of inspection it was slightly shorter ending at 13:45. Some people ate their lunch meal late meaning that the gap between their lunch meal and their evening meal served at 17:00 was short. There was

a risk that they may not eat their evening meal having been served their lunch so late.

The ground floor communal room which could have been adapted for dining was not used. All people remained in their rooms and received very little interaction with staff unless they were being assisted with personal care or to eat.

Sufficient numbers of suitable staff were not deployed to ensure people's needs were met. The manager used a dependency tool to assess individual people's dependency and calculate the number of staffing hours required. The dependency tool did not take into account the building layout, the closure of the dining room or the lack of a working lift. In addition there were a number of relatives who were assisting with the care of their loved ones, had they not been doing this the staff would have been required to do this too. These issues as well as the more complex needs of people, a high staff sickness rate, the skill mix and competence of staff, had not been considered as part of the staffing assessment. Additionally there was a high usage of agency staff that were not as familiar with people.

There was consistent feedback from people, staff and relatives that there were not enough familiar staff. Staff comments included "We need to make sure we have enough staff every day. Staff don't do what they are meant to do" "Sickness is through the roof. Worrying about what I will come into" Relatives said "I never leave feeling concerned – except just at the moment there are more agency staff but some of them are regular, some one-offs" and "Regular nurses are good – agency don't know people." People we spoke with said "Some [staff] are all right, some very abrupt, they think you are calling them just for the sake of it" and "Sometimes use buzzer at night, takes a while, sometimes a long time at night."

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

Care plans contained risk assessments for skin integrity, malnutrition, falls and mobility. When risks were identified plans contained guidance for staff on how to reduce the risks to people. For example, when staff needed to use equipment to move people safely, this was documented, such as hoist and sling details. In the main, this information was clear; however, in one person's care plan the guidance was not clear. In the mobility plan, the guidance for staff was, "2 staff", and "Due to [needs], handlers should consider having an extra person whilst using hoist." It had also been documented, "Two to four carers to attend when moved in bed using slide sheet." This meant it was unclear how many staff were needed to move the person safely; this put the person at risk of unsafe care.

Some people had been assessed as being at risk of developing pressure ulcers. The plans included information such as pressure relieving equipment that was in use and the frequency of required position changes. Position change charts generally showed that people had their positions changed in accordance with care plans; however, this was not seen consistently. For example, in one person's plan it was documented the person needed four hourly position changes. However, the charts did not reflect care plan guidance because on two days running nothing was recorded and other recordings indicated they were not repositioned at the frequency required. This put people's skin integrity at risk.

There was a risk that people may not have received medicines that were necessary to their health. All eight topical (creams) records were incomplete; for example, missing body maps, no administration record but prescribed products in the bathroom, signature gaps on the administration records. Two people had not had their topical medicines applied for nine days, as the product was thought to be unavailable however; there was stock in the treatment room dispensed in December 2018. One of these people said their face was 'ever so sore.'

Staff did not always act quickly once they had identified problems with medicines. For example, one person was prescribed three similar products; nursing staff were aware this was not good practice but had not requested a review from the GP. Another person had not had their prescribed medicated shampoo applied to their scalp as they had not had their hair washed or had a bath or shower for at least four weeks. The staff told us the person preferred a bed bath; when giving bed baths staff did not always wash people's hair. The person's scalp was very red with large flakes of skin; their condition was not resolved. The person had not been reviewed by the GP for an alternative product; there are medicines available that could be applied to the scalp without needing to shower or bath afterwards. This lack of action had put the person's skin integrity at risk and did nothing for their discomfort.

Permanent nursing staff did online medicine training and had supervised medicine rounds before being deemed competent to administer medicines. Care staff also had access to training around topical medicines however not all staff had completed the training. The majority of nursing staff were from agencies and there was not a system in place to check their competency in medicines administration and management. There were a continued high number of errors relating to the administration of medicines over the past few months which placed people at risk.

Medicines prescribed 'as required' were offered to people but there were not always protocols in place to provide guidance to staff to ensure the medicines were administered to people when they were showing signs of requiring them.

People were placed at risk of infection due to poor hygiene practices. On the first day of inspection we observed that on the ground floor of the service the sluice room was left unlocked and could have been entered by anyone in the home. In the sluice room there was a clinical waste bin which had not been properly lined; clinical waste was in direct contact with the bin. There was clean laundry stored on trollies in communal bathrooms and dirty laundry bags were left open in another unlocked sluice room. All of these issues increased the risk of contamination.

There were open and accessible storage cupboards which contained items including syringes, cleaning equipment and gloves used for personal care. Emergency procedures were in place however these were not fit for purpose. Staff had received fire safety training and a number of evacuation drills had taken place, the reports following the drills demonstrated that staff did not follow the emergency procedures as required. In addition to this the high use of agency staff who may be reliant on permanent staff to lead in an emergency situation put the service at risk should an emergency occur.

There were personal emergency evacuation plans (PEEPs) in place for people. However, all of these guided staff to hoist or transfer people into wheelchairs or evacuation sledges. Because the majority of people were unable to move independently, this meant the evacuation procedure was not safe or achievable in the event of an emergency. In the event of an emergency evacuation, there was not enough staff on duty to follow the PEEPs. We have reported these concerns to the fire service.

On the first day of inspection the lift had been out of use for six days and was still out of use a week later. We raised this and a risk assessment was put into place and a plan for a stair lift to be fitted initiated. The provider has confirmed that the main lift requires substantial work before it can be used again.

People were at risk of avoidable harm. There had been multiple incidents in the service in the last 12 months. There were examples of where people had fallen, sustained injuries or been placed at risk of harm due to the provider not ensuring appropriate measures were in place to reduce these risks, or where staff had not followed the person's care plan. We were not assured that the provider learned the lessons from

when things went wrong.

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

Staff recruitment processes did not ensure that suitable staff were employed and in line with the provider's policy. Not all required references had been undertaken, one staff member had been re-employed without up to date references and references had not been obtained from the last known or any previous employer for another.

These failings amounted to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An enhanced Disclosure and Barring Service (DBS) check had been completed for new staff. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. The recruitment process included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Medicines were stored securely in a locked room and medicine trollies. Staff recorded fridge and room temperatures daily, the records demonstrated that medicines were stored at the correct temperatures. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored in a suitable cupboard.

Inadequate

Is the service effective?

Our findings

Staff received training through the provider's essential training programme which included safeguarding, fire safety, first aid, infection control and moving and handling training. The staff training matrix recorded that many staff had not received all training which the provider had deemed essential. The failure to provide effective training had impacted on staff providing safe, person centred care.

Staff gave varying comments on the quality of the training and induction, the majority of which was via e-learning. Staff said "Mostly E learning…read some things and then I forget." "All e-learning apart from manual handling." "Always ongoing training, as and when" and "Always offered training. I get good opportunities within the company." About the induction staff said "No induction, hadn't worked in care before. First day paired up with someone and then told to go and help someone with person care."

People we spoke with gave variable views about how well they thought staff were trained. "Some staff ok, some mixed. Some are very well trained, some not" and "I think they are properly trained." A relative said "Core of carers are very good, from the old group."

Staff supervision and appraisals were not effective or carried out in line with the provider's policy. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The supervision matrix recorded that supervisions had not been taking place at the frequency set by the provider and that most staff had received between two and three supervisions in the last year. We looked at the supervision records of four members of staff and found not all had been provided them with feedback about their performance or development. Annual appraisals had not been undertaken. We were not assured that the provider had ensured that staff performance and progress was monitored effectively. This was highly important given the issues within the service.

Staff said ""Don't think I have ever had supervision, not had a one to one" and "Can't do supervisions at the moment as don't have enough staff." "I think my last supervision was in June [2018]."

Senior staff confirmed that training and supervision had fallen behind whilst there had been changes in management and a high usage of agency staff as agency nurses could not undertake supervision with staff they did not know.

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

People had been assessed for the risk of malnutrition. People's preferences for what they liked to eat and drink had not always been documented and where it had been, it was limited. For example, in one person's plan, it was written, "Eats what [they] want to" and in another person's plan, "Likes coffee in a cup."

Care was not effective as speech and language team (SALT) guidance was not always being followed and put people at risk of choking. SALT advice and support had been sought when needed however it was not

always followed. When people needed to have specialist diets or thickened drinks, this was written in their care plans. In one person's plan it was written, "Level 1 fluids, no spout." We observed staff did not follow this consistently and gave us different accounts of how they assisted the person. The guidance in their room was different from the care plan and did not reflect the SALT advice. We informed a senior staff member of this and they said they would address this with staff and amend the contradictory information in the summary of needs.

Fluid intake could not always be accurately monitored to ensure people's hydration needs were met. Some people were having their food and fluid intake monitored. In the main, these were completed by staff. Staff had also documented when people refused food or drink. However, the quality of documentation was not of a consistently high standard and it was unclear if concerns about poor fluid intake were escalated to senior staff. For example, on some of the fluid charts staff had completed a running total of intake throughout the day, but these were not always accurate. Running totals had been added by staff on some charts, but not all, which meant there was inconsistency of documentation. The written total intake for one person on one day was 930 millilitres, but this had been miscalculated and the actual intake was 730 millilitres. On another day, staff had documented the person's intake as 1000 millilitres, but, again this was incorrect and the actual intake was 740 millilitres. Fluid charts did not always have a target amount written so it was unclear how staff knew if people had drunk enough. The charts for one person showed that on one day their fluid intake was 680 millilitres, but this was not referred to in the daily notes as being an adequate intake for the person.

These failings amounted to a breach of Regulation 12 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".

When people had been assessed as lacking the capacity to consent to their care, the standard of documentation was variable. For example, one person had been assessed as not having the capacity to consent to living at the service. A best interests' decision meeting had taken place which detailed who had been involved in the decision and how it had been reached. This person also had bed rails in place. However, the documentation in relation to how this decision had been reached was not as detailed. There was nothing to describe if staff had considered any less restrictive options or how they had reached the decision to have the bed rails in place. The form was dated in early 2017 and there was nothing to show it had been reviewed since then.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. DoLS applications had been made as required.

When people had capacity to do so, they had consented to their care and treatment. This was documented in care plans. For example, one person had declined any further active treatment. The plan showed that staff had assessed the person's capacity to do this and were respecting the person's wishes.

The decoration within the service had not been adapted to meet people's needs. There were few adaptations to support people living with sensory impairment or dementia to safely navigate around the service. There was no attempt to differentiate between areas of the home which would be helpful for visitors as well as for residents and there were no items or decor which may stimulate memories for people. We noted that the clock within the main foyer displayed the wrong time; this could be disorientating for people.

People had access to healthcare professionals however as demonstrated in other sections of this report staff had failed to recognise when care was unsafe or inappropriate. We therefore could not be assured that appropriate referrals were made when there were concerns. We were also made aware that the lack of a working lift had mean that people had been unable to attend hospital appointments.

Requires Improvement

Is the service caring?

Our findings

The provider was not caring as they had not put effective resources put into place to ensure that people were well treated and received care in a respectful and person centred way.

There was a culture amongst some staff of being task orientated and undertaking their role in a way that suited their own convenience rather than providing person centred care. One person said "I like a shower every few days, depends who is on some staff happy to do and some less keen." A member of staff said "I feel like a lot of the carers are just not bothered [to support bathing and showering] with the high dependency people because they're too difficult if they need two staff."

We were not assured people were receiving adequate personal care given the level of staffing and staff culture. We asked the provider to undertake a personal care audit for the previous four weeks and submit it to us. This audit reflected many people were being given 'bed baths' regularly rather than receiving showers or baths. A bed bath did not necessarily include people's hair being washed. Of the 26 people resident in the service only six people had received a bath or shower in the previous four weeks. The personal care audit reflected a correlation between the people that required the assistance of a hoist and two staff to support them and the lack of showers and baths. There was a lack of assurance that people received the appropriate assistance with their personal care. This presented a risk of skin breakdown, neglect and a failure to preserve people's dignity.

There were institutionalised care practices in place which did not respect people's individual needs and preferences. We were told that night staff gave personal care to all people that were 'nursed in bed'. Staff said "People who stay in bed get washed by the night staff" and "The night staff, normally wash people that don't get up then the day staff can concentrate on the people that wish to get up." The manager confirmed that up to six people on the ground floor and eight people on the first floor were given their personal care by the night staff. When asked why we were told that night staff asked people first and it was their choice as recorded in their care plans. Consented waking times were not consistently recorded in care plans; some people were being woken to be given personal care only to return to sleep, some of these people were living with dementia and their preferences had not been considered.

Senior staff confirmed that they were aware that there were some staff that undertook care at their own convenience. They explained that they were trying to change this culture. However, until we asked the senior staff to produce an audit of the personal care provided they were not aware of the extent of the problem.

We were also told by a relative that at night on occasion their relative had received care from a member of staff who was not of their preferred gender for personal care; "One night three male care staff and one female, I have said she is only to have female care staff but how can they manage that [when short of staff]?"

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

Peoples' dignity and respect were not always protected. We observed several examples of peoples' dignity being compromised within the service . We heard staff talking loudly about people in corridors and public areas. We also heard staff talking about and to people using infantile language for example "She's a good girl." On occasion people were not treated with dignity when being supported. For example, we heard the emergency call bell sound as a member of staff was assisting someone to eat in bed. The member of staff shouted loudly and frustratedly "For god's sake is someone going to get that?" directly into the person's face. The staff member did not take into account how this may have startled or frightened the person they were assisting.

We observed that at mealtime's relatives who were present in an upstairs lounge exchanged banter between themselves, staff and their loved ones. Other people were ignored by staff and not included socially.

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

People's independence was not promoted as most people remained in their rooms and were not encouraged to come out unless there were activities on. Relatives we spoke with told us that they had seldom been involved in care plan reviews but that this was beginning to change. One relative said "We were both involved and this week had a review which they did with [person]."

We did observe some instances of good care from staff for example staff explaining to people what they were being served for lunch and exchanging pleasantries whilst in passing. People said "Staff are lovely, all nice" "They ask me what I want to wear" "Staff are ok – they are kind." Relatives said "Day time staff are fantastic and know [person] and how to do things and "Carers are the best but they need more."

Requires Improvement

Is the service responsive?

Our findings

Care plans were not consistently person centred. Care plans were in the process of being updated by a member of senior staff. They told us they had started but had yet to finish reviewing every person's plan. This was reflected in the plans we looked at. Some of the plans had more detail than others; however the plans which had been updated did not always provide enough detail for staff and plans did not always provide information about people's choices and preferences.

Some of the information within plans was conflicting. For example, one person had an amputated limb. However, the care plan referred to different limbs. For example, in the pain assessment, staff had documented, "Right foot amputation." The mobility plan for this person referred to, "Left leg below knee amputation" and, "Please support my left leg whilst giving care." In the skin integrity plan staff had written, "Right below knee amputation." This meant it was unclear how staff should support the person because of the conflicting information.

Other plans lacked detail. For example, the seizure plan for one person informed staff to, "Support [them] to keep [them] safe and GP has prescribed [medication] to be given if seizure lasts more than 5 minutes." This did not provide staff with enough information on what steps to take if the person experienced a seizure, or how to keep them safe.

We looked at the plans for two people who had urinary catheters. There was no guidance for staff about catheter care or how to prevent a urine infection. The signs and symptoms of infection had not been documented. Both people were having their fluids monitored, but there was no guidance to inform staff what an acceptable urine output was for each person. The charts for one person showed that on three consecutive days the person had not passed any urine. There was nothing documented in the daily notes to show that staff had noted this or escalated it to a senior member of staff.

Charts for another person were similar. On 13 January 2019, staff had made one entry in the output column, which read, "400 ml, not emptied." There were no further entries for the day. On 15 January 2019, there was no recorded output for a 24-hour period. Again, there was nothing documented to indicate this had been noted by staff or escalated. This meant there was a risk that people's output was not being monitored effectively.

Personal hygiene plans were person centred in places. For example, we looked at some plans where staff had written that people liked to wear make-up, jewellery and the clothes they preferred. Peoples preference for male or female staff to support them with their hygiene had been documented however we were informed by a relative that when short staffed this preference was not always met. In other plans, we saw it had been written that people liked a shave daily, but did not state whether this was a wet or dry shave. Some people's preferences for when they liked to get up and go to bed had been written, but this was not seen consistently. Although some plans referred to people liking to watch television, their preferred programmes had not always been written.

There was a lack of meaningful individual activities for people. We found that activities were not monitored by the provider for their suitability or for their provision particularly for people who stayed in their rooms or in bed. There was a daily weekday timetable of activities on display within the service; there were no activities at the weekend. Activities included: Bingo, ball games and pampering sessions. We asked the provider to produce an audit of peoples' activities for the four weeks previous to the inspection. We found that four people had received no interaction (social contact) over the four-week period and other people received no more than one or two interactions a week. People who had relatives closely involved were more likely to receive activities. A relative said "They [staff] get [person] up more now, at one time [person] was in bed for up to two weeks, I raised it and now they get [person] up. Weekends [person] is mostly in bed." We observed that some people did not leave their room all day and the only interaction they received was when they were given personal care or food. One member of staff said ""Everyone is washed and dressed but people don't get up." People's emotional and social needs were not being met.

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

Complaints were not being consistently identified or investigated to enable the provider to respond or make improvements. The provider had a complaints procedure and people and their representatives said they knew how to complain. Two complaints had been made in the last 12 months which had been resolved. However other records recorded details of complaints that had been made to the staff and manager; these had not been recorded or followed up as complaints. This meant that the provider was unable to use the detail of these complaints to assess for any trends or improvements. This was particularly important as we found that there was significant dissatisfaction amongst people and relatives with regards to some of the issues that had not been recorded as complaints.

These failings amounted to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans in relation to people's communication needs were detailed. People's life histories had been documented. This meant staff were able to learn more about people's lives prior to moving to the service. When people had expressed a preference in relation to spiritual needs, this had been written. For example, one person had a weekly visit from their church minister.

There were advanced plans for end of life care in place. Some people had chosen not to discuss their wishes for how they wanted to be cared for at the end of their lives. When people had been willing to discuss their preferences, the information was limited to funeral plans and people wanting to be comfortable. There was no information about any special wishes people might have.

Inadequate

Is the service well-led?

Our findings

There were widespread and systemic failings identified during the inspection; we identified nine breaches of regulations; the shortfalls related to key aspects of the service; safeguarding, safe care and treatment, treating people with dignity and respect, person centred care, staffing, complaints, recruitment statutory notifications and good governance.

This service was rated Requires Improvement at three consecutive inspections in December 2014, July 2016 and February 2017. At the February 2017 inspection the service was also rated Inadequate in the Well led domain. Following this improvements were made and at the following inspection in October 2017 the service was rated Good for the first time. Since then the provider has been unable to sustain a good level of service or build on improvements. The history of this service demonstrates that the provider cannot sustain a good quality of service over a long period of time and many of the shortfalls found are repeated from previous inspections.

The provider's quality assurance systems and processes did not ensure that they were able to mitigate the risks relating to the health, safety and welfare of people and others who may be at risk in the service. The quality assurance systems were ineffective in directing sufficient resources into the areas that required improvement within a reasonable timescale. The provider had undertaken a large number of audits over several areas of the service and knew of many of the failing standards prior to the inspection. The provider had however failed to act on serious concerns despite the service having had involvement from external agencies for several months.

The majority of the providers' action plans were to be met by the manager. This meant the manager was unable to role model good care or provide oversight on 'the floor'. The manager was also tasked with investigating 16 safeguarding events. With some of the provider audits there was new paperwork or procedures introduced for staff. Staff told us they did not always know the reasons for these changes and that they were confused as to what was the correct way of doing things as there was repetition in the paperwork they completed. Comments from staff included "There is repetition of paperwork, need to sort out what paperwork needs to be in place. There is duplication, this needs to be sorted." "Paperwork is silly, recording the same things in different places. Don't have time to complete the paperwork."

Poor leadership was an issue from the provider level down; the failures to meet standards were compounded by a lack of effective leadership. The provider had failed to provide sufficient support to enable the manager to undertake their role effectively and to a good standard. There had been vacancies amongst the senior and nursing staff and a high level of sickness amongst care staff. This had affected the manager's ability to manage the service. This had meant the manager had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The lack of permanent nursing staff meant that care staff had little leadership whilst undertaking their role. When things went wrong nursing staff did not always take responsibility for reporting relevant incidents or take action to prevent recurrence. The staff culture within the service meant there was a lack of respect for senior staff and we saw care staff were openly insubordinate. We observed and heard staff openly criticising the manager

and provider amongst themselves and with relatives of people using the service. Staff meeting minutes also reflected this.

Staff and relatives made varying comments about the manager and senior management support. Staff comments included "The manager has had too much to do…staff have been resistant to change." and "Manager is approachable…no senior level support just new and on her own." Relatives said "I go to relative/residents' meetings, been to two since [manager's name] here, able to raise things" and "Newish manager, I get on ok but on a couple of occasions thought I had upset [manager] but [manager] has been ok. People we spoke with all made positive comments about the manager.

Sickness levels were high and the provider had failed to properly initiate procedures to manage sickness absences. There was a pattern to some of these absences; some staff took time off sick and then picked up extra shifts on their return at an overtime rate. This had caused friction between staff and had been poorly managed as the provider was focused on retaining staff.

Communication about changes in the service was poor. There was no effective handover between shifts and key information about people was 'lost'. Staff comments included: "No handovers, I normally start at 8am, told what floor to work on and that is it. Started doing a written handover about a week ago." "Don't know anything when you come in. Someone had been put on a thickener and I didn't know." "On a late shift handover doesn't happen." "There are no memos, emails, letters, texts in place to communicate to staff." One member of staff described not knowing a person had died until they went to their room to find them gone.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. We saw records which were incomplete and incorrect. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to safeguarding including allegations of abuse and neglect and when DoLs had been authorised. This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in October 2017, was appropriately displayed at the home and on the provider's website.