Castle Villas Limited

Clover House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days on 12 and 13 March 2018. The inspection was conducted because we received concerns in relation to provision of food, staffing and care practice. The last inspection of this service was completed in December 2016 and was given a rating of Good.

Clover House is a residential care home situated near to the centre of Halifax. The home provides accommodation, personal care and support for up to 39 older people who may be living with dementia or other mental health problems. Accommodation at the home is provided over four floors, which can be accessed using a passenger lift. At the time of our inspection there were 29 people living at the service.

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

There were not enough staff to safely meet the needs of people living at the home

Recruitment processes were followed to make sure new staff were safe and suitable to work in the care sector. Staff had received training but this was not evidenced in their practice. For example, although staff had received moving and handling training, we witnessed unsafe and inappropriate moving and handling manoeuvres.

Risks to people's health and wellbeing were not managed effectively. For example people who were nutritionally at risk were not receiving nutrition to meet their needs and alarm systems were not being used properly to alert staff to falls in people's bedrooms.

Medicines were administered as prescribed but systems for managing medicines required improvement. We made a recommendation in relation to this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

Mealtimes were chaotic and people did not receive the nutrition and hydration they needed to maintain their health. People were not routinely offered choice of food and drinks.

We saw district nurses were involved in some people's care. However staff had not referred people's weight loss to the appropriate health care professional.

We observed some caring approaches from staff but people's privacy and dignity needs were not met.

Care records were not person centred and not always up to date.

Visitors told us they were satisfied with the care their relatives received.

An activities programme was in place but we saw little evidence of people engaging in meaningful activities during our inspection.

Complaints were managed in line with the complaints procedure.

There was little evidence of effective leadership. Staffing was not appropriately organised and systems for auditing the quality and safety of the home were not effective. Records relating to people who lived at the home were not well maintained or kept securely.

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 time frame.

If not enough improvement is made within this time frame 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.

We identified eight breaches of regulation. These were in relation to staffing, person centred care, safe care and treatment, meeting nutritional and hydration needs, dignity and respect, need for consent, safeguarding service users from abuse and improper treatment and good governance.

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

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

Risks to people's health and welfare were not managed well. These had not been recognised or reported as safeguarding issues.

Safe staff recruitment procedures were followed. Staffing levels were not sufficient to meet people's needs.

Some improvements were needed to make sure medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective

People did not receive the nutrition and hydration they needed to maintain their health.

The service was not working in line with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff had received training but this was not evidenced in their practice.

Is the service caring?

Inadequate

The service was not caring.

We saw some caring interactions but people's privacy and dignity needs were not respected and maintained.

Is the service responsive?

Inadequate

The service was not responsive

People did not receive person centred care that was appropriate to their needs.

People were not supported to make choices. There was a lack of meaningful activities for people to engage in.

Is the service well-led?

Inadequate

The service was not well led.

Audits of quality and safety were not effective.

Records were not managed appropriately.

There was a lack of leadership and management of staffing to make sure care was delivered appropriately

Clover House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 over two days on 12 and 13 March 2018. Both days of the inspection were unannounced. Two inspectors attended on the first day and two inspectors and an assistant inspector attended on the second day.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

As this inspection was made in response to information of concern, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed how care and support was provided to people. We met and spoke with many of the people who lived at the home, however due to complex care needs; most people were not able to tell us about their experiences at the home. We also spoke with two people's relatives, five people who lived at the home, five members of care staff, the cook, a district nurse, and the registered manager.

We looked at eight people's care records in detail and checked information in another two people's care records. We looked at four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked around communal areas, bathrooms and some bedrooms.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we had received information that there were not enough staff available to meet people's needs safely. Over both days of our inspection we found this to be the case.

Staff rotas showed there were usually five staff on duty during the day and two staff at night for the 29 people who were using the service when we visited. The registered manager told us six people needed the support of two staff to meet their needs. Two of these people were being cared for in bed. Care staff had other responsibilities, particularly during the afternoon, when they were responsible for laundry duties and preparing afternoon drinks, heating the tea time meal and preparing the suppertime drinks. Care staff were also responsible for loading and unloading the dishwasher. This meant that not all care staff were available to provide care and support to people. The registered manager told us they used a dependency tool to calculate the numbers of staff required. However, other factors such as the fact that the accommodation was arranged over four floors and care staff extra duties were not taken into consideration.

The registered manager told us they were trying to recruit new staff to increase the staffing level at night to three. They told us they 'usually' had three staff at night. However, when we looked at the staffing rotas we saw that between 15 February and 12 March 2018 there had been only five occasions when three staff were on duty during the night. The registered manager agreed with us that two staff were not sufficient at night, particularly in view of the service being set over four floors and we saw they arranged agency cover for the night and the following night.

On the first day of the inspection while we were sat in the lounge a person stood up from their chair. They were unsteady on their feet and almost over-balanced; as we were sat next to the person we were able to steady them back into their seat. No staff were present or had been in the lounge for at least 15 minutes.

We saw another person in the lounge with a lithium battery which they kept putting in their mouth. We told staff about this when they returned to the lounge.

We concluded there were not enough staff available to meet people's needs or to maintain their safety.

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

Risks to people were not well managed. We saw staff left a drinks trolley unattended in one of the lounges and a person picked up a jug of Horlicks, drank from the jug and put it back down again. When staff came back in they were unaware this had happened until we told them.

The registered manager told us one person who was at risk of falling out of bed had a sensor in their bedroom which detected any movement and alerted staff by triggering the call bell. On the second day of the inspection we went to see this person in their bedroom and the alarm was not triggered. A staff member came back with us to the room and confirmed the sensor was switched on but had not triggered the alarm.

We reported this to the registered manager.

Whilst looking around the home, we saw a person hanging over the edge of their bed. We went to their assistance standing on the pressure pad which should have sounded the alarm. As the alarm did not sound we made the person safe and pressed the call bell. Again the alarm did not sound. We had to make sure the person was safe and leave the room to find staff. When care staff attended they told us the alarm system for the room was switched off.

These examples meant people could have fallen from their beds without staff being alerted.

Nutritional risks were not well managed. People's care records showed they had lost significant amounts of weight yet there was scant evidence to show this was being addressed. For example, one person had lost 10kgs since their admission to the home in October 2017 and had a BMI of 19. Their nutritional assessment stated they were to be weighed weekly, yet records showed they had been weighed only once in February 2018. The provider informed us following the inspection that weekly weights are kept separately.

Another person's care records showed they had lost 2.6kgs in a month and had a BMI of 18. The care records advised on 28 February 2018 that the community matron was to be contacted. There was no evidence to show this had been done or that any other healthcare professional had been informed.

We observed safe moving and handling practices were not followed by staff putting themselves and people who used the service at risk of injury. For example, staff did not the fit the handling belt properly on one person and proceeded to try to pull them out of their chair with the belt.

This meant people were not receiving safe care and is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe Care and Treatment)

We looked at how medicines were managed at the home. Medicines were stored in a lockable trolley or in a locked cupboard in a locked room in the basement. Room temperatures were taken daily of the basement room but no temperatures were taken of the lounge where we saw the medicine trolley was situated throughout our visits.

Medication Administration Records (MARs) showed medicines, including topical medicines were administered as prescribed and the deputy manager told us that time critical medicines were administered at the right time. There was a system in place for booking in medicines received at the home but we found this to be confusing and meant we could not accurately check balances of medicines to reconcile the amounts available with the amounts received and administered.

Protocols were in place for the use of 'As required' (PRN) medicines.

We saw the deputy manager was frequently interrupted by other staff or by answering the telephone whilst administering medicines.

We recommend the service considers current guidance on managing medicines safely, and take action to update their practice accordingly.

Systems and equipment were in place to manage infection control. Hand wash facilities and antibacterial wipes were available in all bathrooms and toilets. We spoke with the cleaner who told us they felt they had the time they needed to complete their work.

Staff we spoke with demonstrated an understanding of abuse and told us they would not hesitate to report something if they thought a person was at risk. They told us they had received training in safeguarding people. However, staff had not identified the issues in relation to people losing weight and lack of effective alarm systems or failure to use the alarm system as putting people at risk and therefore requiring referral to safeguarding.

This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safeguarding service users from abuse and improper treatment)

We made five safeguarding referrals following this inspection, one of these was a whole service safeguarding alert.

We looked at four recruitment records and saw appropriate checks were taken before staff were offered employment at the home.

Accidents and incidents within the home were reported appropriately and the registered manager had an overview of all incidents to look for any common themes for which action could be taken to mitigate against.

Inadequate

Is the service effective?

Our findings

Prior to this inspection we had received information of concern that people were not receiving adequate nutrition and that there were insufficient food supplies in the home. Whilst we found adequate stocks of food were in place, we observed people's nutritional needs were not being met.

Although we saw snacks such as cream cakes, fresh fruit, hard boiled eggs and milkshakes were brought out in the morning, afternoon and for supper, we were concerned people were not always receiving sufficient to eat and drink. One person told us snacks were not always offered at supper time, they said it depended who was on duty and sometimes they were only offered drinks.

We saw people were not always given sufficient time or support to eat. For example, we saw people were brought meals which were left in front of them and they only ate a few mouthfuls and the meal was eventually taken away. It was difficult to see how staff knew what people had eaten as different staff brought in meals and took them away and food and fluid charts were not filled in contemporaneously. This meant we could not be assured that food and fluid charts were an accurate reflection of people's intake.

We observed some people ate very little. One person told us they were hungry and we had to ask staff to bring them some more food.

On the first day of the inspection we arrived at the home as the tea time meal was being served in the dining room at 4.30pm. The choice of food was tomato soup; battered fish fillet with baked beans, sandwiches and jam tarts. When we asked the care worker what was in the sandwiches they opened them up, sniffed them, showed them to us and then put them back on the tray. They told us the fillings were tuna, beef paste and marmalade. The care worker told us they had cooked the fish and heated up the beans and soup; the sandwiches had been made by the cook before they left at 2pm. The care worker told us two people required a pureed diet and said they had been given fish, taken out of the batter, blended with mashed potato. There were 14 portions of fish two of which the provider said were extra-large and could be divided into two portions. However there were 29 people living at the home. This meant there were insufficient quantities of the cooked meal for people to be able to make choices.

We saw portions were small and there was no care or consideration given to people's individual needs. People having fish received a small portion, some with beans, others without. Those having sandwiches were given three or four sandwich quarters. No one was offered the tray of sandwiches so they could choose and help themselves; the care workers carried the sandwiches over to people in their hands. The hot food was not on a heated trolley to keep it warm. The mealtime was chaotic as there were not enough staff to provide people with the support they required. We saw one person had finished their fish and beans and was trying to eat another person's sandwiches with a spoon. The person whose sandwiches they were eating walked away from the table having eaten none of them. Staff were not aware of this.

We saw similar experiences for people at lunchtime on the second day of our inspection. Although some people were offered the choice of a baked potato, the majority were not and were given their meal of sweet

and sour chicken with vegetables and mashed potato ready plated. We saw one person received only a few spoons of cold soup for their meal as staff were not available to support them. Another person tried to eat their meal with their knife but gave up and left the table. We saw a staff member ask one person if they were enjoying their meal, they said no. No alternatives were offered or any further questions asked and the person got up and left the table. This meant people were not given the choice or support they needed to receive a diet to meet their needs.

We saw one person sitting in the lounge with their food in front of them left untouched and cold. After around 15 minutes the registered manager came into the room and asked the person if they had finished. They said, 'Yes I don't want any more'. However the registered manager then said 'Come on you can eat a bit more' picked up a spoonful of cold food and put it in the person's mouth.

At tea time on the second day of our inspection the choice of food was chicken soup, sandwiches with a filling of either tuna, cheese spread or jam and choc chip cake bars. We saw people were given a small bowl of soup and a plate with three sandwich quarters. We asked the care staff what people who required a pureed diet were having to eat and staff did not know. We went to the kitchen with one of the care staff and we were shown a plastic jug which the care worker said was the pureed food the cook had left them to heat up. None of the staff knew what the food was which meant they would not be able to tell people what their meal was or make an accurate record of people's nutritional intake.

People were not provided with juice at mealtimes and although one person asked for some repeatedly they were not served any. No condiments were available.

There were no effective systems in place to ensure people were receiving enough to eat and drink. Although food and fluid intake was being recorded daily the records did not reflect what people had eaten or drunk. For example, entries stated 'breakfast ate full' with no detail of what the person had eaten. Similarly there were no details of drinks with all entries stating the same quantities '1 cup/300mls'. On the second day of the inspection at 3.50pm we checked these records for two people. Records showed both people were at risk of malnutrition. The records had not been completed. We had observed both people throughout the day and saw they had eaten very little.

We looked at the fluid intake charts for one person. Records did not show any fluid offered to the person during the night which indicated the person had often not received any fluids for over 12 hours. One record showed they had not received any fluids between 4.20pm and 8am the following day. The amounts of fluid recorded as taken on the person's intake chart differed from the amount of fluid recorded as taken by the person on their daily record.

On the first day of our inspection at 5pm we saw one person in bed. A care worker told us they had given the person food and a drink at 4pm, however we saw the person's mouth and tongue were very dry. The food and fluid chart showed the last drink the person had was 'mid-afternoon' and the last food at lunchtime, although there was no detail to show what food or drink had been given. This person's care records showed they were at very high risk of malnutrition and required high calorie fortified food and drinks with regular snacks. There was no evidence to show this was being provided. When we returned on the second day of the inspection a new food and fluid chart had been put in place which detailed the food and drink the person was receiving.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Meeting nutritional and hydration needs)

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were unsure which people had a DoLS authorisation in place. When we initially asked the deputy manager and a senior care assistant which people had DoLS they were not able to tell us but later gave us a list of people who they said had DoLS authorisations. They were not able to tell us if the authorisations included any conditions. Another senior care assistant told us everyone had a DoLS authorisation. When we checked the list we saw people named whose authorisations had expired. The registered manager told us they had conducted an audit of DoLS in February 2018 and they were aware that three had expired. They told us they had submitted applications for further authorisations for these people.

Records relating to mental capacity and DoLS were confusing. For example, one person's care file included an assessment completed by their social worker stating that the person's daughter had a lasting power of attorney (LPA) in place for property and affairs and personal welfare. However, a mental capacity form in this person's records stated that there was no LPA in place. This form was undated and unsigned.

We saw records of best interest decisions. However we did not see evidence of best interest meetings being held to support or discuss these matters before decisions were made. In one person's records we saw staff had recorded that the registered manager would make decisions in the person's best interests.

We saw staff did not give people explanations of what they were doing. For example, on numerous occasions we saw staff telling people to go with them without giving any explanation about where they were going or what they were going to do.

We concluded this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Consent)

Records showed that staff received induction, training, and supervision on a regular basis. Induction was over four days and people then followed the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. Training was delivered mostly through 'Social care TV' with fire safety and moving and handling training delivered face to face. However, our observations were that staff did not put this training into practice. For example, we observed staff performed unsafe and inappropriate practice in relation to moving and handling. When we asked one member of staff what training they had received in relation to supporting people living with dementia, they were not able to tell us.

We concluded this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing)

Records showed that some referrals to healthcare professionals were made as the need arose. We spoke with a district nurse who told us staff had followed the advice of the district nursing service to heal one

person's sore skin. However, we noted that referrals to healthcare professionals had not been made for two people who had experienced significant weight loss. This meant the weight loss may not be investigated for possible underlying causes or treatment prescribed as needed.

Inadequate

Is the service caring?

Our findings

Whilst we observed some caring interactions, staff routinely showed a lack of respect for people. For example, we heard staff members frequently referred to everyone as 'darling', 'sweetheart' or 'love'.

We saw some staff lacked understanding in how to communicate with people living with dementia. They did not explain things in ways people could understand or give people time to take in what they were saying and respond. For example, we saw two staff assisting a person to transfer from a chair to a wheelchair using a handling aid. The person was visibly anxious and upset as staff had taken away the doll they were cradling, yet the staff were focussed on completing the task and kept repeating the same instructions to the person. The person clearly did not understand what the staff wanted them to do and eventually the staff removed the handling aid and left the person in the chair. There was no attempt to reassure or comfort the person or to give the person back the doll they had taken from them. We reassured the person and gave them their doll.

People's dignity was not respected. There was a lack of attention and consideration given to people's appearance. For example, we saw people with dirty fingernails, some people's hair had not been brushed properly, one person was wearing torn clothes, others had dried food stains on their clothes and gentlemen did not appear to have been supported to shave. Some people whose care records showed they wore glasses did not have glasses on.

We saw one staff member helping a person to have a drink. Some of the drink was dribbling out of the person's mouth and we saw the staff member wiped the person's mouth with the back of their gloved hand. Some people's care plans said staff used picture communication cards to help the person make choices. We did not see any evidence of these being used.

On another occasion we observed a person walk into the dining room visibly upset and crying. No staff intervened or attempted to comfort them. We sat with this person and asked what was wrong, they said, 'I don't like it, it's not fair'. The tissue the person was holding was wet and kept falling into the soup, which staff had put in front of them without any communication or attempt to comfort the person.

One person walked into the lounge with a staff member and the staff member helped the person into a chair next to us and left. When we turned to speak to the person we saw they had faeces on their hand. We brought this to the attention of the registered manager who arranged for another staff member to help the person.

We saw one person in bed. Their bed covers had fallen off and we saw an incontinence pad had been placed between the person's legs. They had not been provided with any underwear or pyjama bottoms. Another person in bed did not have a duvet inside the duvet cover and a third did not have a pillow case on their pillow.

In one person's bedroom we saw bags and suitcases piled up. When we asked the registered manager what

these were they told us they were videos belonging to the home. When we asked why they were being stored in the bedroom they said the person was only at the home for transitional (short stay) care. We also noticed one of the wardrobes in the bedroom was being used to store videos and saw the drawers in the room were dirty with bits of rubbish stuck in them. Although the registered manager asked for the room to be cleaned, this demonstrated a lack of respect for the person.

Staff showed a lack of care and consideration for people. On the second day of the inspection in the afternoon people were offered cream cakes which we saw they enjoyed. However, there were not enough tables in one of the lounge areas and we saw five people had to balance their cream cake on a saucer on their knees. No napkins were given out and people's hands were sticky and bits of cream cake were falling onto their clothes. We asked staff for napkins and took these to people. One person who had been assisted by a care worker with their lunch was not given any help with their teatime meal. The person was brought soup and sandwiches which were put on a table in front of their chair in the lounge and then staff left. We saw the table was not close enough and as the person was lifting the spoon to their mouth the soup was spilling down onto their clothes. They were not offered or given a clothes protector. The person then put their sandwiches in the soup and was trying to eat the sandwiches with their spoon.

We saw cutlery and crockery designed to help people living with dementia was used for everybody, whether they needed it or not. On the afternoon of the second day of our inspection a tea trolley was brought into the lounge with china tea cups on it. However, nobody was given their drink in one of these cups.

We witnessed a number of occasions when staff failed to respect people's privacy and dignity. Staff spoke openly about people within their and other people's hearing. For example, when we discreetly alerted a member of staff to a person who had been incontinent of faeces, they pointed at a person and said, 'You mean this one?' On another occasion when we asked a member of staff if they knew which people were at risk of weight loss they pointed at people saying loudly, 'She's losing weight, so is he'.

We saw one person trying to get themselves a drink from the trolley. Instead of offering support to enable them to do this, a member of staff said, 'Come out of the way and sit down'.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Dignity and respect)

Two visitors we spoke with told us they were satisfied with the care their relatives received at the home.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care and we observed staff worked in a task focused way that was not responsive to people's needs. Care records were not person-centred or sufficiently detailed to guide staff in how to deliver the support and care people required. Many of the care plans contained the same standardised phrases. For example, falls care plans all referred to people wearing appropriate footwear with rubber soles, making sure there were no obstructions in corridors or wires they could trip over. Nutritional care plans for people who were nutritionally at risk all contained the same standardised phrases about prompting/encouraging with meals, fortified diets and using dementia friendly crockery and cutlery.

There was no personalised information to show people's individual preferences around food and drink or how support should be provided. Personal hygiene care plans lacked details about bathing and showering such as whether people preferred a bath or shower, how often they liked to have one and the support they required from staff. This meant care and support was not planned with a person centred approach.

Care plans had not been updated to reflect people's current needs. For example, one person's falls care plan dated April 2017 referred to the person getting up in a chair, yet staff told us the person was nursed in bed and had not got up since November 2017. Another person's care plans were dated November 2016 and said staff were to support the person to shave, yet the person had a full beard. Another person's care plan dated December 2016 stated the person had a beard, yet we saw the person was clean shaven. This meant care plans were not up to date and reflective of people's current needs.

The care plan for a person whose skin integrity assessment showed them to be at very high risk of pressure damage had not been updated to reflect their current care needs and required interventions as directed by the district nurse.

We saw staff did not always work in line with people's care plans. For example, we saw staff using moving and handling equipment for a person whose care plan and related assessment said they did not require equipment for transferring. The use of this equipment appeared to confuse and irritate the person. When we asked staff why they were using it they told us it was because the person was not well that day. The person told us they were perfectly well and did not require this equipment to be used.

Care records did not always evidence whether appropriate care had been delivered or reflect events. For example, food and fluid charts did not evidence people had sufficient to eat and drink because the daily fluid intake was not totalled and food eaten was not accurately recorded. One person's care plan stated any aggressive or confrontational behaviour was to be recorded on a behaviour incident form. We witnessed an aggressive and confrontational altercation between this person and another person who used the service. A staff member took appropriate action to de-escalate the situation however this incident was not recorded in the daily notes or on the behaviour incident form. The last entry on the behaviour incident form was September 2016.

One person's care records showed they had received baths and showers. We had seen this person was being

nursed in bed. When we asked a member of staff about this they told us it was a mistake as the person was not able to bathe or shower.

We did not see people supported to use the bathroom unless they had been visibly incontinent and staff did not respond in a timely way when people asked for the toilet. An example of this was a person who told staff they needed the toilet quickly. The member of staff told the person they would have to wait until they could find somebody to help them. The person then had to wait over ten minutes for assistance.

Staff did not appear to be alert to people who had been incontinent. When we arrived on the first day of our inspection we saw one person had been incontinent. Staff did not notice this and despite us alerting them to this did not take any action to assist the person to change.

One person had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place dated October 2015. There was nothing on the form to show this had been discussed with the person or their relative and the valid till end of life box had not been ticked. We saw a hospital discharge letter dated October 2017 had identified the DNACPR form had not been completed properly however there was no evidence to show this had been addressed by the service. This meant staff could not be assured the DNACPR was reflective of the person's wishes.

Although an activity programme was in place, we did not see people engaged in meaningful activity. On the second day of our inspection we saw a tea dance was advertised for the afternoon. We saw a person came in to sing but this was very soon after lunch and not all people had been supported to leave the dining room to join the activity.

We saw some people engaged with dolls which appeared to benefit them. However when one person fell asleep and dropped their doll staff, although aware of the situation, did not pick the doll up for them. We helped the person when they were putting themselves at risk of falling from the chair trying to reach the doll.

People were frequently told by staff by staff to sit down without given any reason to do so. When we asked a member of staff why they told people to do this they did not answer us. However, we did notice on one occasion, a member of staff asking a person if they would like them to walk with them.

We saw a member of staff turn the television off and put music on instead. They had not asked the people in the room if they were watching the television or if they wanted to listen to music. On another occasion we noticed a person sitting in a position which made it difficult for them to see the television. They were craning their neck trying to see it. The person had previously been sitting where they had full view of the television and was watching the horse racing. We asked them why they were there and they said "They (staff) put me here."

This meant staff failed to support people to make choices and engage in activities of their choice.

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

We saw some personalised information about end of life care in two people's care files. These had been completed in 2016 and gave detailed information about the person's wishes such as the type of music they would like to listen to, who they would like to be with them and their funeral arrangements.

We saw where people had raised concerns or complaints; these had been managed in line with the complaints procedure. We discussed with the registered manager the benefits of recording whether the complainant was satisfied with the outcome.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. They were also the nominated individual for the service. Staff rotas showed the registered manager worked office hours at the service four days each week. They told us, and staff confirmed they often worked into the evenings.

Our observations on both days of our inspection were of a lack of effective leadership and organisation. For example, staffing was not organised effectively. Although the registered manager told us they had recognised there were not enough staff to meet people's needs during the night, they had failed to address this. We also noted staffing was not organised to make sure inexperienced staff were supported by those with more experience of the needs of people living at the home. This lack of organisation led to the chaotic atmosphere and lack of appropriate care we witnessed on both days of our inspection.

The majority of issues we identified during our inspection including unsafe moving and handling, lack of staff for support for people to eat and drink, , and lack of respect for people's dignity were not identified and addressed by the registered manager during our visit despite them being present throughout.

The registered manager told us they conducted a range of audits to assess the safety and quality of the service. Audits covered a number of areas including mattresses, bedding, laundry, staff training, DoLS, care plans, medicines, and environment. None of the issues we found during our inspection such as risks to people not being recognised or reported as safeguarding issues, alarm systems not being operated properly, lack of people's weight monitoring and person centre care throughout had been highlighted through the audit process which meant the audit process was not effective and people continued to receive inadequate levels of care.

On arrival on the first day of our inspection we saw a large pile of paper care records on a floor level shelf in the lounge area. Other care records were piled on a table and on top of the cupboard containing care plans which we found to be unlocked. The registered manager told us this was because they were in the process of archiving some records. We saw people who used the service picking up records from these piles and taking them to other areas. This failure to store records appropriately meant that confidential information could be accessed by anybody living at or visiting the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good governance)

A member of staff told us that staff meetings took place every couple of months and that they felt listened to and found these helpful. We did not see any evidence of service user or relatives meetings.

We saw satisfaction surveys were sent out to people who used the service or their relatives on an annual basis. We saw some feedback from the most recent surveys was positive.