Blacklake Lodge Ltd

Blacklake Lodge Residential 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

This inspection visit was unannounced and took place on 28 February 2017. At our last inspection visit on 20 January 2015 we asked the provider to make improvements to the deployment of staffing, supporting people with their decision making and their stimulation. The provider sent us an action plan in April 2015 explaining the actions they would take to make improvements. At this inspection, we found improvements had not been made and we observed additional areas of concern. The service was registered to provide accommodation for up to 37 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 32 people were using the service. The overall rating for this service is Inadequate which means it will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had did not have 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 provider had employed a new manager; however they had left the service after less than a month. Another manager had been recruited; however they had not commenced their employment with the home until the end of March 2017.

We saw that the previous rating was displayed in the reception of the home as required. The manager understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse.

We found that staff had not received recent training in safeguarding adults and showed limited understanding. The provider had not recorded accidents and incidents and documented the support people were getting after they experienced a fall. Risk assessment that had been undertaken were not in date or relevant to the current risk levels people had and we could not be sure the support reduced the risks for the people.

We found people's medicines had not been managed safety. Some people had not received their medicine and other people had not been supported when they refused their medicine over a period of time. The stock of medicines was not monitored and staff had not received the appropriate level of training.

The rights of people who did not have capacity to consent to their care were not consistently protected because the provider did not always follow the associated guidance. There was a significant shortfall in mandatory staff training. Staff competences were not checked regularly in various areas of practice including moving and handling and medicines administration.

People did not always have access to healthcare professionals as required to meet their needs.
Care plans did not demonstrated people's involvement. People and their relatives told us they were not consulted about their care.

The service could not demonstrate how they sought people's opinions on the quality of care and service being provided.

People enjoyed the food, however they were not always offered adequate drinks throughout the day. People were not supported with meaningful daytime activities and we saw the lack of activity had an impact on some people's behaviour.

Management systems in the home were not robust. The provider was not actively involved in the day to day running of the home. There had not been a consistent manager for the last six months.
Care staff did not feel supported in their role. There were no quality assurance systems in place to identify areas that needed improvement.
The provider was not meeting the Care Quality Commission registration requirements. They did not send notifications to CQC for notifiable incidents, such as serious injuries.

People had mixed views about the staff and the level of kindness. Some people had their dignity compromised. We found the service had a policy on how people could raise complaints about care and treatment however there was no evidence to demonstrate how complains had been received and dealt with.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009.
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
Safeguarding's had not reported and there were no systems in place to manage the concerns raised. Risk assessments had not been completed to ensure risks had been considered and measures put in place to reduce the risks. There were not sufficient staff to support people's needs. Medicines were not managed safely to ensure people received their medicine as required.

Is the service effective?

Inadequate

The service was not effective
The rights of people who did not have capacity to consent to their care were not consistently protected because the provider did not always follow the associated guidance. Arrangements for staff training, were not consistent and were not adequate to ensure all staff had the
necessary skills and knowledge to carry out their roles safely. People did not receive the appropriate support to access health care when they needed it. People were not always supported to maintain their independence or be supported with the appropriate dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring
People did not receive consistent care which was kind and individual. Independence had not been encouraged. People's dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not responsive
People did not receive care that met their needs. Care records did not always contain the most up to date information about people. This meant the provider could not demonstrate they were safely meeting people's current assessed needs. There were no activities to stimulate people and people told us they were bored. People and relatives could raise complaints about care and treatment however there was no evidence to demonstrate

how complains had been received and dealt with.

Is the service well-led?

Inadequate

The service was not welled

The provider was not actively involved in the day to day management of the home and there had not been a manager in post to support and run the home. The provider did not meet CQC registrations requirements as they did not send statutory notifications for notifiable incidents.
Processes to assess safety and quality assurance were not effective to cover all areas of care practice. Medicines audits had not been completed to identify areas of concern and maintain people's medical needs. Staff did not feel supported in their role.

Blacklake Lodge Residential Home

Detailed findings

Background to this inspection

We carried out this inspection visit 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. Our inspection was unannounced and the team consisted of two inspectors and an 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 care service.

This inspection visit was planned following the receipt of information of concern. We also reviewed notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We spoke with the local authority who provided us with their current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us at the inspection visit.

We used a range of different methods to help us understand people's experiences. We spoke with seven people who used the service and six relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas. We also spoke with four members of care staff, the cook and the provider. We looked at the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs and care records for six people were reviewed to see if they were accurate and up to date. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive

improvement. After the inspection we spoke with two social care and health professionals who worked closely with the home.

Inadequate

Is the service safe?

Our findings

At the previous inspection in January 2015 we asked the provider to make improvements to ensure people were safe using the service. We reported on these in our last report. During this inspection we found that Improvements had not been made and people were not protected from harm.

People were not safe. One person said, "I don't feel happy or safe. I want to go to another care home." A relative said, "[Name] has not been safe, they fell out of bed a few times." We saw that when incidents had occurred safeguarding referrals had not been made. We saw two incidents had occurred which would have required a safeguard referral to be made, when people had received harm. Safeguarding's enable professionals to review the risks and taken action to keep people safe from harm.

Staff we spoke with had not received training in safeguarding and had limited understanding about the different signs of abuse around safeguarding. One staff member said, "We have not had training for a while. I don't feel if I made a referral anything would happen." This meant that we could not be sure staff had the understanding of how to recognise signs of abuse, the actions they should take and when to raise a safeguarding referral. For example, we found that one person had sustained a significant bruise, staff were aware of this but no consideration had been given to how this had occurred and no record made of it.

We saw that a safeguarding concern had been raised by an external professional who visited the home and this had been investigated by the relevant authority and substantiated. A social care professional told us that during the safeguarding investigations they requested for the person to be supported with their toileting needs on a regular basis. At the follow up meeting they saw records which showed the persons care needs had still not been addressed in line with the guidance provided. This meant we could not be sure that the provider understood their responsibilities in relation to safeguards.

This demonstrates a breach of Regulation 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were not sufficient staff to support people's needs. One person said, "I wait a long time, up to half an hour." Another person said, "There are not always enough staff at different times." A relative said, "Sometimes I have to search for a member of staff if I need one." Another relative told us, "Last Saturday, I sat here for over an hour and didn't see a staff member." Staff members also confirmed that there were not sufficient staff to meet people needs. One staff member said, "There is not enough staff and we cannot provide personal care as often as we should or spend time talking to them [people that used the service] as we would like." Another staff member said, "There are sometimes more chiefs than Indians." A health care professional told us, "There has been an issue with the numbers of staff on duty, this has been reported to me by several health professional from our team. Until recently there had been a refusal by the provider to employ agency staff."

On the day of our visit one relative told us, "[Name] is only just getting up, its 11.30am, that is not ideal, I

hope they have had breakfast?" All the relatives we spoke with expressed concerns as to the level of staffing. The late time was not related to the person's choice, but in relation to the availability of the staff to support the person sooner.

During the inspection we saw people had to wait to be supported. One person said, "I called the bell this morning, but they were late and I had to wait ages." We saw during the day that on three occasion's people had to wait to receive their personal care. These people were sat in wet or soiled clothes for a period of time varying from 10 minutes to 20 minutes. A relative we spoke with told us, their relative had to wait over 40 minutes on Saturday, during which time they lay wet in their bed. On two occasions we had to seek staff to support a person's needs as there were no staff available and people needed staff assistance to support them and for their safety. This demonstrated there was not enough staff to ensure people received the support from staff when they needed it.

Throughout our inspection we saw that staff were not deployed or given clear guidance to ensure people's needs were being considered. For example during our visit we saw the lounge area was not supported by staff for large periods of time. There were a number of people in the lounge who required staff assistance to keep them safe and there was no staff available for them. This put people at risk of harm, when they mobilised around the home or when they requested assistance.

This demonstrates a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

During the inspection we saw three situations of potential incidents were people did not receive the correct level of support. For example, one person got up from their chair; they did not receive the support they required or assistance with a mobility aid. Another person reached for their frame. This had been placed out of reach; the person struggled to move the frame so they could use it. These people had been identified as being at risk of falls and these incidents put them at further risk of them occurring. On all of these occasions staff were not available to offer assistance.

We saw falls risk assessments had been completed, however we saw for some people the risk level was not consistent with the support provided. For example the risk assessments had identified some people as high risk, however the care plan referred to them as low or medium. We saw that risk assessments had not always been completed for risks associated with people's care. For example, it was identified that some people walked around the building at night. These people had movement sensors to alert staff when they moved, however there were no risk assessments in place. There was no information about how staff should respond to these people and there was no consideration given to if this mitigated the risks to people's safety while protecting their rights. There was not any ongoing information recorded about these and no evaluation of the use of the sensors. This meant we could not be sure that risks relating to people's health, safety and welfare had been assessed appropriately and that people were supported in line with their level of risk.

People were not supported appropriately to change position and prevent damage occurring to their skin. We saw one person remained in the same positon all day. We discussed this with the staff, they told us, "They should have pressure relief, but they don't like us moving them." Pressure relief is a term used to reduce the pressure on people skin area to avoid a sore being developed. Without the pressure relief care we could not be sure the person received the level of care to ensure they did not get skin damage. We checked

the records for this person and there was no entry of any pressure relief being provided. Staff were failing to mitigate the risks relating to this persons health and welfare.

Information provided by records and relatives identified that several people had fallen and this had not been recorded. For example, one relative told us, "[Name] had fallen. I only discovered this when they flinched when I touched their knee. It took several conversations with the office until they finally admitted they had fallen out of bed a few times." We looked at the records of accidents these did not reflect the falls relating to this person or other people we identified had fallen from some the daily record entries or in relation to people's sustained injuries. There was no evidence of action being taken to reduce the risks following a person's fall. This meant we could not be sure people were being supported to ensure their environment and their care was provided to make them safe.

We saw some people required equipment to transfer. There was no guidance relating to this in people's care plans. One person's care plan had identified they used a walking stick to mobilise. We saw this person used a frame. This meant we could not be sure staff had the information available to support them when assisting a person with specialist equipment in a safe way. We also could not be sure that the equipment recorded was the most appropriate to meet their needs and reduce the risks associated with their mobility.

People with behaviours that challenge others had not been supported and the risks to the person and others considered. There was no plans provided to identify the possible behaviour or triggers. Staff had not been provided with any guidance to provide a consistent approach. We saw that care had not been recorded when a person had refused care or had expressed a reluctant to receive care.
We saw the staff provided inconsistent support to people. For example, one person was shouting, a staff member moved them to a different part of the lounge, however the person continued to shout and move their chair backwards. Another staff member approached the person the first staff member said, "I have tried everything." It was not clear what interventions had been tried or if the staff had insight into what actions could reduce the behaviour." This meant we could not be sure people were supported in a consistent way. When health care professionals requested this level of detail to identify the level of support the person had received this was not available. A health care professional told us, "There is a general lack of understanding of common conditions in the home. Staff do not seem to understand the various presentation of a patient with dementia and how to approach them and manage the challenges they present in order to deliver care."

People were not protected from harm because their medicines were not managed safely. We saw that two people had not received their medicine as prescribed for two weeks. The prescription had not been followed up with the pharmacy and staff had not identified this as a risk to the person health. A safe and well check was completed by the local authority staff following the inspection. Further medicines errors were identified. For example, one person had been refusing their medicine; this had not been reported to the GP to consider other options of supporting the person with their medicine needs.

We saw there had not been stock checks on the medicines. We saw that on two occasions people had run out of their medicines. This meant we could not be sure people had enough stock in line with their prescriptions. Staff had not always been responsive when a person required a new prescription. One relative told us, "A prescription had been completed by the GP, because it was late in the day staff said they would have to wait until the following day. We then retrieved the prescription as it was important they start the medicine quickly."

We saw that some people require medicine on an as required basis (PRN). For some people this medicine was to assist them to become calm when they were distressed. The records showed this medicine had been given daily, there were no records to show why the medicine had been given and if it had reduced the

person's level of anxiety. This meant that we were not clear of the impact of the medicine on the person's health and wellbeing. We saw other people received medicine on a PRN basis; for their pain relief. There were no protocols to establish when or why this medicine was to be given. Some people had constantly received their pain relief, however there was no documentation to establish the reason why and if further medical intervention should be considered for their pain management

Some people had been prescribed topical creams, there was no medical administration record (MAR) or a body map to show where the cream should be applied or how often. Other people had prescribed creams which required storage in a secure place. We found the cream to be in the person's room with no medical label attached. This risk was increased as staff told us the person had fluctuating capacity and this medicine could be dangerous if ingested.

Systems were not adequate to ensure that people did not receive out of date medicines. Some people required eye drops, these had not been dated on opening. The date of dispensing was November 2016. Eye drops should be consumed within 4 weeks of opening, therefore we could not be sure these were still valid in line with their prescribed guidance. This meant people were not protected from harm because their medicines were not managed safely.

This demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw that checks had been carried out to ensure that the staff who worked at the home was suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

Inadequate

Is the service effective?

Our findings

At our previous inspection in January 2016, we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured when people lacked capacity that they received an assessment and that any decision was made in the person's best interest. At this inspection we found that further improvements were still required.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. People can only be deprived of their liberty to 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 Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. We saw that people who had fluctuating capacity were not supported to make decisions in relation to daily living choices. For example, where a person wished to sit, we saw people had to sit in the vacant space.
We saw during in the midday meal in one dining area, all the people were given a clothes protector. We saw one person objected, however the staff insisted the person had one on. We heard the staff making reference to the clothes protectors, "Put bibs on them or else we will have to change them after diner which is a waste of time." We saw how one person was not given the choice around the time they wished to go to bed. The person told us they wished to go to bed early, however the staff told us they were following guidance from a social care professional. This person's views had not been considered. Any health reason for the directed 'bed' time had not been explored, assessments and the least restrictive practice considered.

No one in the home had a capacity assessment. We saw decisions had been made stating the person did not have capacity; however no assessment had been completed to confirm this. For example one person received support with their finances; however there were no assessments or processes which showed how the decisions had been made. A health care professional said, "Staff do not seem to understand that some people need guidance to make decisions. The home had taken these people knowing they have mental health needs, however do not have the skills to support them."

DoLS requests had been made to the local authority. These had been made without an assessment being completed to consider the persons level of capacity in understanding if their liberty was being deprived. Some people had a DoLS authorisation. This had not been reflected in the care plan to consider the person's needs. Other people had restrictions placed on them in relation to motion sensors and use of door stops; they had not been referred to the authorising authority for an assessment.

This demonstrates an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff had not received the training they required to support their role. One staff member told us, "We have not had any training this year." Another staff member said, "We did training on safeguarding a couple of years ago, nothing recent." Some staff were not able to explain what they had learnt from previous training. We spoke with the provider about staff competency following any training; they confirmed that at present this has not been happening.

Staff had not been provided with training to support them to meet people's needs. Some people at the home had behaviours that challenged. Staff told us they had not received any training to enable them to manage this. One staff member said, "I have not had any training in this area since I have been in post." Another staff member said, "Some staff don't know how to speak to people and manage them." A health care professional told us, "Staff do not understand how to support people with transfers and give them instruction in simple tasks, such as standing from an armchair. I have witnessed staff watching people standing from an armchair whilst pulling up on their Zimmer frame."

The provider had not ensured the staff had completed medicine training prior to them administering medicines. No competency checks had been completed. One staff member said, "I have not had medicines training, I think we have some booked." We spoke to the staff about the errors in medicines administration. They confirmed they had not taken action swift action to support people to receive their medicines or that they had a clear understanding of all the aspects required to complete the medicines administrations for people.

At the last inspection the provider completed an action plan which stated, ' Additional training for Mental Capacity Act and Deprivation of Liberty Safeguards training had been completed by all staff over four training days' we could not see any competency checks that had been completed to ensure staff had understood the training and the requirements of the Act. Staff we spoke with had limited understanding of both the Act or DoLS requirements and confirmed they had not received any training recently in this area.

We saw there were two staff completing a shadow shift as part of their induction. These staff were observed on occasions throughout the day to be unsupported by an experienced member of staff. They had not received any mandatory training for their role. This put people at the service at risk as the provider could not assure themselves that staff had received the right training to enable them to meet people's needs. The provider was unaware of the requirements in relation to the care certificate which sets out common induction standards for social care staff and was introducing it for new employees. The provider told us this is an area they will look into along with the other areas of training identified as not being completed.

This demonstrates a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People did not always have enough to eat and drink. One person said, "I am up early, then it is a long time to wait for another cup of tea." One relative said, "I am going to query whether they have enough to drink, as there are no drinks around." People had been offered a drink mid-morning and mid-afternoon, however there were no other drinks available in the main lounge area or in peoples individual rooms room for people to access. People were only offered tea. One person's care plan stated they don't like tea or coffee and preferred juice. We saw this person was given tea. There was no monitoring of peoples fluid intake and this meant we could not be sure people had been receiving enough to support their hydration needs. We saw that some people had been weighed; however their weight loss had not resulted in any action. For example, one person had lost a considerable amount of weight in six days, this had not been referred to the health care professional.

We saw that not all the staff understood people's dietary requirements. There was nothing to identify people's specialist diets. We discussed people's dietary needs with the cook. They told us, "The staff informed me of people preferences, however I have nothing written." Another staff member who worked in the kitchen said, "I don't think anyone is on soft or puree diet, but I don't do the care plans." One person was on a fortified diet, when we asked kitchen staff could not confirm this person had received a meal which had been fortified. .This meant we could not be sure people receive their specialist diet for their needs. There was a risk that people were not receiving meals that were suitable for their dietary needs and this could have put people's health at risk.

We observed the midday meal. This was offered in two dining areas. In one dining area they had table cloths, however no napkins or condiments. One person had brought their own condiments. Another person told us, "The only thing missing with this meal is some salt." We asked the staff about condiments, they told us, "We tried having salt on the tables, but it goes in tea and everywhere." We saw that some people were not seated at the table correctly and got pieces of food over their clothing. Staff did not acknowledge this or support people to be better positioned to eat their meals.

People were not supported to maintain their independence. For example, people had not been offered equipment to support them to manage their own meal. We saw one person struggled for five minutes with their spoon upside down; we intervened and request a plate guard for this person. This meant we could not be sure people received the support they required to enable them to remain independent.

We saw that referrals had not been made to health care professionals in a timely manner. One relative told us how they had asked for physiotherapy for their relative after they had fallen. The home had said they would make a referral, however this was not done. We saw how two people required support with their continence needs. Health care professionals told us they had requested these people received an assessment, however records and staff confirmed these had not been made. During this period these people continued to receive support from incontinence wear which was not reflective of their own needs.

When health care professional had visited we saw records had not been updated to reflect people's needs and advice and guidance had not been updated. For example, a three day food chart had been requested for a person, this had not been completed. This meant we could not be sure people's health care needs were being met.

Requires Improvement

Is the service caring?

Our findings

We saw that some staff had formed positive relationships; however other staff showed a lack of respect to people. This was observed through the use of in appropriate language, 'he's a double 'these need 'feeding' and put a 'bib on them.'

There were mixed feelings about the relationships with staff. One person said, "The daytime carers treat me well. At bedtime not always." Another person said, "The staff are very good, but it's not like home." A relative said, "The staff are wonderful and they do not get enough credit for their efforts." Another relative said, "I feel they work very long hours, they are so busy and run off their feet".

People had not been given the opportunity to contribute to aspects of the home. For example, they had not been encouraged to make suggestions to the menu. The cooks said, "They have-not been asked about preferences and future choices." We saw some care plans reflected peoples likes and dislikes, however these had not been shared with the cook to consider how they could be incorporated into the menu planning

People were not encouraged to be independent. One person said, "The staff stop me walking, even though the Doctor said I need to walk to support my legs." Another person said, "I worry about walking on my own for fear of falling." A relative for another person told us, "They are supposed to encourage [name] to walk, but they just use the chair."

Some people felt they were unable to go to bed when they wished. Part of this was due to the bed not being made. A relative also confirmed that beds were often left unmade until the evening. We discuss this with the staff, they told us, "This person has continence needs, if the bed in not made they won't lie on it. If they lie on it too early then it gets wet."

People told us they did not always feel respected. People said, "The staff are kind, but lack of time means they are rushed." A health care professional said, "There is a reluctance to move people from the day room to their own room to support their privacy and dignity, when we provide them with medical care." This meant we could not be sure people received consistent kind care that was dignified.

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Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we asked the provider to make improvements in the stimulation on offer to people. We reported on these in our last report. During this inspection we found that the provider had still not made these improvements.

People were not encouraged or supported to access their interests or engage in some stimulation. One person said, "I am in the chair all day" Other people said, "There is a list on the wall, but it doesn't happen. I have asked twice for armchair exercises but nothing happens." Another person said, "There are no activities. I watch the television, but a singer comes in once a week." We saw that in the afternoon an external entertainer provided some singing entertainment. It was clear this person was a regular and some people enjoyed this. Other people were sat in a different lounge. One person said, "I prefer the quiet in here." Some people who were sat in the lounge with the singer seemed unsettled; they were not offered an alternative. People we spoke with told us they were bored. One person said, "We get bored at times and would like some activities on a regular basis." Another person told us, "I remain in my room, but would benefit greatly from having someone to chat with me."

A health care professional said, "I do not believe there is a structured activities programme in place to stimulate these residents, they are often sat around the lounge with the television on with no stimulation."

People and those important to them had not been involved in identifying their needs. One relative said, "At the meeting we had it was established that there was no information on [name]."They added, "It was agreed that we would have a meeting every three months but none have taken place."

We saw the care plans did not reflect people's current needs. For example, some people required support with their continence care. One plan stated that the person was able to use the facilities independently. Staff told us, the person should be wearing continence aids during the day. It was observed that this person was not wearing any continence aids and they were sat in wet clothes. Another person's plan stated they could change themselves. We saw and staff confirmed this person required assistance with personal care. These care plans were not reflective of people's needs and people were not receiving appropriate care. Other care plans had incorrect information recorded. For example, it stated one person should receive a soft diet with thickened drinks. Staff confirmed this was for a period when the person was unwell; however the plan had not been updated. This meant the information didn't reflect the care needs of people and there was a risk that staff would provide unsafe care for people that did not meet their needs.

The provider had introduced a computerised care system. This meant there were two systems running alongside each other. A staff member we spoke with said, "I have not looked at the care plans since it went on the computer." Another staff member said, "I don't feel confident using the computer, I am happier with written logs. I have not completed any logs since it has gone on the computer." This meant that information was not readily available to meet people's needs. For example, when we asked for information we had to wait for a staff member to finish on computer and then for another who was competent to use it. A health

professional told us, "There is poor communication and record keeping. When you review a person and ask questions staff don't generally know the answers without consulting a folder."

This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was a complaints procedure in place; however we could not be sure they had followed this as there were no recorded complaints. People told us they had raised concerns; however they had not been addressed. One person said, "I complained about my bed not being made. However nothing has changed." Relatives told us concerns had been addressed; however they had not had any formal correspondence. This meant we could not be sure the provider was being transparent with people and relatives when they raised concerns.

Inadequate

Is the service well-led?

Our findings

The leadership of the service was inconsistent. The provider did not have a thorough understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and how these should be implemented within the service . The provider told us they had been responsible for the financial side and had left all the care aspects to the registered manager. When the registered manager left the home, the provider had made arrangements for a senior staff member to support the running of the home, whilst they recruited a new manager. This person left the home before the new manager started. When the new manager did commence their employment they only remained at the home for two weeks. This meant the home was without a manager for over six months. The provider was unable to provide the leadership required due to their lack of understanding in relation to the regulations and required care needs of the people living at the home.

When the home did have a long standing manager the provider had not met with them to discuss the home or to obtain an overview of the home and any concerns or improvements which maybe required. This meant the provider had not considered their role as the responsible individual for the home to ensure the registered manager was complying with the regulations

The provider was unable to provide us with any audits and quality assurance tools. We saw that none had been implemented. We discussed the lack of audits with the provider; they acknowledge that there was a gap in this area and they needed to establish audits in the future. This showed us that there was not an effective system in place to monitor the quality of the service.

Incidents that had occurred in the home had not all been documented. We saw that in some records of the incidents actions had not been taken to reduce future risks for people. For example, one person kept falling from their bed, after several falls the family were asked to purchase bed rails for this person. The provider had not taken any immediate action to support the person to reduce the risks. By not recording all the incidents the provider could not consider any reoccurring risks to people or the home environment. Audits in relation to medicines had not been completed and this meant the provider had not been able to identify the range of concerns which would have been highlighted prior to the inspection visit. This meant we could not be sure the provider had the systems in place to ensure that risks to individuals were appropriately monitored or that actions had been taken to minimise these risks.

The care plans and risk assessments had not been reviewed. Some people had been living in the home for many years and some areas of risk had not been reviewed. For example, when people had a change in their health needs these had not been recorded or reassessments of their needs completed. This meant that we could not be sure people received the correct level of care to support their needs. There were no systems in place to enable the provider to identify this or to monitor the ongoing care that people received.

Systems in place had failed to identify where there was a reasonable doubt in relation to a person's capacity to make a decision that mental capacity assessments had not been carried out nor best interest decisions

completed. Systems had failed to identify that appropriate processes were not being followed to assess, monitor and mitigate risks relating to people's welfare.

We saw that staff were not guided to know how or who to support. The allocation of tasks did not ensure people's basic needs were being met and showed a reactive approach to peoples care. For example, when people had an accident this was responded to, however planned care for that individual could have avoided the accident occurring. There was a lack of effective monitoring of these situations which meant that people's health and safety was put at further risk.

Staff were not adequately supervised. They told us they did not receive the support they required for their role. Staff had not received any supervision to support their role, to identify their training needs and any guidance they required. For example, we saw some staff referred to people in an inappropriate way. The provider had not identified this and given staff the correct training and guidance to know how to support people. We saw that people had not been supported to give their consent to care and some staff did not understand the importance in giving people choices or how to support people with their decision making.

We saw meetings had not been held with people who use the service or the people who are important to them, to discuss the service and future improvements. Although relatives felt able to visit the home when they wished, all those we spoke with identified that communication was of concern. Relatives we spoke with were unclear of the management arrangements. One relative said, "Since the previous manager left we are not clear who is running the home." Other relatives said, "We have not been kept informed of all the changes, it's just what we hear from the staff." And, "There has been no correspondence from the home." This meant we could not be sure the provider was being open and transparent with the running of the home and the impact this could have on the care that is being provided.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There is a legal requirement for providers to inform us when specific events happen. We call these notifications. We found that in the last six months we have not received notifications in relation to safeguarding and serious injuries to people. We spoke with the provider about this. They told us they did not realise they needed to send us this information. This meant they had failed to report incidents relating to any possible impact on people's needs.

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

Roles and responsibilities within the home were not clear and staff were unsure who they were accountable to. For example, the previous owner of the home spent a lot of time within the home; however they had no role in the running of the home. Staff told us they did not know who to report things to, the previous owner or the current owner. One staff member said, "The lack of management has had a real impact, not knowing who is in charge."

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on their website when a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed the ratings certificate; however the correct information was not displayed on their website. We spoke with the provider about this

and they agreed to make the appropriate changes to the website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not reported significant events that occurred in the home. We had not received notifications from them for important information affecting people and the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured the care was personalised to meet the person's needs. People had not been consulted about their care and preferences. The provider had not provided stimulation to people to support their interests and hobbies or support their wellbeing

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not considered people having consent to their care in line with legislation and guidance. People had not received an assessment or provided with the support to ensure that decisions were being made in their best interest when they were unable to make decisions themselves.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. People had been placed at risk from not receiving their medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured their processes were robust to protect people from harm. Staff had not received training relevant to their role to enable them to recognise different types of abuse and how to report concerns

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not been established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Experience of using the service had not been obtained from people. Communication with people using the service and those important to them had not been established to share how the home was being managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people. The provider had not ensured the staff received training at a relevant level to

provide them with the skills to keep people safe at all times.