Gilead Care Services Ltd

Gilead House

Inspection report

Quality Street
Merstham
Redhill
Surrey
RH1 3BB

Tel: 01737648300
Website: www.gileadcare.org.uk

Date of inspection visit:
27 November 2017

Date of publication:
24 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Gilead House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Gilead House is registered to provide nursing and personal care for up to 22 people. There were four people living at the service at the time of our inspection.

This inspection site visit took place on 27 November 2017 and was unannounced.

There was a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 was also the Provider of the service.

At the last inspections on 12 May 2017 and 19 July 2017, we asked the provider to take action to make improvements in relation to the safety of people, the recruitment practices of staff, how people are being safeguarded against the risk of abuse, staff training, the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the involvement of people in their care, how people were respected, activities for people, the leadership at the service, the quality assurance and significant events being notified to the CQC. We found that these actions had not been completed.

People were not always being protected against the risk of infection. Staff were not always washing their hands and were not always following good practice in relation to clinical waste. Infection control procedures were not always being followed and according to the service policy.

Risks to people's care was not always being monitored in a safe way for example in relation to weight loss, people's mental health and ensuring people had access to staff at all times. Medicines were not always being managed safely. Accidents and incidents were not always followed up with actions taken to reduce risks to people.

People were not always protected against the risk of abuse. Robust recruitment was not in place to ensure that only suitable staff were working at the service.

We found that people's needs were attended by staff on the day of the inspection. However we have recommended that there are sufficient staff at all times so that people are not left unattended.

Staff had not received effective supervisions and nurse competency had not been assessed. Service mandatory was not effective and this was reflected in the practices we identified. Staff had not ensured that people had the capacity to make decisions for themselves as appropriate assessments had not taken place. However DoLS applications had been submitted to the local authority in the correct way.

There were times where people were left socially isolated and there was a lack of interaction from staff. People did not always have choices around their care delivery.

There were not sufficient activities taking place for people and they were not offered trips outside of the service. People told us that they were bored. Care plans lacked detailed guidance for staff and were not person centred.

Although relatives were happy with the care being provided we found that there was a lack of leadership at the service. Staff were not appropriately monitored and poor conduct was not investigated. Complaints were not recorded and investigations did not take place when complaints were made.

Quality assurance was not robust and did not identify all of the shortfalls we identified. Audits did not have actions plans in place to ensure that any shortfalls they identified were addressed. Records were disorganised, they were not always accurate and had conflicting information. The provider had not informed the CQC of significant events that occurred at the service, as required by their ongoing registration with the Commission.

Other risks to people's care were monitored by staff including the risk of falls and skin integrity. Other aspects to the management of medicines were dealt with appropriately including being aware of people's allergies and keeping medicines at a safe temperature.

In the event of an emergency staff had guidance in relation to how to support people if the service had to be evacuated. There was also a plan in place to ensure that people were evacuated to a safe place.

People were satisfied with the food at the service. People had a choice of what they wanted to eat and drink. There was sufficient amounts of fresh and nutritious food and drink available for people. Other than one concern regarding health care appointments people had access to health care treatment where needed.

People and relatives fed back that staff were kind, caring and respectful to them. We did see occasions where staff were attentive to people's need and provided dignified care. Relatives were able to visit when they wanted and people were able to personalise their rooms to make them feel more homely.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious 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.

Risk assessments were not always being undertaken where there was a need. Medicines were not always managed in safe way; however we did see some aspects of medicines administration that were safe.

We have made a recommendation that the appropriate numbers of staff are always available for people.

Staff were not always raising concerns where alleged abuse may have taken place.

Robust recruitment checks were not in place that ensured that only suitable staff worked at the service.

There were appropriate plans in place in the event of an emergency at the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not acting in accordance with the MCA 2005. People's capacity had not been assessed before decisions were being made on their behalf. However DoLS applications were submitted to the local authority in the correct way.

Staff were not always competent to carry out their role and training was not always effective.

People enjoyed the food at the service. Other than one concern people had access to health care professionals when they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always have time to spend with people. People did not always have a choice around their care delivery.

Staff did treat people with dignity and we saw occasions where staff were kind and attentive.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Inadequate

There were not sufficient activities for people to be involved in. People told us that they were bored.

Care plans were not written in a person centred way and did not always include guidance for staff around how care was to be delivered.

Complaints were not investigated or improvements made where necessary.

Is the service well-led?

Inadequate

The service was not well- led.

The provider continued to breach regulations from previous inspections.

There was not adequate management and leadership at the service.

Audits were not being used as an opportunity to make improvements.

Staff conduct was not always being addressed by the provider.

Notifications that are required to be sent to the CQC were not being done.

Gilead 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.

Gilead House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Gilead House is registered to provide nursing and personal care for up to 22 people. There were four people living at the service at the time of our inspection.

This inspection site visit took place on 27 November 2017 and was unannounced. The inspection team consisted of two inspectors and a specialist nurse.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. We reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with the provider who is also the registered manager, three people, one relative and four members of staff. We looked at a sample of three care records of people who used the service, medicine administration records and training records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

Inadequate

Is the service safe?

Our findings

At the previous inspections in May and July 2017 we found that risks to people were not always acted upon to keep people safe. At the previous inspection people's nutritional needs were not monitored appropriately, people's health needs were not being monitored and accidents and incidents were not always being followed up with actions taken. We found that medicines were not always being managed in a safe way and safe evacuation procedures were not in place. At this inspection whilst we could see that some improvements had been made, for example in relation to evacuation procedures, there were aspects to the safe care and treatment that remained a concern.

Although people we spoke with and the relative told us that they and their family member felt safe at the service we found that people were at risk of unsafe care.

People were not always protected against the risk of infection as appropriate measures were not in place. Since the last inspection the provider had installed a sluice machine to wash commodes and other soiled items. However on the day of the inspection there was a sign on the door of one of the communal bathrooms that stated, 'sluice clinical waste' that indicated that staff were using the bathroom to wash soiled items. The provider told us that they could not be certain that staff were using the sluice room as instructed.

In any care setting, hand hygiene is the most important activity for preventing the spread of infection from one person to another. We found that this was not always happening which put people at risk. Examples included a sink in the sluice room that had built up dirt and grime and it was evident that staff had not been washing their hands in there even if they had been using the sluice machine. The bin used to store clinical waste was kept in the garden. The bins had not been locked and we saw that clinical waste bags were in there. Staff were not aware that the bins needed to be secure to avoid unauthorised access, in line with the Department of Health's guidance on Safe management of healthcare waste. Although there was a check list completed by staff to show that people's rooms had been cleaned there were no check lists to identify when the communal areas had been cleaned including the lounge, dining room and bathrooms. Although the communal areas looked clean there was no evidence to show that they had received a deep clean to ensure that they were free from potential risks. After the inspection the Provider sent us evidence that the carpets at the service had been deep cleaned. There were people at the service that wore net knickers (to assist with keeping continence aids in place) however these were 'communal' knickers. This increased the risk of spreading infections. The service infection policy stated, 'Ensure staff have up to date training on infection control'. Nine members of staff had not received any training in infection control.

Risks to people's care were not always managed safely. For example, a MUST (a screening tool to identify adults, who are malnourished, at risk of malnutrition) had not been used by staff to manage risk. For one person staff were asked to record "Any unplanned weight loss in last 3-6 months." Staff had recorded that there had been "no unplanned weight loss in last 3-6 months" however the person had lost six kilograms of weight since admission to the service six months earlier. The MUST had been completed for the person on three separate occasions and on each occasion the person's height had been recorded differently with a

difference of nearly 30 centimetres. This meant that the tool was not being used effectively to assess the person's nutritional risks. Although the person's meals were being monitored there was a risk that staff were not acting on the most appropriate information.

Where people's food and fluid was being recorded there was no target amounts to identify if the person had eaten and drunk sufficient amounts. After the inspection the provider confirmed that fluid totals were being used on some charts however this was not consistent. Another person had been diagnosed with a mental health condition. There were no risk assessments in place in relation to the hallucinations the person had or what actions staff needed to take when these occurred. The only record of the person's hallucinations were on their daily notes but there was no evidence of any actions that had taken place to address this. One person had been left in their room on the morning of the inspection. We asked them whether they had access to a call bell if they needed to alert staff. They said they were aware they had one but did not know where it was. We noted that it was hanging on the wall behind them out of reach. Staff had not ensured that the person had access to their call bell before leaving them in their room. Soon after we visited the person in their room they were then supported to sit in the lounge.

There were aspects of the administration of medicines that were not safe. One person had been prescribed a medicine for their mental health condition. There are specific side effects to the medicine that staff needed to be aware of. However the nurse on duty administering this medicine was not aware of the side effects and no monitoring was taking place. There were gaps on the Medicine Administration Record (MAR) where staff had administered medicines but not signed to say this was done. This increased the risk of medicines not being given as and when prescribed. There was no evidence that the nurses had been competency assessed to ensure that they had the skills required to administer medicines.

Accidents and incidents were not always followed up with actions taken to help control risk and prevent them from happening again. For example on one incident form it stated that the person's MAR had the wrong medicines recorded on there. There was no follow up information recorded around how this was addressed or whether the person was actually given the wrong medicine. Another incident form stated that a person had sustained a "superficial" injury to their arm as a result of them becoming agitated. There was no additional information on how this could be addressed to reduce this risk of this happening again. A third person fell from their chair onto their knees. No information was recorded on how this risk could be reduced.

Failure to safely manage risks to people and the poor management of medicines is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in May 2017 we found that recruitment practices were not robust. On this inspection we continued to find that the provider was not following their own policy in relation to the recruitment of staff, and their recruitment practices did not fulfil the requirements of schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider told us that two references were required for each member of staff before they started work. In three of the recruitment files we looked at one did not hold any references and two files only had one reference in each. The provider told us that they knew that the references were still outstanding and that they had been meaning to chase this up. However all three members of staff had been working without the provider being fully satisfied that they were suitable. References needed to be undertaken to ensure staff were of good character which is a requirement of being registered with the Commission.

All staff had undertaken enhanced criminal records checks before commencing work. Application forms had been fully completed; with any gaps in employment explained. The provider had ensured that staff had

the right to work in the country.

As the recruitment procedures to ensure that staff employed were fit and proper this is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in May 2017 we found that safeguarding concerns had not been referred to the CQC or the local authority. The lack of reporting was putting people at risk. The local authority was the lead agency in deciding how concerns would be investigated. The provider told us prior to the inspection that all staff would be provided with safeguarding training to improve their knowledge of when incidents should be reported. At this inspection we found that this had not improved.

People were being put at risk because incidents of alleged abuse were not always being investigated. We identified from an accident report form that one person's relative found that their family member had a "fresh cut" and bruise on their arm. When a senior member of staff asked the person how this occurred they recorded that the person stated, "grabbed by a man by her arm." No further investigation had taken place. A member of staff told us at the inspection that it was more likely to have been that the person had delicate skin and not as a result of abuse. However as no investigations took place they could not make this determination. There was no evidence that the person had made false allegations in the past. We have notified the Local Authority of this incident. Although staff told us that they would report any concerns they had about abuse, and we saw that the telephone numbers of who to report concerns to outside the service were on a staff noticeboard, they were not putting this into practice and appropriately reporting possible abuse.

Failure to have an established system in place to refer safeguarding concerns and to ensure that staff understood what constitutes an alleged safeguarding incident is a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff levels had not been assessed based on people's dependencies. We were told by a member of staff that usually there was one nurse and one care worker each day. We noted from staff meeting minutes that staff had raised a concern in relation to leaving people unsupported in the lounge when two staff were required to support a person with their continence needs. It was agreed; (according to the minutes) that administration staff or kitchen staff (who would not have had the training and experience to provide support) would then support people in the lounge. Another suggestion that was recorded on the minutes was that one person (that was at risk of falls) be left in bed in the morning until all other people had been supported. According to the rota there was always one nurse and one care assistant on duty each day. However, there was one person that always required two members of staff for support with their care needs.

During the inspection there were appropriate numbers of staff deployed to meet people's needs. This was because in addition to the one care worker and one nurse on duty, additional staff had arrived at the service (after the inspection had started) to provide support including the provider and another senior member of staff. When people requested support from staff this was provided quickly. One person told us, "If I need anyone, they are always there."

We recommend that the provider reviews their system for determining the numbers of staff required so this is based on the dependency needs of people to ensure that people receive support when they need it.

There were other assessments were undertaken to identify risks to people. This included risks around their mobility and their skin integrity. The care plans identified the potential risk and gave instructions and guidelines to staff in order to manage those risks. Staff had knowledge of people's risks and we saw plans

being put into action on the day of the inspection. For example those people that required creams applied to their skin were having this done. Those people that required walking aids had these to hand when they were moving around the service.

Equipment was available to assist in the evacuation of people. Fire exits are clearly marked and free from obstruction and fire evacuation plans were displayed throughout. Staff understood what to do in the event of a fire. There were personal evacuation plans in place for people that provided staff with guidance of what they needed to do to assist people. There was a service contingency plan in place to provide staff with guidance of what they needed to do in the event of an emergency for example a fire or a flood.

There were aspects to the management of medicines that was safe. There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use. Temperatures for both the medicine room and the fridges were checked daily. The MAR chart had a dated picture of the person and details of allergies, and other appropriate information for example if the person had swallowing difficulties. The stock balance of each medicine was written on the MAR chart and the date the medication was opened was written on each box or bottle along with the name of the person.

Inadequate

Is the service effective?

Our findings

At the previous inspection in May 2017 we identified that staff did not always have the knowledge and skills required to support people. On this inspection we found that this was still a concern. We also identified that detailed pre-admissions assessments did not take place at the previous inspection. We did not review pre-admission assessments again as no new people had been admitted to the service since the last inspection.

Staff were not sufficiently qualified, skilled and experienced to meet people's needs. Although the provider had evidence of the nurse's revalidation the clinical competencies of the nurses had not been assessed appropriately. The provider told us that they had undertaken competency assessments for nurses. When we reviewed the assessments we found that the nurses had self-assessed their competency skills which were then signed off by the provider. On one of the forms one nurse had ticked that they had 'no experience' in unexpected death protocols, tissue viability, wound assessments, and bandaging principles. A second nurse had ticked to state that they had 'no experience' in MAR, lifting belts (to assist in mobilising people) or tissue viability. Despite this the provider had taken no steps to address this lack of knowledge and there was no evidence that nurses had been observed in practice. Although there was a clinical lead nurse working at the service they had not undertaken clinical supervisions with the nurse staff.

Although other staff were up to date with the mandatory training this was not always effective around their practices. We saw from supervisions with care staff that staff had requested additional training. One supervision record stated, "I would like to do more training to enhance my skills." There was no record of what training they wanted or that this had been provided. The supervisions that took place were no effective in identifying staff shortfalls or addressing any gaps in staff knowledge. We had identified on the day of the inspection shortfalls around infection control, MCA, safeguarding and clinical knowledge. The service training policy stated, "All staff will receive training in their roles, and this training will ensure that certain standards of competence are met." The provider was not following their own policy in relation to this.

As there is lack of staff training, knowledge and competency this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in May 2017 we found that the requirements of the MCA were not being followed. People had not been assessed in relation to their capacity to make specific decisions. Where decisions were being made for people there was no evidence to show that this was in their best interest. We found on this inspection that this had not improved.

MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. One member of staff told us that all four people living at the service lacked capacity to make decisions. They told us that they relied upon the relatives to make decisions on their behalf as they had power of attorney (this is a legal agreement that enables a person to appoint a trusted person - or people - to make decisions on their behalf). However the provider had not obtained any evidence that the relatives had power of attorney for their family members.

Decisions were being made for people without an appropriate specific MCA assessment. People we spoke with said they did not understand why they had to take their medicines, or what they were for. No assessment of their capacity around the decision to have their medicines had been completed. Staff could then not be certain that they were administering medicines with people's informed consent. There was a note in one person's care plan that the person's relative's view was that future medical appointments for the person should not be attended. There was no evidence that the relatives were able to make this decision for the person and no MCA assessment to establish if the person lacked capacity in relation to this. The provider confirmed that these appointments would now be attended by the person. Another person was advised by a health care professional to restrict certain aspects of their diet. The person took the decision to ignore this advice which put them at risk. No MCA assessment had taken place to ensure that the person had the capacity to make this decision or that they understood the risks. There was no evidence that decision specific MCA assessments had taken place or any evidence of best interests meetings. We asked the provider why decision specific assessments had not taken place and they told us that they thought they had. The only MCA assessments that had taken place were in relation to whether the person understood about whether they should live in a care service.

As the requirement of MCA and consent to care and treatment was not followed this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We noted that DoLs applications had been completed and submitted in line with current legislation to the local authority for people living at the service.

People told us that were satisfied with the food on offer. One person told us, "They [staff] come and ask 'Do you like this? Do you like that?'" Another person said, "I can eat anything {I want]." The chef was aware of people's individual dietary needs and preferences and these were also listed on the kitchen wall. The guidance around one person's restrictions around eating and drinking needs from the speech and language therapist was also on display. The chef told us that they cooked food from scratch. We saw that people had two choices of meal and they told us that they enjoyed the food on the day. People had the choice of where they wanted to sit at meal times and we saw that one person chose to eat in their room and this was respected.

Other than the concern identified with one person's health care appointments other people had appropriate access to health care services in their ongoing care. There was evidence in care plans that a wide range of healthcare professionals were involved including the Tissue Viability Nurse, GP, speech and language therapist, physiotherapist, optician and dentist. Staff were aware of what they needed to do to monitor a person's health. One told us, "The GP used to visit weekly but now the surgery calls the home each week to ask if any of the residents needed to see a doctor and only attend if necessary."

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in May 2017 we identified that people were not receiving care in a person centred, dignified and respectful way. On this inspection we found that whilst there had been improvements we did identify some concerns around lack of interaction and choices of care delivery.

People told us that staff were friendly and treated them well. One person told us, "I get on with them [staff]." Another told us, "They really look after you." One relative told us, "[Member of staff's name] had energy and empathy." They said of another member of staff that they were "Very motherly but very professional."

Despite these comments we found at times that people did not receive social interaction with staff. For example one person was brought into the lounge and left on their own for an hour before any staff interacted with them. We saw from meeting minutes in September 2017 that this had also been raised as a concern by relatives. However this had not been addressed. There was a person who was in their room on the morning of the inspection. When asked if staff came into their room to see how they were they stated, "Not really." There was very little information in people's care plans about their backgrounds and who they were that would assist staff in generating conversations with them. One member of staff when asked was not able to tell us what one person's background was and confirmed that they had not asked about this information.

People did not always have choices around their care delivery. According to their care plan, one person had requested that they only received personal care from female staff. However there was a record in their care plan from the provider stating, "Doesn't matter female or male she can accept any." This showed that the choice had been taken away from the person. Another example of the lack of choice centred around one person who was at risk of falls. The minutes from a staff meeting stated, "[Person's name] shouldn't be coming out this early from bed, she should be the last to get up." The reason given (according to the minutes) was so that staff could attend to other people first. The choice of when to get up had not been offered to the person. The decision to get the person up last was to fit in around the staff. We observed on the day of the inspection that the person was the last to receive morning personal care.

As people did not always have choices around their care delivery and did not have meaningful interactions with staff this is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some kind and caring interactions with people. During lunch one member of staff sat with people at the dining table asking them how their meal was. On another occasion a person spilled their drink. Staff reassured the person and ensured that they were ok.

We looked at care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans were reviewed regularly by staff and signed by people, relatives or representatives. We found evidence that people and/or their representatives had regular and formal involvement in ongoing care planning.

When staff provided personal care to people this was provided behind closed doors to protect people's dignity. We observed staff knock on people's doors before they entered. When staff spoke with people they did this in a polite and respectful manner. One relative said, "Dignity is respected here."

People were able to personalise their room with their own furniture and personal items so that the rooms felt more homely. We saw that family and visitors were able to visit the home whenever they wanted.

Inadequate

Is the service responsive?

Our findings

During the inspection in May 2017 we found that people were not being provided with activities that they enjoyed, pre-admissions assessments had not been completed in any detail and care plans were generic and lacked specific personal information about people. On this inspection we found that this had not sufficiently improved to meet people's individual needs and preferences.

We asked people whether they felt there were sufficient activities for them to take part in. One told us, "No not really. Just sit there and listen to the radio or the television." Another told us, "No not very much at all. All we do is this drawing stuff [referring to the pictures we saw around the lounge]." We also asked people if any trips took place outside of the service. One person told us, "No I don't go out." When asked if the person got bored they said, "You do rather."

There was a lack of person centred activities and engagement for people living at the service. During the morning of the inspection there were no activities taking place. There was no activities coordinator employed at the service and staff during the morning were busy providing personal care to people. One member of staff told us, "We have a family member that does some activities and staff do activities." One relative confirmed to us that they provided activities in the service. However activities were not person centred on people's individual interests. In the afternoon a member of staff sat with a person doing a puzzle. However there was another person in their room who told us that there was nothing meaningful for them to be involved in. One person's care plan stated, "I am able to participate in activities that are conducted in the home. I require some encouragement and support from the staff to do this."

There was a risk that staff were not providing the most appropriate care to people. Where a particular mental health condition had been identified there was not always guidance for staff. There were no behaviour or support plans in place or information on what interventions had been tried to support the person. One member of staff was unable to tell us whether the mental health diagnosis was recent to the person. Another person's care plan recorded, 'Care plan for impaired physical mobility' which stated "Provide range of motion exercises every shift." This did not happen during our inspection and there was no evidence that it ever happened as it was not recorded in their care plan. In the DoLS application for one person it stated "[Person's name] can be both verbally and physically challenging." However in the person's initial assessment the section headed 'Challenging behaviour', the provider had recorded "No history." There was no evidence anywhere else in the person's care plan that they had exhibited challenging behaviour since moving in to the service. The provider told us that the person did at times display this challenging behaviours but there was no guidance for staff on how to best support the person.

Care and treatment was not always provided that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we recommended that the provider reviewed the complaints procedures as they were not always recording complaints when they were received. This had not improved on this inspection.

Complaints were not always investigated and responded to appropriately. We were aware of complaints that had been made by relatives (according to the minutes of the relatives meeting) in relation to staff leaving people unsupported and staff sleeping on duty. There was no evidence that these complaints had been investigated or any actions taken. We asked the provider to send us evidence of the complaints records as they could not locate this on the day of the inspection. To date this has not been provided.

As complaints were not always recorded, investigated and proportionate action taken this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspections we identified that there was a lack of robust quality assurance processes in place, the provider (who is also the registered manager) did not have knowledge of all events occurring at the service and the people and relatives were not always involved in the running of the service. The provider sent us an action plan to advise that all of these actions had been addressed. However on this inspection we found that this was not the case and sufficient improvements had not taken place.

Relatives at the service told us that they were satisfied with the care being delivered. They stated that since their family members had moved into the service they felt that their family member's conditions had improved.

Despite this positive feedback from relatives we had continuing concerns about the management and leadership at the service. The provider told us that they attended the service every day during the week. However when speaking to staff and reviewing the signing in book we found that this was not the case. When we asked staff who the day to day manager was there was conflicting information provided. Two staff told us that the manager on duty was the nurse however one member of staff told us, "There is a lack of leadership." There was no structure in place to ensure that staff were clear on what their responsibilities in place. When we spoke to the provider they told us that they knew that they should not have registered as the manager. They told us that they had been actively recruiting a registered manager and that this was because they knew they did not have the time or skills for this role.

Robust systems were not in place to address the conduct of staff. We saw from staff meeting minutes in September 2017 that there had been complaints from relatives that staff had been falling asleep on duty. The response (according to the minutes) was that staff may be feeling unwell and staff should be open if they feel unwell. At a meeting with the local authority on the 8 November 2017 the provider stated that there were staff at the service that were working elsewhere. They stated that they may be coming on duty after having worked a shift at another service which could account for them falling asleep. People were being put at risk if staff were falling asleep on duty. However on the inspection there was no evidence that this had been addressed by the provider.

There were insufficient quality assurance systems in place to ensure the best delivery of care. Although there had been residents and staff meetings these were not always used to make improvements. During these meetings it had been raised that people had been left on their own in the lounge and we found that this was still happening. Audits that took place did not always identify what we had identified. For example a hand hygiene audit and recruitment audit had taken place in October 2017 and no concerns had been identified despite the shortfalls we identified on the day. Where audits had taken place there was no action plan in place to identify when the shortfall would be addressed. For example the provider had commissioned an external audit to review the MCA assessments for people. The auditor had identified that MCA assessments needed to be decision specific for people. The provider had not addressed this when we inspected.

Records were not always being maintained or updated with accurate information. One care plan had

contradictory information which could lead to confusion by staff on what care was required. For example, one care plan stated, 'Care plan to promote and maintain skin integrity. Turn and position patient every two hours.' When we asked a member of staff for the person's turning charts they told us they did not need repositioning as the person was able to turn themselves in bed. Their care plan also stated in one part that they had a history of falls and in another part that they had no history of falls. The records showing the application of creams were not always being completed accurately. All four people in the service required creams to be applied each evening. However staff were recording that all four people had they creams applied at the same time each evening at 22.00 which would not be possible given there were only two members of staff on duty. The records that were kept in the office at the service were disorganised. On the day of the inspection there were documents that could not be located and had to be provided after the inspection.

The PIR that was completed did not reflect the care that was being provided.

As there was a lack of leadership, systems and processes were not established and operated effectively and records were not always accurate this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in May 2017 we identified a breach in relation to the lack of notifications that needed to be notified to the CQC. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found that this was still not happening. On the day of the inspection we identified that a person had alleged abuse had taken place. CQC had not been notified of this and the provider was not aware that the incident had taken place. This is a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was contact with by staff with health care professionals in relation to the care being provided. Tissue Viability Nurses and Speech and Language Therapists had been contacted by staff to obtain advice about the best delivery of care for people.