Care Quality Commission

Scaleford Care Home Limited

Scaleford Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 21, 22, 23, 24 & 28 July 2015.

Scaleford Care Home is situated in a residential area of the Marsh in Lancaster and overlooks the River Lune. Bedrooms are situated over two floors and a stair lift is available to assist people with poor mobility to gain access to the upper floor. There are three lounge areas and a dining room. There were 20 people living at the home on the first day of inspection. This reduced to 19 people on the third day of inspection.

A registered manager was in post at the time of the inspection, however before we visited the home we were informed by a registered person, that the registered manager was going to be absent from their post for 28 days or more. A registered person is registered with the Care Quality Commission to manage the service. 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 service was last inspected 29 January & 02 February 2015. The registered provider did not meet the requirements of the regulations during that inspection as multiple breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Summary of findings

2010 were identified. Breaches were identified in assessing and monitoring the quality of service provision, safeguarding people from abuse, cleanliness and infection control, requirements relating to workers, management of medicines, safety, availability and suitability of equipment, respecting and involving people who use services and supporting staff.

We also identified continued breaches to consent to care and treatment and staffing.

The registered manager sent us an action plan explaining what they were going to do to rectify these breaches.

People were not safe. Suitable arrangements were not in place to protect people from the risk of abuse. Processes were not in place to ensure that safeguarding alerts were identified, reported and responded to appropriately. Safeguards were not in place for people who may have been unable to make decisions about their care and support. Management of falls and behaviours which challenged the service was poor.

Suitable arrangements were not in place to ensure that medicines were managed correctly. We noted that ointments and creams were not appropriately stored in a secure place to ensure they were only used by the person for whom it was prescribed. Procedures for administering soluble tablets did not take into account risk of other people taking the medicines. Medicines were left unobserved on the table. Staff signed for soluble medicines before the person took the medicines. A sharps box and needle was not stored securely to protect people from harm.

Staffing levels had not been assessed by the provider to ensure that staffing levels met the needs of the people who lived at the service. Staff members told us there was not enough time to carry out all their required tasks and this was evident by the poor quality of the paperwork. Only five of 19 care plans were up to date.

We observed poor standards of hygiene and cleanliness throughout the home. Infection control processes were poor, placing people at risk of harm from infection. Action plans set by the Local Authority infection prevention team had not been completed.

Training for staff was poor and staff said that they were not supported within their role. Recruitment procedures were not robust to ensure the suitability of staff employed. There was no induction process in place for new staff and key training for all staff was incomplete.

Management of the home was poor. Equipment was not maintained to a safe standard. There were no quality audits in place to ensure that the service provided was meeting the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Leadership was described as poor. There was a closed culture within the home and staff were not encouraged to be involved in how to make improvements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

You can see what action we have taken at the back of the report.

Summary of findings

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.

The provider had failed to ensure that staffing levels were deployed to ensure the safety and welfare of the people who lived at the home. Robust recruitment procedures were not implemented and always followed.

Accidents and incidents were not consistently recorded and reported to other agencies in the appropriate manner.

Premises and equipment were not appropriately managed and maintained and people's safety was compromised. Procedures to manage the spread of infection were not adequately managed.

The provider failed to have suitable systems in place to ensure that medicines were managed safely and stored securely.

Is the service effective?

Inadequate

The service was not effective.

The provider had a poor understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and had not followed guidance accordingly. Consent was not gained by appropriate means and people were being unlawfully deprived of their liberty.

Staff were not equipped with the skills and knowledge required to carry out their role.

Health needs of people using the service were sometimes met. Records demonstrated that health professionals were consulted with for support and assistance.

People's food and nutritional needs were being met.

Is the service caring?

Requires improvement

Staff were not consistently caring.

People who lived at the home and their relatives told us staff were caring. We saw that staff treated people with patience and compassion. Staff showed a genuine interest in the people who lived at the home.

Privacy and dignity was sometimes compromised

Is the service responsive?

Requires improvement

The service was not always responsive.

Processes to respond, record and manage complaints were not in place. Complaints had not been responded to and acted upon.

Summary of findings

Care records were inaccurate and not up to date. This meant that risks to people's health and welfare were not appropriately managed, placing people at risk of harm.

An activities coordinator was in place to organise activities but the activities did not always take place if there were not enough staff on shift.

Is the service well-led?

Inadequate

The service was not well led.

Systems and processes were not in place to ensure that the service provided met the required regulations.

Staff turnover was high and the provider was unable to retain staff. Staff described the management of the home as weak and reported a negative atmosphere with a culture of blame.

Quality systems were not in place to ensure quality of service provision was achieved and that premises were safe and conducive to the needs of the people who lived at the home.

Scaleford Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection carried out over five days on 21, 22, 23, 24 & 28 July 2015. The team consisted of three adult social care inspectors and an inspection manager on day one and two inspectors on each visit thereafter.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

We undertook this inspection in response to some concerns we had received in relation to the care being provided at the home and to check whether the provider had made improvements to ensure they were now meeting their regulatory requirements.

Prior to our visit we spoke with the Local Authority contracts and commissioning team, the Local Authority safeguarding team and the Local Authority environmental health team to gain information relating to the quality and safety of service provision. The Local Authority contracts team confirmed that they were currently working with the service provider to improve the service being provided.

Information was gathered from a variety of sources throughout the inspection process. We spoke with nine staff members at the home. This included the registered provider, the care manager, the cleaner and five members of staff responsible for delivering care.

We spoke with three people who lived at the home to obtain their views on what it was like to live there. We observed interactions between staff and people to try and understand the experiences of the people who could not verbally communicate.

We carried out an observational assessment using a SOFI (Short observational framework for inspection) over lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three relatives and a friend of a person who lived at the service to discuss how satisfied they were with the care provided.

To gather information, we looked at a variety of records. This included care plan files belonging to six people who lived at the home and recruitment files belonging to five staff members. We also viewed other documentation which was relevant to the management of the service including minutes of team meetings, cleaning schedules, health and safety certification & training records.

We looked around the home in both public and private areas to assess the environment to ensure that it was conducive to meeting the needs of the people who lived there.

Inadequate

Is the service safe?

Our findings

We spoke with three people who lived at the home. They told us that they liked living there and that they felt safe. One person said, "All the staff are grand, they talk to me and make me feel safe, they make me feel like nothing is wrong."

We also spoke with three relatives and friends of people who lived at the home. No-one expressed any concerns about the safety of people who lived at the home. One relative said, "I've no complaints. The staff are friendly and keep me informed. I know [relative] is safe here."

Although relatives and people who lived at the home felt that people were safe this did not reflect our findings.

At our inspection in January 2015, we identified a breach in staffing. We received an action plan from the registered manager that demonstrated that the provider was continuing to face difficulties to recruit staff to work at the home. The registered manager informed us that staff turn-over at the home had increased since the last inspection and that they had been unable to fill staffing vacancies as they arose.

The day before our inspection on 21 July 2015, we were provided with information from the Local Authority contracts team that highlighted they were concerned with staffing levels at the home. The Local Authority team supplied us with a rota for that week. The rota listed all the staff that were working at the home. We compared the list of staff against the information we had from our inspection in January 2015. This showed that since January 2015, eight staff members had left the service and three members of staff were working their notice. Five new staff had been recruited, but two of these had left. As part of the first day of inspection 21 July 2015, we spoke with the registered provider who confirmed that this was the case.

During our inspection visits in July 2015 we spoke with the registered provider about recruitment and staff turnover at the home. The registered provider said, "We need a manager and we need staff."

We reviewed how the service was being staffed to make sure that there was enough staff on duty at all times, to meet people's needs and keep them safe. At our last inspection in January 2015, we noted that staffing levels were inadequate, staff employed told us that they were stressed and under pressure to work long hours. We used this inspection to see what steps had been taken to ensure sufficient numbers of suitable staff were on duty to keep people safe and meet their needs.

We looked at the rotas for the service to assess staffing levels. Rotas from the two weeks prior to the inspection demonstrated that all care staff were rota'd to work thirteen hour days. Staff were also rota'd to work thirteen hours per day for the next two weeks.

We spoke with six members of care staff, every member of staff said that staffing was a problem. Staff said that since the previous inspection nothing had been done to alleviate staff from working long shifts. One staff said that they regularly worked four thirteen hour days each week. Another staff member told us that the job was stressful and that they had accepted the job on the basis that shifts were seven hours long but due to continued difficulties with staffing they had to work thirteen hour days. One staff member told us that the long shifts also caused disharmony between staff stating, "Staff sometimes get wound up with each other because of the long hours."

Staff said that they were still stretched and unable to carry out their full duties diligently. One staff member stated that, "Staffing levels were horrendous."

Staff told us the registered manager had recruited some staff since the last inspection; however some of these staff members had no experience in working in care. Staff told us such staff needed a lot of support when they first started work and this impacted upon them as they were already finding it difficult to carry out their own roles and responsibilities.

The registered provider told us staff sickness still continued to be a problem. On two of the five days we visited the home two different staff members called into work sick. One other staff member was absent from work due to sickness for the whole duration of the inspection. On the first day of inspection we asked the registered provider for a copy of the rota. The registered provider informed us the rota was not complete as staffing levels were not achieved and they were currently working on arranging staff cover for that week. This demonstrated that although staffing levels on the first day of inspection were complete, suitable arrangements were not in place to ensure staffing levels

were adequate and maintained. The registered provider informed us they were using agency to maintain staffing levels. The rota confirmed that agency staff were being deployed to work at the home.

We asked the registered provider what action had been taken to assess the dependency levels of the people who lived at the home but they were unable to provide any evidence to show dependency levels had been assessed and reviewed. The registered provider said this would have been the registered manager's job.

We spoke with the registered provider about recruitment and asked them how they had progressed since the last inspection. The registered provider said they had recruited some staff but there had been difficulties retaining staff. The registered provider said, "Staffing has not been addressed properly, we need more competent staff, some staff should not have been taken on. We need to change the ethos of the home; we need to attract good staff. We need to employ more staff and have a bigger bank of staff."

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to ensure that fundamental standards of care were achieved.

We looked at recruitment processes carried out by the registered provider to ensure they were robust, to protect the people who lived at the home. To do this, we looked at four staff files belonging to people who had been recruited since the last inspection. The registered provider did not have rigorous systems in place to assess the suitability of people who were to be employed. Effective systems were not in place to make sure staff were only recruited who were suitable to work with vulnerable adults. Although two staff members informed us they were unable to start work until a valid Disclosure and Barring Service (DBS) check had been completed we found evidence in another person's file that suggested this person had worked for over eight weeks on an ISA first check. An ISA first check is the first stage of screening of a person by the (DBS), who check that people are of suitable character to be employed within a care setting. ISA first checks allow staff to be employed in urgent circumstances before the full DBS check is completed. In order to work using an ISA first check, staff must be constantly supervised within their role and are not permitted to undertake personal care. We asked the care manager if this person had been appropriately supervised for the eight weeks whilst they were awaiting their DBS confirmation. The care manager confirmed they had not been supervised for this period of time.

Two of the four staff employed since the last inspection had incomplete applications within their files. Staff members had not provided a full employment history despite it stating on the application form to do so. There was no evidence to show that the registered manager had explored these gaps in employment. A full employment history allows a manager to ensure that they can account for the previous history of the person and allows managers to assess the suitability of the applicant. This had been discussed with the registered manager at the previous inspection but still had not been actioned.

Following the inspection in January 2015, the registered manager provided an action plan which stated that a new procedure was in place for recruitment. We asked the registered provider if a new recruitment policy had been drafted since the last inspection. The registered provider said that he was unaware of one as this was not within his remit and could not find any evidence to demonstrate that this had been actioned and worked upon. The care manager was also unaware of a new policy.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider did not have suitable systems and processes in place to ensure that people who were employed were of good character and had the competence, skills and experience which are necessary for the work they are performing.

The registered manager had stated within the action plan returned in July 2015 that infection control systems and processes had been implemented to increase the standard of cleanliness and hygiene at the home. As part of this inspection process we undertook a visual inspection of all areas of the home and the external grounds to assess the cleanliness of the environment and to identify that infection control procedures were now in place to ensure that the provider was now complying with regulations.

A visual inspection of the home on 21 July 2015, demonstrated that infection control procedures were not being consistently applied. During the visual inspection we found bathrooms were unclean. Six of the seven toilets had stains in the toilet bowl. We observed six commodes in

Is the service safe?

bedrooms which were also unclean. There was a strong smell of urine emanating from two bedrooms which infiltrated a whole corridor. We found carpets in two bedrooms had urine stains embedded within them. We also noted one bed had soiled bedding upon it. Two bedrooms had also been made up but had not been hoovered. We found crumbs on bedroom floors even though bedrooms had been tidied.

A visual inspection on the second day showed conditions had not improved, commodes and toilets were still dirty and we identified two beds that had been re-made up by staff even though the bedding was soiled and stained. This posed an infection control risk. Whilst undertaking the visual inspection on the second day we were accompanied by the registered provider. An inspector asked the registered provider if they thought living conditions within the bedrooms were of an acceptable standard. The registered provider said that "They were not" and "they would not be happy for their relative to live in them."

We spoke with a friend of a person who lived at the home and asked them what they thought about the standards of cleanliness at the home. The friend said, "I can't fault the care. It's just the home. It needs cleaning [Resident] lived in a lovely clean home. She would have never lived like this."

We looked at the procedures in place that identified who was responsible for cleaning. Night staff were responsible for cleaning of the kitchen, communal lounges, toilets and bathrooms. There were clear systems in place for cleaning toilets. However there was no evidence this procedure was being followed.

The action plan submitted stated cleaning duties were performed by the cleaner with some light cleaning duties being assigned to night staff. Day staff however informed us they were responsible for cleaning of people's rooms on a daily basis.

We looked at a schedule for cleaning of people's bedrooms. This included checking floors for stains and vacuuming as necessary. We spoke with staff and asked them about cleaning duties. Staff said there was no clear indication as to who was responsible for which jobs but all staff said they were unable to fully undertake cleaning as staffing levels at the home prevented them from carrying out all of their tasks. One staff member said, "Better care comes before cleaning."

One of the bedrooms had an offensive odour, we spoke with the care manager about how this was managed. They told us the bedroom was cleaned weekly. We viewed cleaning records for the person's room. Records showed this person's carpet had not been cleaned for two weeks. The previous month it had not been cleaned at all.

We viewed the cleaning roster for night staff. We noted gaps on the document which showed cleaning had not been signed for. Records for the month of July demonstrated no cleaning tasks were undertaken for eleven consecutive days. We spoke to the registered provider about the cleaning schedules, the registered provider said they were unsure as to whether jobs had been completed and recorded as they had not been responsible for managing the staff. The registered provider said, "I need to manage the situation to improve standards."

A cleaner had been recruited since the last inspection. They were recruited for twenty hours per week. We asked the registered provider what the cleaner was responsible for. The registered provider was unsure as this had not been their remit. The care manager said the cleaner was supervised by the registered manager and they also were unaware of the cleaner's full responsibilities.

We spoke with the cleaner. The cleaner said they had been given a one day orientation from the registered manager. The cleaner told us they "do what they can" to ensure cleaning is completed. The cleaner confirmed care staff were responsible for undertaking cleaning duties when they were not on shift.

We spoke with the care manager about the cleanliness of the home. The care manager said cleaning within the home required improving. The care manager said she had approached the registered manager about this to suggest more cleaning duties should be allocated to the cleaner. The care manager said, "The problem is, no one is doing anything."

We spoke with the registered provider about the conditions of cleanliness at the home and asked what progress had been made since the last inspection with regard to the infection control action plan set by the Local Authority infection prevention lead. The registered provider said they had not completed it fully and had only undertaken, "The

easy tasks including installing hand wash dispensers." This demonstrated that the risk to spread of infection continued from the previous inspection, placing people at risk of harm.

Personal Protective Equipment (PPE) was not fully available for staff. Two staff told us the provider gave them gloves to wear but aprons were not readily available. On the first day of inspection we noted that no staff members wore aprons. Aprons were provided by the fourth day of inspection.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provide had failed to assess, manage and control the risk of spread of infections within the home.

People were not protected from abuse and harm. Care records reviewed noted that safeguarding incidents had taken place since the last inspection in January 2015. We identified an incident in which a person using the service had been physically challenging towards people who lived at the home and staff. We spoke with the care manager about this incident; the care manager said they had been informed by the registered manager the incident had been reported. However we spoke with the Local Authority who confirmed they had not received any alert relating to this incident.

We also identified an incident at the home that had resulted in a service user being harmed by a piece of equipment which had not been reported as a safeguarding concern. We asked the care manager about this incident and whether or not they felt this should have been reported as a safeguarding concern. The care manager told us it was a safeguarding incident but was unaware as to whether or not it had been reported. Our system showed it had not been received as a safeguarding alert.

During the course of the inspection, we were made aware of a situation in which one person that required staff supervision had exited the home through a downstairs window. This persons care records evidenced this incident had occurred. It was also identified that this person was missing for some time and the police were notified. We asked the care manager about this incident and whether or not it had been reported to the Local Authority safeguarding team. The care manager told us she had not been made aware of this incident until we pointed it out. It had occurred on their day off and no one had communicated it to them. The registered provider said they were also unaware of this incident. Our system showed this had not been notified to us. It is a requirement that incidents involving the police are communicated with the relevant bodies in order for them to be monitored and assessed.

We asked the registered provider who was responsible for the management of safeguarding alerts. The registered provider said it would have been the job of the registered manager. The care manager told us that reporting of safeguarding alerts was the responsibility of the registered manager and no one else in the company was allocated that task. The care manager said that forms were left out for staff to complete after such incidents and that the registered manager would then deal with them. Incidents that happened in the absence of the registered manager would be dealt with when the registered manager was next in work. The provider was unable to find any evidence to show that a log of all safeguarding alerts was maintained and when alerts had been made.

We looked at the provider's policy for safeguarding vulnerable adults. The policy failed to give direction to staff as to how to report a safeguarding concern to management or what actions to take when the manager was absent. There was no reference to contacting the Local Authority of referring to CQC. This demonstrated that the provider did not have an appropriate system and process in place for reporting safeguarding concerns and to ensure partnership working with the Local Authority and the Commission.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes were not established and operated effectively to prevent abuse of people who lived at the home.

We looked at records relating to accidents and incidents. The provider had taken action since the previous inspection and had implemented a system so that all accidents and incidents were centrally stored and logged. Completed accidents and incident records showed that one person had fallen fourteen times since February 2015; another person had fallen ten times. On one occasion this had resulted in a serious injury.

We asked the care manager if these people had been referred to the falls prevention service to improve the

person's safety. The care manager said that one person had and this would be recorded in the person's appointments log but the appointments log failed to demonstrate that any referral had been made to the falls prevention service

Accident records relating to another person who lived at the home showed this person had frequently fallen. This person was found on the floor by staff six times during the period of March 2015 to July 2015 when left unsupervised. This placed the person at risk of injury. Despite the frequency of this occurring and staff being aware of these behaviours staff had not put any controls in place to prevent this from re-occurring to protect the person.

We asked the registered provider how the risk of injury following falls was managed. They said that this would have been the registered managers task and were unable to provide any evidence to show it was being suitably managed.

We were informed by the provider that there were two people who lived at the home who displayed behaviours which challenged the service. We looked at records and noted incidents had been recorded where people who lived at the service had been physically aggressive.

We spoke with staff and asked them how they managed behaviours which challenged the service and they told us that they were not equipped to manage the behaviours of the two people.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) as the provider had failed to assess the risk and do all as reasonably practical to manage the risks to ensure safe care and treatment.

People were not safe as the registered provider did not have adequate systems in place to ensure equipment being used at the home was in safe, working order. At the inspection in January 2015, we identified that the annual portable appliance testing certification had not been renewed. The registered manager agreed to carry this out as a priority and stated within the action plan that this task had been carried out. We asked the registered provider if this task had been undertaken, they were unable to state whether or not it had. They could not find a certificate to demonstrate that it had.

The provider had systems in place to deal with fire and evacuation and staff had received training in fire safety in May 2015. Following our inspection in January 2015, recommendations were made by the fire service that the provider purchased evacuation sledges to be used in emergency to transfer people who lived at the home downstairs and staff were trained to use it. We asked two staff members where the evacuation sledge was stored. Both staff were unaware of the location of the evacuation sledges.

We sourced a set of team meeting minutes that showed that evacuation sledges had been discussed; however the minutes did not reflect information provided by the Fire and Rescue Service.

We asked the care manager if staff had been trained to use the sledges during the annual fire safety training provided in May 2015. The care manager was "not sure." During the visual inspection of the home on the second day we asked the registered provider to show us the evacuation sledge and to confirm that staff had been trained to use it. We were taken to a spare bedroom which was being used to store unused equipment. The evacuation sledge was in there amongst other equipment. The evacuation sledge was still in unopened packaging, this suggested that the evacuation sledge had not been shown or demonstrated to staff. We asked the registered provider if staff had been shown how to use the sledge. The registered provider replied, "It didn't look as if they had."

Prior to the inspection taking place, we were contacted by the senior environmental health officer at Lancaster City Council. They made us aware of issues relating to the boiler and the ventilation in the kitchen. We were made aware that during their inspection they noted there was no hot water to the kitchen and some of the bedrooms. They were informed by the registered provider there was a fault on the boiler which required repairing. The environmental health officer also informed us the gas cooker had been labelled as unsafe to use by a gas safe engineer. The environmental health placed an improvement notice upon the home and instructed them to repair the boiler and have the ventilation issue addressed by 30 July 2015.

On the first day of inspection we noted that the gas cooker was being used by staff to cook lunch. We asked the registered provider if the repair to the boiler and work to the ventilation had been carried out. The registered provider told us all work had been carried out and both the boiler and the gas cooker were now back in use and safe. We asked to look at the certification to show that it was

now safe to use the cooker. The registered provider stated he did not have a certificate as he had completed the work to the ventilation himself. The registered person was not an approved gas safe engineer. The registered provider confirmed the boiler was back in use and being used to supply hot water. On the fourth day of the inspection we were informed that the boiler was still unsafe and had been switched off once more.

The registered provider had also failed to ensure that the premises were properly maintained. We asked relatives and visitors what they thought of the environment. One relative we spoke with said, "It [the property] could do with a lick of paint. It needs brightening up a bit. I think it could do with being decorated. These people in here don't have much to look forward to; if it was a bit brighter it would be nicer for them."

Whilst undertaking the visual inspection of the home, inspectors noted that premises were poorly maintained. We found wallpaper was peeling from a bedroom wall, there was cracks in the plaster and a damp spot on the wall. Inspectors noted a crack in one bedroom sink which had been sealed over using tape, not only was this an infection control risk it was also a hazard as the person could cut themselves on the broken enamel. Two bedrooms had a set of broken drawers within them and one bedroom had a ripped headboard. One bathroom had a hole in the wall, where an electrical fan had been taken out due to it setting on fire over 18 months ago and had not been repaired. A hole in a bathroom ceiling that was identified and brought to the attention of the registered manager at the previous inspection had still not been repaired. The provider said it had not been repaired because it was linked to a ventilation pipe within the kitchen which still required repairing.

We found bedrooms had missing light bulbs and light bulbs that did not work. This placed people at risk of falling due to inadequate lighting. We asked the registered provider about systems in place to replace light bulbs, he informed us that staff were supposed to change light bulbs as soon as they noticed they needed replacing and said, "They obviously aren't doing as they are told. Standards have slipped. They need a manager and direction."

The environmental health officer had informed us that following a visit in June 2015, they had made recommendations that old unused furnishings being stored outside the home were removed as a means to reduce the risk of rodent harbourage. On the first day of inspection we noted these old furnishings were still being stored outside of the home and had not been removed as suggested.

We asked to see the maintenance schedule and records for the upkeep of the building. The registered provider was unable to locate any schedules or records. The registered provider told us they were responsible for the maintenance and upkeep of the building, however explained they had been away from work for a period of three months. The registered provider did not know where schedules were being kept and stated that he thought it was obvious staff were not doing their job correctly and completing maintenance requests.

We also asked the registered provider who completed maintenance checks of the building. The registered provider stated this was their job but they had not completed a check of the building this week due to having to work on covering the tasks of the registered manager. The registered provider could not provide any paperwork to evidence regular maintenance checks took place.

During a visual inspection of the home we noted window restrictors were fitted to some but not all windows. The restrictors were fitted were not suitable and sufficient and when forced could be removed from the window. This meant the premises were not secure.

This was a continued breach of regulation 15 of the Health & Social Care Act 2008 (Regulated activities) Regulations 2014 as the provider had failed to ensure that all equipment used was properly located and properly maintained.

We found best practice for administering medicines was not always followed. The person who was administering medicines confirmed they had received additional training to undertake the role and felt confident doing it. We were told the registered manager ordered the prescriptions and we saw that a system was in place for the receipt and recording of dispensed items. Medicines administration records were appropriately signed when a person had refused their medicine but we noted the reason for refusal was not recorded on the MAR sheet. This meant an audit was not kept to ascertain why people were refusing medicines.

During the observation we noted soluble medicines which required to be given in water were given out first. The staff

member signed for the medicines to state they had been taken before the medicines were administered. We observed the staff member taking multiple medicines that were soluble from the cabinet and mixing them with water. The staff member used water glasses which were the same as glasses used over lunch time. It was difficult to assess which glass had whose medication within them. Once the medicine had dispersed it was impossible to tell them apart from a plain glass of water. The glasses were placed on the dining table for the people and were left unsupervised. We had to intervene when we saw at least two people who were about to be escorted away from the table without taking their medicine. It was also unsafe to leave these medicines unattended, particularly when it could have been mistaken for a drink and is easily in reach of people who have disorders of perception that make them vulnerable.

During the course of the visual inspection of the home, inspectors also identified a number of creams and ointments which had been left in people's bedrooms and were not being stored securely. It was noted some of these creams being stored in people's rooms had not been prescribed to that person. We noted that in one room, two tubes of steroids were left on the side, there were no body maps or instructions available to guide staff as to where the steroids needed applying. We asked the care manager about this and they informed us that these were creams and ointments which were no longer in use and would ensure they were removed immediately.

We also noted a full sharps box and an unopened needle and water ampules were being inappropriately stored in a person's bedroom. Although the sharps box was secure there was a risk that a person who is confused may open this and be exposed to a sharps injury. There was no explanation as to why these were in the room and they were still present in the room on the second day of inspection.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure that medicines were appropriately managed in line with current legislation and guidance.

Inadequate

Is the service effective?

Our findings

All of the four people we spoke with told us that the care provided was good and that they were happy with the care. One person said, "I live here, it's alright, but I can't compare it to elsewhere. Everybody is cheerful."

Two of the relatives we spoke with said that the staff at the home were very good at communicating with them. One relative said, "The care is good. I am always kept up to date with my relatives health needs. If their condition changes they always contact me." Another relative said. "It's not exactly the Ritz but the care is good."

Although people and their relatives using the service said that the care they received was good we found that effective care was not always delivered.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

At our previous inspection in January 2015, we highlighted to the provider the need to be compliant with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards, (DoLS) We had asked the provider to complete an action plan to demonstrate how and when compliance would be achieved. The registered manager failed to state within the action plan how they had planned to become compliant.

Whilst carrying out the visual inspection of the home inspectors noted that restrictions were in place which would restrict people's movements. We observed that the front door had a lockable key code upon it and only staff had the code to open the door. 5 bedrooms had "Wandamats" in place. "Wandamats" are sensored mats that trigger an alarm when pressure is placed upon them. These mats alert staff when people are walking around rooms. Care plans demonstrated that these mats were in place to alert staff when people were up during the night. Two bedrooms also had bedsides upon them to secure people in the bed. Bedroom doors were locked throughout the day and people who lacked capacity did not have keys to their bedrooms. This meant that access to bedrooms was restricted.

Whilst visiting the home, an inspector observed a person asking how they could get out of the property. The person wanted to go shopping. Staff restricted movements by using distraction techniques to prevent the person leaving. There was no DoLS in place for this person.

Care records belonging to another individual showed that the individual had tried to leave the building on five occasions within a five day period. We asked the care manager if a DoLS application had been made to restrict this person from leaving and we were informed that it had not.

We spoke with the care manager to ascertain if all other DoLS applications had now been made. The care manager said that they were still on-going with this task. We asked to see the copies of all completed applications and were given a file containing applications for five people. Of these five people, only three people were currently living at the home and one was due to leave. The care manager said that they still had to complete DoLS applications for the remaining sixteen people who lived at the home. They had been unable to complete them before now as they had been too busy carrying out other tasks.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people using the service were being deprived of their liberty without lawful authority.

The MCA provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be, and is not, implemented then people are denied rights to which they are legally entitled.

The care manager said that all people who lived at the home lacked capacity. We looked at care records belonging to people who lived at the home to ensure that decisions being made on behalf of people were being made in accordance with the Mental Capacity Act 2005. Of the six files that we looked at, every person had forms in their file in relation to consenting to personal care and having photographs taken. Some people had consent forms to allow the provider to manage their finances for them.

Inadequate

Is the service effective?

There was clear indication within three people's files that the people did not have capacity. One person had legal arrangements in place with a solicitor for the management of their finances as they lacked capacity. However a staff member had recorded that they had discussed finances with the individual and that the person had consented to the provider to look after their petty cash. Within another person's records legal arrangements were in place for a solicitor to manage the person's finances. It was clearly documented that the solicitor could only make decisions in regards to the person's finances but staff had requested and accepted consent from the solicitor to manage the person's personal care. We identified these anomalies with the care manager who said that she had delegated the task of receiving consent to a senior member of staff and they had realised now that they had made mistakes. However despite knowing these consent forms were invalid they were still present in peoples files. This demonstrated that the provider continued to have a poor working knowledge of the MCA.

Although the care manager informed us that everyone who lived at the home lacked capacity there was no evidence in people's files to show that capacity assessments had been undertaken for people. We asked the care manager if any capacity assessments had been undertaken. They said that they were not aware of any. This indicated a lack of understanding around the assessment of mental capacity, the ability to consent and the correct processes to ensure someone was protected from harm.

Two people who lived at the home had hospital beds in place with bedrails in situ. Bedrails can be used to protect people from falling out of bed; they also deprive people of their liberty. Staff confirmed that bedrails were used at night time. There was no information within the people's files to show that a capacity assessment had been carried out prior to a decision being made to use the bedrails. There was also no evidence to suggest a best interests meeting had taken place to ensure that this was the least restrictive option available and in the best interests of the person. The care manager said that the agreement to use the bedrails was made in conjunction with the district nursing team but said that she was not aware of any best interests meeting being documented. The provider had failed to follow their own policy in this instance and had failed to complete the paperwork as stated within their policy.

This was a continued breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure that care and treatment was provided with the consent of the relevant person and that procedures were followed in accordance with the 2005 Act when people did not have capacity.

We asked staff about their awareness of the DoLS. Staff told us that they had received no training in DoLS and awareness of the MCA 2005. One staff member told us that they did not know about it as it was not their job to do so. One staff member said that she had been given a place on a Mental Capacity awareness training day but had not gone as she "had a rare day off."

We looked at training records to assess how many staff had been provided with the training in this area. The up to date training grid showed that only the registered manager and the care manager had received any training in this.

Prior to carrying out the inspection, we reviewed the action plan completed by the registered manager in relation to managing behaviours which challenged. Within the action plan the registered manager informed us that staff had completed training in behaviour that challenge. We spoke with staff to see if they thought they were equipped with the skills required to carry out their tasks fully. Two care staff informed us that they had not received any training in behaviours which challenged to provide them with skills to carry out their role effectively.

At the beginning of the inspection we were made aware that one person had been admitted to the home on respite but returned home early as the provider had been unable to manage their behaviours. These behaviours had been identified prior to the placement commencing, however the provider had not put effective systems in place to support the person, and this included ensuring that staff were competently trained to work with them. One staff member said, "We are dealing with residents who are inappropriately placed. We haven't the training."

The lack of training for staff within the area of behaviours that may challenge put both staff and people who lived at the home at risk of harm.

We looked at the training matrix which was maintained by the registered manager. The registered manager had started to make some improvement with the training

Is the service effective?

matrix by adding the dates on which staff had completed training. The training matrix also showed that an additional six members of staff had attended dementia awareness training since the last inspection.

The training matrix identified that there were 16 staff employed to work at the home. None of the staff had received full training as set out on the matrix. Five staff members on the training matrix had commenced work since the last inspection in January 2015. Only one of these staff members had attended any training since commencing work. The cook had still not received any food hygiene training and the cleaner had also not been provided with any training relative to their role.

We spoke with staff to confirm whether or not training had been provided to enable them to develop skills and knowledge. Four staff said that they had not been offered any training by the registered manager. Two staff said that they had been offered a day's training but had been unable to attend.

We asked staff about provisions for induction. Staff said there was no set induction and that they were shadowed staff at the beginning of the employment. The care manager expressed concerns about the standard of induction for new starters. The care manager stated that it was their role to ensure that staff were doing their job correctly but said that at present they did not have the time to delegate and guide new staff. We asked the registered provider about training and induction. They said that at present they were not aware of any formal system for staff induction as this had been the registered manager's job.

One staff member stated that new staff were being recruited without any experience of working in a care setting. Another staff member expressed concerns about the number of new staff being recruited at the home and the lack of training provided. They expressed concerns, saying, "We have got inadequate staff working with inadequate staff."

The chef was absent from work for the duration of the inspection and a carer was standing in for them in the kitchen. The staff member said, "I've not had any food hygiene training, I'm waiting to do this but I know how to do it."

This was a breach of regulation 18 of the Health & Social Care Act 2008, (Regulated Activities) Regulations 2014, because the provider had failed to ensure that staff received appropriate training to carry out their role.

People we spoke with said that the food provided was good and had no complaints. Relatives also said that the food was good. We observed food being served at lunchtime, people were offered a range of choices to meet their preferred requirements. During the lunchtime meal we observed the cook asking people what they would like for their tea.

Observations at lunch time were positive. Staffing levels were deployed appropriately to ensure that those who required support with eating received help in a timely manner. Staff took the time to interact with people and make the experience a positive one. Drinks of water and cups of tea were available during meal time for those who required it. People's dignity was maintained as people were offered aprons to protect their clothes from staining. Plate guards were used for people who required them.

We observed people being offered drinks and biscuits throughout the day. This meant people were given enough fluids and snacks to meet their individual needs.

Individual care files showed that records were kept of all health professionals input. Records showed that the home worked closely with the District Nursing team, the Rapid Intervention Team and peoples GP's. One relative told us that there relatives health needs were always met and that they were always communicated with after relevant appointments. On the day of inspection one person was complaining of tooth ache. The care manager informed us that this person had been to the dentist the day previous and had been prescribed pain relief to manage the pain. The staff took this person's needs into consideration at lunch time and offered several different meals to take into account that this person was finding it difficult to eat. This demonstrated on this occasion that staff had acted in a timely manner to address the person's pain and showed empathy towards the person.

Requires improvement

Is the service caring?

Our findings

Relatives of the people using the service said that the staff were caring. One person said [Relative] has been here for years. They have done well. Staff here are friendly and caring and I've never had the need to complain."

Staff spoke fondly about the people they cared for. One staff member described them as "My ladies." Another staff member became upset and said that staffing levels and cleaning tasks were taking them away for caring for the people. A further staff member said, "I do go home and worry about them [the people who lived at the home]. The rooms could do with tidying but its nicer spending more time with the residents." All staff remained committed to the people they supported despite the negative working conditions they described.

We observed some positive interactions throughout the inspection between staff and people who lived at the service. On one occasion we observed a staff member supporting a person to go downstairs using the stair lift. The staff member showed patience and offered the person support by staying with them at all times. The staff member communicated with the person, making small talk and showing a caring approach.

We also observed another staff member taking time out to from their tasks speak with a person who had limited communication. The person was shouting trying to get the staff member's attention and was becoming frustrated. The staff member realised that the person was trying to attract their attention and came over and bent down to get eye contact with them. The staff member then used appropriate touch to calm the person down. The individual soon calmed down and appeared relaxed again.

We also observed the registered provider sitting with another person who was showing signs of distress. The registered provider noticed that the person was distressed and pulled a chair up to sit with the person. Because of the person's condition, their speech was limited and the person did not respond immediately. The registered provider demonstrated patience and waited for the person to find the words. The registered provider stepped in and assisted at appropriate times.

Staff were aware of people's likes and dislikes and engaged in conversation with people about their interests. Staff showed a good understanding of the individual choices and wishes for people within their care. We observed staff laughing and joking with people and people looked comfortable in the presence of staff.

We also saw staff were very patient when accompanying people to mobilise from one room to another. This showed concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety. We overheard one staff member joking with one person as they were walking, stating that they would be running the London marathon this time next year. This was well received by the person who started laughing.

Throughout the day we observed staff enquiring about the comfort of people who lived at the home. Staff routinely enquired to ask people if they were ok. Staff responded in a timely manner when people asked for assistance. One person who lived at the home said, "Staff are alright here, they will do owt for you. If I need help they will come. They give me a brew when I ask for one."

Throughout the inspection we observed relatives and friends visiting people who lived at the home. Staff ensured that visitors had a place to meet with people in private. Visitors said that they were always made welcome by staff.

Although some progress had been made since the inspection in January 2015 to address privacy and dignity this was still not being fully achieved. Locks had been fixed in most bathrooms to ensure privacy and dignity but we found one communal bathroom had still not been fitted with a lock. The registered provider acknowledged that this had not been done and said that it must had been an oversight.

We observed some poor practice of staff members entering bedrooms belonging to people without knocking beforehand. Although staff assumed that the rooms were empty they did not check and knock beforehand.

We recommend that the provider looks at systems in place to address and promote the privacy and dignity of people who live at the home.

Requires improvement

Is the service responsive?

Our findings

One person who lived at the home told us that they had no complaints as the staff were so good at helping when required.

Relatives we spoke with all said that they were happy with the care provided. One relative said, "I've never had a need to complain. The staff are great."

We looked at care records belonging to six people who lived at the home. There was evidence in the files that care and treatment were personalised to meet their needs. Families and the people receiving care were included in the assessment and care planning process. Staff supported and encouraged people to express their views and wishes, to enable them to make informed choices and decisions about their care and support. Two files contained information relating to the person's preferences and life history. Life histories enable staff to have an understanding of the life experiences that have shaped the person into the person that they now are.

We found that care provided was not always responsive as records were not always up to date and accurate. We found one person who was at high risk of falls had documentation in place that stated that the person had last fallen in February 2015. When we looked at accidents and incidents we identified that the person had fallen a further fourteen times since this date but the accidents had not been transferred and recorded in the person's personal file and the person's falls risk assessment had not been updated.

One person who was at high risk of falls also had missing information relating to falls within their records. We found ten falls had occurred since February and these were not recorded on the person's fall record and consequently their falls risk assessment and care plan had not been updated.

Another person's file showed that the person had experienced pressure sores but the risk assessments which relate to pressure care had not been updated for two years to show that this person had pressure sores and was at risk. Records belonging to this person also indicated that this person had been involved in an accident but there was no corresponding accident report in the accident record.

Records belonging to one person who lived at the home indicated that this person had Clostridium difficile (C-diff.) C-diff infection is a type of bacterial infection that can affect the digestive system**.** Symptoms of C-diff can range from mild to severe and can be life threatening. Older people are most at risk from the infection, especially those who are frail or with medical conditions. The care plan file recorded that infection control procedures were in place to manage this. When asked to describe the procedure in place staff were unaware of the procedures. We were later informed that the procedure in the file was not up to date, hence why staff were not following the procedure. This could present confusion to staff as care was not consistent with what was documented in the care plan.

Records belonging to two people who had bedrails in place failed to evidence that risk assessments had been undertaken to ensure the suitability of using the bed rails prior to bedrails being used. We asked the care manager about this and they said that this was the responsibility of the District nursing team. There was also no documentation in place to advise staff on how often bedrails should be used and whether bumpers were required.

Care provided was not always responsive to need as the provider failed to learn from incidents and assess the risk accordingly. Records showed that staff were aware of one person's desire to leave the home at any cost. The person had tried to leave the home by a window on a daily basis for three consecutive days. Despite these incidents occurring staff left this person unsupervised in the lounge with an unsecured window. Consequently this person exited the premises from the window when left alone. This placed the person at risk of harm as they required support when out in the community.

This was a breach if regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to assess the risks to the Health and Safety of people who lived at the home.

We spoke with the care manager and expressed concerns about the quality of the paperwork. The care manager said that they were aware paperwork was out of date. The care manager said that following the last inspection they had delegated tasks to senior staff to update files but seniors had refused to do this task. We asked the care manager how many files were up to date. The care manager said that five of the nineteen people who lived at the home had up to date records.

Requires improvement

Is the service responsive?

There was evidence in one person's file of input from the Community Home Liaison Team (CHLT.) Staff described this person "challenging" and had requested support and guidance to manage the behaviours. The CHLT had put in place an "Antecedent, Behaviour, Consequence, (ABC) Chart to monitor the person's behaviours and had requested that the provider completes the record for two weeks. The chart in the record had only been completed for two days. This meant that inappropriate behaviours were not effectively recorded and reported on as a means to understand and predict behaviour.

This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014 because the registered provider had failed to ensure that records were kept up to date and accurate.

Although feedback from people who lived at the service and relatives was positive, we received negative feedback from staff about the responsiveness of the provider. Staff informed us that following the inspection in January 2015 care staff came forward and wrote letters of concern to the registered provider. Staff informed us that these concerns were never addressed and staff were not responded to.

We asked the registered provider about this and they acknowledged that staff had raised concerns. We asked to see the letters of concern but the registered provider said that they were unable to locate them and was unable to say whether or not investigations had taken place following the letters. The registered provider could not tell us what content was in the letters, stating that the registered manager must have them. This demonstrated that the provider failed to have appropriate systems in place for responding and acting upon complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to establish and operate effectively an accessible system for receiving, recording and handling complaints.

During the inspection in July 2015 we found that improvements had commenced to increase the activities on offer to people who lived at the home. When we spoke with people at this inspection, people could not tell us what activities were on offer but we saw evidence that suggested activities had increased. A member of staff had been allocated the role of activities coordinator but staff said that this role was in addition to their caring role and that the person was "running themselves ragged." Although activities had increased staff informed us that carrying out recreational activities relied on full staffing being in place and staffing had recently impacted upon the frequency of activity taking place. Completed activity records suggested however that activities were still taking place on a daily basis.

The provider had started keeping logs of all activities that people took part in and individual records showed that people had participated in some activities. There was evidence of two people being supported to access the community, people being encouraged to take place in gentle exercise and cooking. On the first day of inspection we observed staff encouraging people to participate in throwing and catching a soft ball. The staff member knew who would benefit from participating and who would not enjoy the activity and involved people accordingly. On two days we visited we observed people benefitting from having their hair styled from a visiting hairdresser. One relative confirmed that the hairdresser visited weekly and that their relative took great pleasure in having their hair styled weekly. We noted that equipment belonging to people had been personalised with name tags made by the people who lived at the home.

Whilst we were visiting we noted an activities schedule had been placed on the wall. The staff were planning to organise an afternoon tea party for one of the days that week. Staff were talking with the cook and planning in what items they were required to purchase. We observed staff completing quizzes with people, reading the newspaper to people and having sing a long sessions. People were actively engaged and enjoying the sessions on offer.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in place, however we received information before the inspection that the registered manager was absent and was likely to be absent for a significant period of time.

Following the inspection in January 2015 we identified multiple breaches to regulations and we requested that the provider completed an action plan to demonstrate how and when they were going to achieve compliance. The registered provider told us that the registered manager had not made them aware or involved them in the action plan. They said that the registered manager had not communicated with them about the action plan. We therefore supplied the registered provider with a copy to look over and comment on.

During feedback with the registered provider we expressed concerns about the accuracy of the contents and the registered manager's records that stated actions had been completed. The registered provider said, "I can pick holes in the action plan. I've not seen it before but I know it's inaccurate. Staffing has not been addressed properly; more competent staff should have been taken on. Lounges haven't been cleaned. It's inaccurate." When we asked the registered provider of their intentions to make improvements they said, " I can turn it around but not overnight".

Despite staff turn-over being highlighted as a concern at the inspection in January 2015, there was no evidence available to demonstrate that the registered manager had carried out any analysis to see why staff were not committed to staying with the company. All the staff we spoke with said that staff turnover was a concern. Two staff members said that things had become worse since the inspection in January 2015. The care manager stated that despite the registered manager recruiting new staff, retaining them was difficult and said that staff, "did not stay for longer than ten minutes." Two staff said that the provider was unable to keep good staff, both saying, "All the good staff leave." There was no evidence to suggest that concerns expressed by staff in the last inspection report regarding long shifts, lack of training, supervision and workloads of staff had been addressed by the registered manager in an attempt to improve working conditions and retain staff. There was no evidence to suggest that the registered manager had not reviewed the job roles since the last inspection and staff still described workloads as high and impacting upon service quality.

Staff were negative about the way in which the service was managed and the effectiveness of management. Staff said that the culture of the home was closed; management was unwilling to listen to concerns, comments and suggestions as to how the service could be improved. One staff member said, "I have tried making suggestions but they go unheard. That's why people are leaving. We need a manager and we need a new structure."

All staff described a negative working environment in which staff were not happy. Two staff said that staff were not appreciated by management and were not supported by management. One staff member described the registered manager as "Unapproachable." Another member of staff described a "blame culture" within the home saying that if things went wrong they felt that blame was placed upon them.

Staff also said that there was a lack of management presence and direction from managers. The care manager said that due to workloads they were unable to complete their role as a manager and were unable to offer guidance to staff. One staff member said, "There is no structure, no management and no leadership." One staff described a difficult situation they had encountered a week earlier and said "management were nowhere to be seen."

One staff member spoke of the lack of effectiveness of the registered manager and said that staff did not listen to or respect the registered manager. They said that sometimes staff did as they chose. The staff member used an example of when changes were implemented and staff refused to accept the changes and refused to do the task in hand.

The care manager said that they had tried to make changes since the last inspection but had been powerless to do so as staff were reluctant to work with them and had complained to management to have the actions over-ruled. This meant that necessary work was not been completed and people's files were not up to date.

We spoke with the care manager about an incident that had been reported in one person's care records. The incident suggested that the person had been unlawfully deprived of their liberty stating, "[Person who lived at the service] became more agitated and had to be put in their

room to calm down." We asked the care manager about this incident who said that the incident had been worded inaccurately by the staff member. The care manager went on to say that the member of staff had since had their contract terminated for another reason involving another safeguarding matter. We asked to see the investigation notes from the disciplinary.

The care manager was unable to source any minutes but then explained that they remembered no formal investigation had taken place as the member of staff had resigned before an investigation could take place. Consequently no further action had been taken. This demonstrated the registered manager had failed in their duties to carry out a formal investigation and report to the necessary agencies any concerns about the suitability of this staff member for working with vulnerable people.

The CQC places a statutory responsibility on a registered manager to inform CQC of all safeguarding concerns, serious injuries and deaths that occur within the registered location. However, at this inspection we found evidence to show that the registered manager had failed in reporting incidents to the CQC. Records showed that the registered manager had continued to fail to identify and report safeguarding concerns to the Local Authority and CQC. We identified multiple incidents where people who lived at the service had assaulted other people who lived at the service, one serious injury and evidence of police involvement at the home that had not been reported to the Commission. We also noted that the registered manager had failed to notify the commission when a DoLS for a person was no longer in place.

This was a breach of the Care Quality Commission (Registration) Regulations 2009 because the registered manager had failed to notify the commission, without delay of all notifiable incidents.

During the inspection we noted an incident in which a person was placed at harm when the person left the home unsupervised. We asked the registered person about this incident, the registered person was unaware of this incident and said that the registered manager must have dealt with it. The registered provider was unable to locate any documentation in relation to the incident to demonstrate that the registered manager had offered an apology and informed the notifiable agencies of the event.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Act 2014 because appropriate systems were not established to ensure that Duty of Candour was considered and acted upon when incidents that had the potential to cause or actually cause harm were investigated and reported upon.

Although the registered manager had policies in place, we noted that they were not always fit for purpose and were not consistently followed by staff. A DoLS policy in place did not provide a clear explanation of the principles of the Deprivation of Liberty Safeguards and did not give direction to staff about the processes to follow. There were no further references to signpost the reader further. The safeguarding of vulnerable adults policy directed staff to inform their line manager if they had concerns but did not offer guidance on what to do when the line manager is absent from work. There was no signposting to the Local Authority and no contact numbers were present. There was also no reference to whistle blowing. An accident policy clearly stated that CQC should be notified of serious incidents. During inspection we identified a serious injury that had not been received by the Commission.

Procedures for storing of information was unclear and disorganised. The registered provider was unable to locate documents at our request. Information relating to staff was missing and a full personnel file relating to one member of staff was missing. The registered manager had not completed records to demonstrate what tasks had been completed since the last inspection.

There was no evidence of quality audits taking place. The provider did not have systems in place to identify, assess and manage risks to the health, safety and welfare of the people who lived at the home. Health and safety audits, medication audits, infection control audits and care planning audits did not take place. As a result there were no systems in place to regularly review and improve the service. Consequently the provider did not pick up on the inadequacies in care provision that were identified during this inspection.

The registered provider had no formal systems in place to manage and identify environmental risks. At the inspection in January 2015, we highlighted that the Portable Appliance Testing was out of date. The registered manager had assured us that this work had been completed but the

Inadequate

Is the service well-led?

registered provider could not find any evidence to suggest that it had been done and was unable to verify that it had been done. The registered provider said that he "assumed the work had not been done."

During the visual inspection of the building, inspectors identified several environmental risks that had not been identified, reported and responded to by staff. Lightbulbs were missing, we found a cracked vase in a bedroom, equipment was poorly stored and we identified broken items of furniture. These should have been identified and actioned through quality audits.

We noted that procedures for cleaning of bedrooms and infection control procedures were not followed by staff. These inconsistencies were not picked up by the registered manager and dealt with in a timely manner to ensure consistency and high quality care was achieved. We spoke with the registered provider about this and they said, "The staff need a leader, they need direction to make sure they are doing what they are supposed to do."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess, monitor and improve the quality of the service being provided.

Records showed that the registered manager had held one team meeting since the previous inspection in January 2015. The care manager had started to carry out some supervision's with staff but this was restricted due to their heavy workload. There was no documentation to evidence any other meetings had taken place.

Since the last inspection the registered provider had started holding residents meetings to increase the voice and empower people who lived at the home to have more of a say in the running of the home. The care manager showed us copies of the residents meetings that had already been held. A meeting had been organised for the week previous to our visit but we were informed that this had not gone ahead due to problems with staffing levels. One person told us that they were aware of the meetings but had not attended.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Systems were not in place to ensure that care and consent of people using the service was obtained by appropriate means. The provider had failed to follow the MCA (2005) code of practice when people lacked capacity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment for people using the service was not provided in a safe way. The provider had failed to assess the risks to the health and safety of people who used the service. The provider had failed to ensure the proper and safe management of medicines. The provider had failed to ensure systems and processes were in place to assess the risk of, prevent, detect and control the spread of infections.

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 registered provider failed to protect people using the service from abuse and improper treatment. Systems and processes were nor established and operated effectively to prevent the abuse of people using the service. Lawful Authority was not received to deprive people using the service of their liberty.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered provider failed to ensure that the premises and equipment was clean, secure and properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate an effective system for identifying, receiving, recording and handling complaints. The provider had failed to investigate and respond to complaints raised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and effectively operated to ensure compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. The provider had failed to ensure that training and support was available to enable staff to carry out their role.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have suitable systems and processes in place to ensure that people employed were of good character and had the skills and competencies, skills and experience which are necessary for the work.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The provider failed to act in an open and transparent way, failing to provide relevant information in relation to an incident that had occurred which had placed a person at harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to report all notifiable incidents to the Care Quality Commission.